Past, Present, and Future of the Asylum

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Inspiration

Behavioral health is a component of all healthcare because physical illness always affects one’s mental state. As designers, we take an oath to protect safety and welfare of the public. We support healthcare providers in fulfilling their oath to first, do no harm. What happens when we merge those oaths in the context of society’s most challenging patients: mental health patients?

More people have mental health issues than one may think. The Centers for Disease Control and Prevention estimates 26.2 percent of Americans ages 18 and older—more than one in four adults—suffer from a diagnosable mental disorder in a given year. Mental health patients need protection and safety because of their vulnerability.

Our true character as a society is revealed by how we care for our most vulnerable members. This research exploration takes an historical tour of how society stereotyped mental health patients and neglected their environmental needs, with the goal of transforming mental health environments now and in the future.

Goals

1. Examine the history of behavioral health treatment and facilities and major turning points in facility design (see Appendix B, Fig. 1).

2. Understand how law and policy reform impact the infrastructure needs of behavioral health facilities and the financial reimbursement model of services provided.

3. Transform the future of behavioral health facility design based on recommendations garnered from our research.

Summary History of Mental Health

Early Perception of Mental Illness

In the latter part of the Middle Ages, insane asylums were created to take the mentally ill people off of the streets. These asylums were in reality prisons and not treatment centers. They were filthy and dark and the inmates were chained, being treated more like animals than human beings.

Then in 1792, at an asylum in Paris, an experiment was conducted. The chains were removed from the inmates, and much to the amazement of the skeptics of the time, the unchaining of
these "animals" was a success. It was found that once the inmates were released from the chains, and put into clean, sunny rooms instead of dark, filthy dungeons, and treated kindly as a person and not a wild ferocious animal; many of these people, who were considered hopelessly mad, were able to leave the asylum as a result of their recovery.

Some of the early treatments used to cure the mentally ill were in reality, torture masked as treatment. In the early nineteenth century, English asylums used a rotating device in which the patient was whirled around at a high speed. And as late as the end of the nineteenth century, one treatment swung the patient around while he was in a harness to "calm the nerves" and yet another early treatment branded a patient's head with a red hot iron, used to "bring him to his senses."

The discovery of the syphilis spirochete in 1905 proved that there could be a physical cause for mental disorders. Soon Sigmund Freud came along and he and his followers showed that mental illness can be a function of environmental factors. But even with these alternative ways of viewing and understanding mental illness, along with the new scientific advances, the general public in the early 1900's still had no real understanding of mental illness and viewed those in mental hospitals as objects of fear and horror.

A study of human history will offer many different levels of acceptance, and “solutions” to mental illness. This history extends back hundreds, even thousands of years. It bridges all cultures. Those “solutions” ranged from compassionate to brutal, underscoring that we have only recently begun to understand these illnesses.

One common thread through history is society’s discomfort with experiencing mental health conditions. Mental illness was often responded to with fear. Institutions were the agents that responded to these conditions in individuals. The institutions were typically religious, care giving, governmental, or of a law enforcement nature. Containment or restraining of the afflicted individual was not uncommon. This gave rise to the relatively recent concept of institutionalization—where the afflicted individual would literally remain in the confines of the intervening institution. This was sometimes an indefinite stay.


**Pioneers in Treatment**

Mankind has long struggled to understand, identify, and treat mental illness.

Institutionalization was a prevailing model of treatment in the 1700’s, around the time that the United States was formed. American history in mental health begins with this model, inherited from Western Europe.

The first hospital for the mentally ill in the American Colonies was opened in Williamsburg, Virginia in 1773. Seventy years later, only seven additional “asylums for the insane” had been built in the U.S., despite ever-expanding patient populations. The system was strained. Recognition of this need gave rise to advocates for change. They would become pioneers who
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shaped the model of care from the 1840’s through the early 20th century. Some of the most noteworthy individuals include Dorothea Dix, Thomas Kirkbride and Nellie Bly.

