Deinstitutionalization: A Case Study in Carceral Abolition

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When Decarceration Happened

The premise of the meditation below is that the deinstitutionalization movement in the fields of mental health and developmental disabilities (in the U.S.) can be used as a lightning rod for current prison abolition struggles. Similar kinds of dismissals have been launched against both movements: that closing psychiatric hospitals and "institutions for the mentally retarded" was utopian; that it will never happen under current conditions; that even if it is the moral thing to do we must wait until conditions are right; and if it does happen it is irresponsible and dangerous for many of the inhabitants of these total institutions, as well for as those who do not reside in them. But despite all these critiques, deinstitutionalization did happen, and is still happening right now in many states in the U.S. It can therefore be used as a historical precedent for all movements interested in decarceration efforts.

Defining Deinstitutionalization

Deinstitutionalization can be defined as the movement of people with psychiatric, intellectual, or developmental disabilities from state institutions and hospitals into community living situations, as well as the closure of large (mostly state-sponsored and funded) institutions and hospitals for people with intellectual and psychiatric disabilities. In the U.S., and varying from state to state, the deinstitutionalization of people who were labelled as mentally ill began in the 1950s, and the deinstitutionalization of people labelled intellectually and developmentally disabled gained wider prominence in the 1970s.

The movement of people with intellectual and/or developmental disabilities (I/DD) from large facilities to smaller communal residences is demonstrated by the fact that in 1977, an estimated 83.7 percent of people with developmental disability labels who were receiving residential services lived in residences

of 16 or more people; by 2009, an estimated 86.4 percent lived in community settings of 15 or fewer people, and 73.1 percent lived in residential settings with 6 or fewer people.[1] The trend towards deinstitutionalization of people with intellectual disabilities also resulted in the closure of large state institutions across most of the U.S. By 2011, 11 states had closed all of their state-operated institutions for people with I/DD.[2] Needless to say, these 11 states still have residents with intellectual and/or developmental disabilities, but they attempt to accommodate their needs outside of the institutional framework.

An accompanying shift occurred in the field of mental health with the establishment of community-based mental health centres in the 1960s and the closure of large, state-run mental hospitals in most major cities in the U.S. In 1955, the state mental health population was 559,000—nearly as large on a per capita basis as the prison population today. By 2000, it had fallen to below 100,000.[3] I am not suggesting that institutionalization, hospitalization, and imprisonment in jails and prisons are the same. Rather, I am suggesting that those who want to achieve a non-carceral society should examine one specific historical precedent of decarceration in the U.S. to utilize insights, avoid potential pitfalls, and recognize the strategic moves used during deinstitutionalization that made it successful.

Who Can Be Decarcerated?

The most challenging question often raised in the context of abolition of prisons and institutions is what to do with those deemed as having the most challenging behaviours. In prison abolition circles this discussion is known as "what to do with the dangerous few," and in the realm of developmental and psychiatric disabilities it is the question of "what to do with the most significantly/profoundly disabled." In both cases the general assumption is that these are the populations that will not be able to "make it on the outside" and therefore will always require some sort of segregation and restraint, either for their own good or the public's. However, there is significant debate in both arenas as to whether this assumption is indeed true.

1 Sheryl A. Larson, Amanda Ryan, Patricia Salmi, Drew Smith, and Allise Wuorio, Residential Services for Persons with Developmental Disabilities: Status and Trends through 2010 (Minneapolis, MN: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 2012).

2 David Braddock, Richard Hemp, Mary Kay Rizzolo, Laura Haffer, Emily Shea Tanis, and Jiang Wu, The State of the States in Developmental Disabilities: 2011 (Boulder: University of Colorado, Department of Psychiatry and Coleman Institute for Cognitive Disabilities, 2011).

3 Bernard E. Harcourt, "Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s," Ohio State Journal of Criminal Law 9, no. 1 (2011): 53-87.

Some prison abolitionists advocate for transformative justice and healing practices in which no one will be restrained or segregated, while others believe that there will always be a small percentage of those whose behaviour is so unacceptable or harmful that they will need to be incapacitated, socially exiled, or restrained, and that this should be done humanely and not in a prison-like setting. In the field of developmental disabilities and anti-psychiatry, a similar debate arose alongside early discussions of deinstitutionalization. To those deemed "radical inclusionists" (especially in the field of education), everyone deserves to belong, to be educated with their peers, and to live in a community. For proponents of this attitude, segregation is never a viable response, even for those whose behaviour is challenging and "disturbing" to others. The goal is to make people with and without disabilities aware of social norms (such as raising one's voice, touching others without permission, etc.), but simultaneously challenge social views and attitudes that construct normalcy in particular ways (for instance, having to regulate one's body and behaviour to fit specific cultural expectations). It also entails changing public policy, the education system as a whole, housing and other infrastructure to make them accessible and inclusive to all. In the field of anti-psychiatry such attitudes also involve opposition to psychiatric hospitalization, even of those labelled "psychotic," in favour of treatment or support in the community, among one's peers, and without coercion.