Dorothea Dix (April 4, 1802–July 17, 1887)

An early nursing pioneer, Dorothea Lynde Dix was a noted humanitarian, reformer, educator and crusader. She is perhaps best known for her patient advocacy in fighting to improve the conditions of jails and mental asylums in North America and Europe.

Departing a 24-year career as a school teacher, Dorothea Dix began her second career at the age of 39 as a nurse. Dix was not educated as a nurse, but modern nursing did not yet exist. In fact, Dix became one of modern nursing's pioneers, pursuing the core value that drives the provision of all other nursing care: patient advocacy.

In March 1841, she visited the Cambridge House of Corrections to teach Sunday class for women inmates. The scenes she encountered there, which were nearly identical to those at "mental health" facilities she had toured throughout North America and Europe, changed her life. Mentally ill people were kept in the same facilities with prisoners, chained in dark enclosed spaces, lying in their own filth, without adequate clothing, and abused physically and sexually.

Dix took the matter to court and fought serious battles, some of which she won. She began her drive for improvement of jails and care for the mentally ill throughout Massachusetts. In 1843, she asked the Massachusetts legislature for reforms to end the inhumane conditions of the mentally ill. In 1845, Dix wrote Remarks on Prisons and Prison Discipline in the United States. This work discussed the reforms she wanted the government to implement, including the education of prisoners and the separation of various types of offenders.

During the following decades, her tireless crusade extended far and wide, including outside of the United States. She helped to establish 32 new hospitals in New Jersey, Pennsylvania, Indiana, Illinois, Kentucky, Missouri, Tennessee, Mississippi, Louisiana, North Carolina, and Maryland. She also helped establish a government hospital, which later became St. Elizabeth's in Washington, D.C. And between 1843 and 1880—the main years that she spent advocating for the mentally ill—the number of hospitals for the mentally ill increased almost ten-fold, from 13 to 123. "Where new institutions were not required, she fostered the reorganization, enlargement, and restaffing—with well-trained, intelligent personnel—of already existing hospitals." This achievement indicates that her work led to vast improvements in the fledgling profession of nursing. Her efforts eventually resulted in the founding of special facilities for the insane and destitute in the United States, Canada, and at least 13 European countries. She also sent a document to the United States Congress asking that
five million acres be given to be used for the care of the mentally ill. Dix was a woman far ahead of her time, advocating a role for the national government in such care.

After the war, Dix dedicated the rest of her life to improving the lives of the mentally ill, before retiring at the age of 82. Her 41 years of empathy for the mentally ill can be summarized in her own words: “If I am cold, they are cold; if I am weary, they are distressed; if I am alone, they are abandoned.” Dorothea Lynde Dix died in 1887 at the age of 85 and was buried in Mount Auburn Cemetery in Cambridge, Massachusetts.


**Thomas Kirkbride (July 31, 1809–December 16, 1883)**

Dr. Thomas Story Kirkbride was an advocate of an asylum system based on the tenets of Moral Treatment*. In his annual reports as the superintendent of the Philadelphia Hospital for the Insane and in his published treatise on asylum design and function, Dr. Kirkbride promoted a set of detailed principles that influenced the construction and operation of many American asylums built during the Moral Treatment period. Seen by Kirkbride as active participants in therapy, the asylum buildings and their surroundings were a central component of his concept of treatment.

Kirkbride was a founding member of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII)—forerunner of the American Psychiatric Association—serving first as secretary, then later as president. Through this association and in his writings, Kirkbride promoted his standardized method of asylum construction and mental health treatment, popularly known as the Kirkbride Plan, which significantly influenced the entire American asylum community during his lifetime.

Similar to the asylums so closely associated with his name, Kirkbride aroused strong feelings in others, ranging from profound hostility to deep admiration. Respected and venerated for his accomplishments by his peers, Kirkbride was also reviled by a younger generation of doctors who viewed his extensive influence and stubborn devotion to his beliefs as obstacles to progress in psychiatric medicine. More often he acquired the admiration, respect, and affection of those he treated. In an extreme example, Dr. Kirkbride actually married a former patient after his first wife passed away. This marriage revealed the depth of Kirkbride’s belief that the mentally ill are human beings with much to offer, though suffering from an illness that can be treated and possibly cured.

*Moral Treatment movement focused on social welfare and individual rights. At the start of the 18th century, the "insane" were typically viewed as wild animals who had lost their reason. They were not held morally responsible but were subject to scorn and ridicule by the public, sometimes kept in madhouses in appalling conditions, often in chains and neglected for years or subject to numerous tortuous "treatments"

Nellie Bly (May 5, 1864–January 27, 1922)

Nellie Bly exposed inhumane treatment of mentally ill patients while working as a reporter. She went “undercover” as a mental patient to Blackwell’s Island Insane Asylum to investigate treatment and housing practices. She ultimately wrote a book detailing these abuses in Ten Days in a Mad-House in 1887.

As a result of her visit to the asylum, the City of New York appropriated $1,000,000 more per annum for the care of the insane. Nellie Bly had the satisfaction of knowing that the mentally ill would be better cared for because of her work. The Newseum in Washington DC felt her story had such a great impact in the world of journalism, that they provide a clip of her story on the 3D movie visitor’s watch.

As a result of these individuals’ efforts, the system for treating mental illness changed. It also expanded, with broad political and financial repercussions. Media coverage encouraged a reevaluation of the model of care. The U.S. census of 1840 was the first attempt, at the national level, to quantify the extent of mental illness and retardation. It included a category for the “insane and idiotic.”

By the late-1800’s, a flood of newly built “State Hospitals” had absorbed patients out of the penal system. Patients were typically no longer to be found in jails or almshouses. These new structures were the birth of the Kirkbride model, a marriage of architecture and the delivery of care. These buildings were well-crafted. They were intended to be compassionate places, a retreat from the “vice” of the city where the afflicted could be at ease. Chores and physical labor were virtuous. They were believed to offer purpose, a distraction for idle hands, and unnamed health benefits.

Patient labor was also the fuel for the Kirkbride engine. It allowed the system to exist, from a financial and logistical perspective. The nature of this system—where patients are physically removed from society—also evidenced a lingering fear of mental health conditions.

The evolving names given to these hospitals give some sense of how there were perceived by society:

- Lunatic Hospital
- Lunatic Asylum
- Asylum for the Insane
- Insane Asylum
- State Hospital
- Mental Health Center
- Narrenturm (Lunatic’s Tower)
- Psychiatric Hospital
- Regional Center
- Retreat
- Developmental Center
- Centers (of Hope, of Mental Wellness, etc.)
Evolution of the Mental Health Hospital

The Kirkbride Model

A detailed history can be found in Appendix A.

The Kirkbride plan refers to the design of a new mental asylum as advocated by Dr. Thomas Kirkbride in the mid to late 1800’s.

Following the treatment issues Dorothea Dix presented to the legislature of New Jersey in 1844, the Kirkbride plan instituted in its design and moral treatment philosophy in these new building types. The building form was meant to have a curative effect: “a special apparatus for the care of lunacy and to be highly improved and tastefully ornamented.”


The plan resembles wings and is staggered to allow the connector wings to have sunlight and fresh air. The wings also promoted privacy and comfort for the patients (see Appendix B, Figure 2).

The Kirkbride plans were generally located on vast farmlands and the physical labor required to run the facility, became a mode of their treatment plan. These hospitals were very large and housing thousands of patients. The staffing ratios were very low and staff usually stayed in the hospitals, sometimes in the same wards and the patients.

In the early 1900’s, the hospitals were seen as costly and too expensive to maintain. Many have been demolished despite the efforts of organizations and individuals urging the renovation for alternate uses. For example, Broughton Hospital in North Carolina is undergoing renovations to house forensic patients and to provide updated staff areas. A new facility is designed and will start construction in 2011 (see Appendix B, Fig 6 & 7).

Broughton Hospital rendering

Current aerial photograph
Another Kirkbride plan hospital is undergoing renovation and restoration in Washington DC. St. Elizabeth’s will be the new location for the Department of Homeland Security and the US Coast Guard. The St. Elizabeth’s Campus is considered a National Historic Landmark (NHL) District within Washington.

Some of the Kirkbride hospitals still in use today are:
- 1848 Jacksonville State Hospital at Jacksonville, Illinois (now called the Jacksonville Developmental Center)
- St. Elizabeth’s Hospital at Washington DC. Buildings are under renovation for the Department of Homeland Security and the US Coast Guard)
- 1855 Dayton State Hospital (formerly the Southern Ohio Lunatic Asylum) at Dayton, Ohio (renovated and used as assisted living)
- 1861 Bryce Hospital, Tuscaloosa, Alabama
- 1875 Broughton Hospital, Morganton, North Carolina (Western North Carolina Insane Asylum. Changed to The State Hospital at Morganton in 1890. Changed again in 1959 to Broughton Hospital)
- 1876 Greystone Park Psychiatric Hospital, Hanover, New Jersey (closed in 2008, fate undetermined)
- 1880 Norristown State Hospital, Norristown, Pennsylvania
- 1880–1890 Buffalo State Hospital, Buffalo, New York (designed by H.H. Richardson)
- 1885 Northern Michigan Asylum for the Insane, Traverse City, Michigan (partially renovated and in use as condos and businesses)
- 1891 Sheppard Pratt Hospital, Towson, Maryland (still in use)
- 1895 Fergus Falls State Hospital, Fergus Falls, Minnesota (not in use, owned by city)

http://www.nethelper.com/article/Kirkbride_Plan
Campus Plan

During the 1950’s, a few states and counties began a new thinking of the mental healthcare facility. New treatment models replaced the larger complexes with smaller buildings. This model provided the ability to group different patient types together.

An example of this is the Western State Hospital in Staunton, Virginia.

From their hospital’s web site, Western State Hospital was founded in January 1825 by an Act of the General Assembly becoming the second mental health facility for the Commonwealth of Virginia. (See Appendix B, Figure 4)

The facility’s name was changed in 1894 from Western Lunatic Asylum to Western State Hospital. The facility continued to increase in size through the 1950’s and 1960’s with the opening of a second site in 1949-1950. The facility’s patient population eventually increased to above 3,000 at two sites.

Beginning with the Commonwealth’s move toward deinstitutionalization in the early 1970’s, the population declined substantially until, by the late 1970’s, it stood at approximately 1,350. Further reductions were realized over the last fifteen years as hospital programs were related to sister facilities and the communities. More restrictive criteria for admissions and improved prescreening programs have also been implemented. Substantial improvements in psychopharmacology and community treatment modalities along with earlier intervention have also contributed to reduced census.

Western State Hospital is currently going through another facility change and will move into a new facility in the Spring of 2012.

Community Homes

One type of institution for the mentally ill is a community-based halfway house. These facilities provide assisted living for patients with mental illnesses for an extended period of time, and often aid in the transition to self-sufficiency. These institutions are considered to be one of the most important parts of a mental health system by many psychiatrists, although some localities lack sufficient funding.
Current Trends in Mental Health Care and Treatment

To look at the impact mental health has on the U.S. population, the Centers of Disease Control and Prevention assembled statistics on mental health. An estimated 26.2% of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder. When applied to the 2010 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people. When examining just the outpatient impact, ambulatory care visits to physician offices, hospital outpatient and emergency departments, with mental disorders as the primary diagnosis, numbers 55.7 million.

http://www.cdc.gov/nchs/fastats/mental.htm

Mental Health Statistics (from the CDC web site)

Ambulatory Care
• Number of ambulatory care visits (to physician offices, hospital outpatient and emergency departments) with mental disorders as primary diagnosis: 55.7 million (annual 2005-2006)
Ambulatory Medical Care Utilization Estimates for 2006, table 5

Hospital Inpatient Care
• Number of discharges with mental disorders as first-listed diagnosis: 2.4 million
• Average length of stay for mental disorders: 7.1 days
National Hospital Discharge Survey: 2007, Summary tables 2, 4

Nursing Home Care
• Number of residents with mental disorders: 996,000
• Percent of residents with mental disorders: 67%
2004 National Nursing Home Survey, Residents, table 33B

Mortality
• Number of suicide deaths: 34,598
• Suicide deaths per 100,000 population: 11.5
Deaths: Final Data for 2007, tables 10, 11

The approach to design for behavioral health has been impacted by a global paradigm shift in trends in the care and treatment for the mentally ill. Some of the shifts are:

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<td>Accommodation</td>
<td>Diagnosis</td>
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<td>Provider Focused</td>
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<td>Institutionalized</td>
<td>Community care</td>
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<td>Separate care sectors</td>
<td>Continuum of care</td>
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<td>Disciplined based</td>
<td>Team-based treatment</td>
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<td>Containment</td>
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<td>Dependant patients</td>
<td>Independence and responsibility</td>
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<td>Outdated therapy models</td>
<td>Evidence based treatment models</td>
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These trends drive the planning and design for behavioral health projects and establish goals for the projects which include:

- Operational flexibility to account for the changing patient population
- To provide safe, secure, and dignified environments for family members and staff
- Openness to the community, while providing appropriate levels of privacy to the patients
- Clarity of unit and building organization to facilitate patient orientation and movement
- To provide humanely scaled home-like environments coupled with a community of treatment, recreational and support programs

An example of a compact, new modern plan is Essex Hospital. (See Appendix B, Figure 5.) The original hospital was constructed in the early 1900’s on over 350 acres. At its operational height, over 50 buildings comprised this campus. With the reduction in the mental health population, many buildings were unoccupied and left to sit empty. These vacant buildings soon became in much needed repair and economic studies recommended a replacement hospital. Much of the original land and buildings were sold for developers. This allowed the sales income to fund a new hospital.

The new Essex County Hospital Center was built on 11 acres of property on Grove Avenue that is located less than one mile away from the previous location on Fairview Avenue. The 154,000-square-foot complex consists of five interconnected buildings and can accommodate 180 patients. More about Essex Hospital can be found at: http://www.essex-countynj.org/index.php?section=pr/print/122006

Photograph from: Asylum: Inside the Closed World of State Mental Hospitals by Christopher Payne
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Law and Policy Reform Impact

Most professional groups (nurses, architects, accountants, etc.) are subject to various laws which affect the way these professionals practice. Psychiatrists and other mental health professionals are no exception to this.

In this section, various relevant sections of law relating to psychiatric practice will be reviewed and summarized, with links to appropriate legislation and additional information. It is important to realize that mental disorder, and the mental health laws relating to it, apply not only to the individual who suffers from the mental illness, but also to those who provide care and support such as family and friends when they attempt to get the treatment they feel is required for their loved one. Obviously, the reverse also applies, in that an untreated mentally ill person will likely have a major effect on those that are close to them and who try to manage them.

Over the past 30 years there have been substantial changes in mental health legislation, influenced by patients, legal activists and others. Increasingly, mental health legislation has valued particularly the rights of individuals to make free and informed decisions unless mental illness renders them incapable of making such decisions. Similarly, the amount of time that a person may be detained in a hospital without a formal review has been significantly reduced and various decisions relating to this can now readily be appealed.

Mental health legislation is no longer a simple matter and requires a reading and understanding of not only the basic legal statutes but also of their interpretation by the judiciary and review boards. Issues covered by mental health law include, among other things: Capacity, Consent, Duty to Warn, Emergency Treatment, Public Guardian & Trustee Issues, and Substitute Decision Makers.

An Overview of Political Legislation and Payment Models, Shaping Behavioral Health Care

The Behavioral Health Industry (also called Mental Health) has historically relied upon public funding to sustain its model of care. This remains one common thread through modern history. Even as the model for caregiving has evolved dramatically over the past 150 years, it remains tied to large, public outlays.

In the 19th century, state governments shouldered the cost and infrastructure associated with the delivery of care. This was the genesis of the term “State Hospital.” It was associated exclusively with treatment of psychiatric conditions. States used tax revenues and bonds to literally build and maintain these massive institutions, built on public lands. They maintained this system as a public service—not only for treating the afflicted, but for the remaining population who were made uneasy by little-understood psychiatric conditions.

As patient populations grew, so did State budget outlays. By the early twentieth century, State Hospitals were the single largest expenditure of the New York State budget. The system would ultimately collapse under its own weight. In 1973, a court ruling in Soulder v. Brennan effectively barred patients from performing unpaid work. This had the radical and immediate effect of deinstitutionalization—as
hospitals could no longer maintain themselves. With few options for alternative funding, many patients
were released to the streets within weeks.

http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=347

Smaller, community-based hospitals and models for care were formed to fill the void. This generally
coincided with two major shifts in the American political landscape: the rise of entitlement programs,
and recognition of the need to treat veterans of major wars.

Beginning with depression-era social safety nets, programs such as Social Security, Medicare, and
Medicaid became major payment models for a host of health needs. Today, Medicaid is the largest
single payer for behavioral health services in the United States [http://www.cms.gov/MHS/]. While still
drawing from state funds, a portion of the financial burden is now shouldered by the Federal
government.

The Veterans Administration has also grown into a major force, shaping care and payment models.
Through the VA, a major payer was established for treating Post Traumatic Stress Syndrome and many
other conditions diagnosed in veterans returning from combat. In addition to providing a funding
source, the VA has informed public policy through its own research and advocacy with affiliate
organizations [http://www.thenationalcouncil.org/cs/veterans]. Since the Gulf Wars in the 1990’s,
veterans’ health has held increasing prominence in national and state politics. Public scrutiny remains
focused on veteran services. A 2007 study cited in the Journal of the American Medical Association,
suggested veterans were in greater need for mental health services six months after their discharge and
initial psychiatric counseling. [http://www.thenationalcouncil.org/cs/veterans] In the face of increased
evidence for need, many states have considered and passed legislation expanding services.

Looking beyond Medicaid and the VA, there is an increasing body of legislation, executive orders, and
judicial rulings that are transforming mental health care in the U.S. Beginning with the 1990 American
Disabilities Act; mental health has gained increasing prominence and awareness in the public eye. In
1999 the Supreme Court, in Olmstead vs. L.C., ruled that mental health services should be provided in
the community-focus by promoting the idea that those with disabilities should have complete access to
community life.

As this body of policy and payment models have evolved, so too has the definition of “mental illness.”
This has become of increasing importance, as private insurance and federal/state programs use this
definition to determine benefits [http://content.healthaffairs.org/content/25/3/737.full].

Mental Illness may be defined broadly or narrowly. At its heart is a balance between finite resources,
and a growing body of people seeking treatments. As the stigma of “mental illness” fades, broader
portions of the population become potential patients. Currently, the debate centers on the severity of
impairment, where this concept is often used as a “trigger” for awarding benefits or declining them.
Future debate will likely be framed within a cost-benefit discussion: how to allocate scarce resources to
those most in need, while keeping patients stay as short as possible.
Conclusion

Architects understand the impact that an individual's immediate environment has on their sense of well being; this is what our profession does. Physical surroundings are especially critical when the patients are struggling with a mental impairment. Facilities designed for behavioral health care must provide a supportive and responsive atmosphere—one that shelters, comforts, and contributes to the healing process. New behavioral health facilities incorporate science and technology with therapeutic treatment, clinical application and responds to the needs of the resident patients. These important issues must also blend with spaces of dignified repose in which patients; their families, clinicians, therapists, and staff can all contribute to a healing process that is secure and safe and encompassing.

Next Steps

This first step in the research focused on the evolution of the facility design and individuals that fought for treatment reform.

Our next steps will be:

1. Develop a questionnaire focused on the results of these newer hospitals and the effect they may have on the behavioral elements, length of stay and medication impacts. This questionnaire will be sent to hospitals that went through a major renovation, major expansion or replacement of out dated facilities.

2. Tour recently completed behavioral health hospitals that recently completed a major expansion or replacement facility.

3. Tour several Kirkbride plan buildings, whether in use as a hospital or as a renewed use to understand firsthand the size, zoning and implications of these large hospitals.

4. With the data collected from the questionnaire, report any significant findings which may influence the design of new and renovated hospitals for the mental health patient.

5. Suggest design changes in function, room design or finishes for future projects.
Appendix A
Kirkbride History

The nineteenth century saw considerable growth in state-sponsored treatment of the mentally ill in the United States, and consequently the rise of asylum building. Growing populations and stress levels of American society created an intensifying frequency of mental illness. Activists for humane treatment, new therapeutic methods in Europe, and important changes in public perception created a progressive environment which fostered the establishment of many public “lunatic asylums” throughout the country. These asylums replaced cruder methods of coping with the mentally ill, such as confining them to prisons or poorhouses where they were often abused and their special needs were rarely met.

An asylum became a place of structured improving activity, seclusion from suspected causes of illness, and a certain amount of medical therapy. All of these were intended to cure mental disorders, thus improving patients' lives and the quality of society in general.

The Kirkbride model envisioned an asylum with a central administration building flanked by two wings comprised of tiered wards. This "linear plan" facilitated a hierarchical segregation of residents according to sex and symptoms of illness. Male patients were housed in one wing, female patients in the other. Each wing was sub-divided by ward with the more "excited" patients placed on the lower floors, farthest from the central administrative structure, and the better-behaved, more rational patients situated in the upper floors and closer to the administrative center. Ideally, this arrangement would make patients' asylum experience more comfortable and productive by isolating them from other patients with illnesses antagonistic to their own while still allowing fresh air, natural light, and views of the asylum grounds from all sides of each ward.

It was believed crucial to place patients in a more natural environment away from the pollutants and hectic energy of urban centers. Abundant fresh air and natural light not only contributed to a healthy environment, but also served to promote a more cheerful atmosphere. Extensive grounds with cultivated parks and farmland were also beneficial to the success of an asylum. Landscaped parks served to both stimulate and calm patients' minds with natural beauty (enhanced by rational order) while improving the overall aspect of the asylum. Farmland served to make the asylum more self-sufficient by providing readily available food and other farm products at a minimal cost to the state.

Patients were encouraged to help work the farms and keep the grounds, as well as participate in other chores. Such structured occupation was meant to provide a sense of purpose and responsibility which, it was believed, would help regulate the mind as well as improve physical fitness. Patients were also encouraged to take part in recreations, games, and entertainments which would also engage their minds, make their stay more pleasant, and perhaps help foster and maintain social skills.

A new generation of asylum superintendents began advocating different forms of asylum design based on different ideas of care. And as psychoanalysis, drug-therapy, and other emerging treatments began to be favored, the idea of the asylum as a staging for the Kirkbride Plan became obsolete. Asylum buildings were no longer built in the Kirkbride mold, though many existing Kirkbride buildings continued as important parts of state hospitals well into the twentieth century. Their separate histories have often been stigmatized by methods of treatment not intended by Dr. Kirkbride and his contemporaries, and by the seemingly inevitable problems caused by a combination of overcrowding and a lack of necessary financial support. But each of these buildings owes its genesis to a remarkable humanitarian movement.
to improve the quality and effectiveness of mental healthcare in America—a movement that Dr. Kirkbride was instrumental in driving forward.

Many Kirkbride buildings today are rapidly deteriorating due to years of neglect. With the decline of the state hospital system — due mostly to new forms of treatment, the development of patients' rights, and public outcry over scandals of abuse and unsanitary conditions—these remarkable buildings have fallen into disuse and decay. Sadly, many have been demolished as they were deemed too expensive to renovate, or as commercially useless occupants of valuable land. Many that still exist are threatened with destruction and are rapidly vanishing symbols of an important period in the progress of American mental healthcare.
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Appendix B

FIG. 1
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1950
WESTERN STATE HOSPITAL
VIRGINIA
FIG. 4

2007
ESSEX COUNTY HOSPITAL
NEW JERSEY
FIG. 5
Designed by the Freelon Group
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Fig. 7

Designed by the Freelon Group