Robert McRuer has described Crip Theory as a combination of disability/crip and queer studies, both reclaiming the positions of crip and queer as critical (as opposed to derogatory) positions and subjectivities. Crip theory, therefore, draws "attention to critically queer, severely disabled possibilities in order to bring to the fore the crip actors who […] will exacerbate in more productive ways the crisis of authority that currently besets heterosexual/able-bodied norms."[4] By "severely disabled," McRuer is not merely referring to the level of impairment a person is presumed to have, but as a queer position, a position that questions, a mark of defiance. By reclaiming severe as "fierce" or defiant, McRuer reverses able-bodied standards that view people with severe disabilities as those who will never be integrated (reflecting the adage "everyone should

4 Robert McRuer, Crip Theory: Cultural Signs of Queerness and Disability (New York: New York University Press, 2006), 31.

5 Steven J. Taylor, "Thoughts and Impressions on Institutional Closure," IMPACT (Feature Issue on Institution Closures) 9, no. 1 (1995/6): 8-9.

be included, except for…"). From their marginal state, "severe disabilities" and queer subjects are positioned to re-enter the margins and point to the inadequacies of straight and nondisabled assumptions. Translated to praxis, some prison abolitionists and activists in the fields of developmental disabilities and anti-psychiatry indeed begin their promotion of alternative social arrangements from the positionality of "severe" cases.

It is partially this debate that prompted those advocating for community inclusion to begin with the most "severe" cases when calling for and implementing the move out of institutions. A lesson learned from successful institution closures is, therefore, that those labelled as having the most significant needs should move to community placements early on in the process. If left to the end, such people would most likely be placed in segregated settings because of a lack of skills, experience, ability, or desire in the community to support them. For example, those deemed the most violent and dangerous youth became deinstitutionalization advocate Jerome Miller's symbol as he closed juvenile facilities in Massachusetts in the 1970s, and were the first to be decarcerated.

With regards to prison abolition, the work of Fay Honey Knopp is especially relevant here. After working to draft the abolitionist manual Instead of Prisons, Knopp sought to engage with the "toughest" cases, and she devoted the rest of her life to working with so-called sex offenders and sexual abusers. The thought behind this commitment was that if she can demonstrate the ineffectiveness of prisons for this segment of the imprisoned population, there will be no doubt that prisons should not be the response to lesser criminalizable acts, like property or drug offenses.

Swift Changes Versus Attrition as the Best Way to Decarcerate

Reflecting on the process of deinstitutionalization in the field of DD in the 1970s and onward, Steven Taylor[5] suggests a few successful strategies used in closing institutions in the past and present. The first is to announce the closure far in advance, making sure the move has support from the local community and professionals (this strategy

was used in Vermont–[6] for example).–[7] A riskier strategy, but one with many benefits, is a swift and massive system change from within. Jerry Miller, then the director of the Department of Youth Services in Massachusetts, emptied all but one juvenile facility in the state in three years. Miller's method–[8] was to create swift changes, thus preventing professionals and those in positions of power to revolt against his closure efforts. Miller was concerned that a lengthy reform period would only invite opposition from the staff and parents, as well as judges who could send more "juveniles" into the school, thus preventing it from closing. Miller closed juvenile corrections institutions without seeking the approval of the legislature and with no real cooperation of any other agencies, except for specific individuals with whom he had good working relations. The plan was to initiate group homes as alternatives to incarceration of youth in Massachusetts, and once they were set up with federal funds, the state would divert money from the empty institutions and reform schools into the new units. This was done solely under the jurisdiction of the Massachusetts Department of Corrections, a move that raised much animosity from politicians and policy makers both outside and inside the department.

Another, more subtle, strategy used for deinstitutionalization was the gradual depopulation of an institution to the point where it was no longer cost effective to keep it open (this tactic was used in New Hampshire).–[9] This strategy could be characterized as "abolition by attrition," as described by Knopp et al. with regards to prisons.–[10] According to the attrition model, the function and power of prisons would be slowly worn down. One component of abolition by attrition is to decarcerate or release as many prisoners as possible, such as those who are deemed psychiatrically or mentally disabled, those who have a drug or other substance dependency, and young offenders. The second component is to excarcerate (create mechanisms that prevent and avoid incarceration) by establishing community probation programs, and decriminalizing whole categories, such as crimes without victims. The point is to decarcerate prison populations one by one—first the young, then the mentally ill, and so on. Canadian abolitionist Ruth Morris critiques the attrition model by asserting that it is indeed an aggressive reform effort, but a reform effort nonetheless.–[11] The

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This strategy was used in the closure of Brandon Training School, Vermont's only public institution catering to people with developmental disabilities, which opened in 1915 and closed in 1993, after 20 years of legal and advocacy battles.

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See Bonnie Shoultz, Pam Walker, Kathy Hulgin, Bob Bogdan, Steve Taylor, and Charles Moseley, Closing Brandon Training School: A Vermont Story (Syracuse: Center on Human Policy, 1999).

8
Jerome G. Miller, Last One over the Wall: The Massachusetts Experiment in Closing Reform Schools (Columbus: Ohio State University Press, 1991).

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Taylor, "Institutional Closure," 8-9.

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Honey Fay Knopp and The Prison Research Education Action Project, Instead of Prisons: A Handbook for Abolitionists (Syracuse, NY: Prison Research Education Action Project, 1976).

11
Ruth Morris, Penal abolition, the practical choice: A practical manual on penal abolition (Toronto: Canadian Scholars' Press, 1995).

12 Harcourt, "Reducing Mass Incarceration."

problem of chipping at the margins of the system is that the centre remains intact. According to Morris, gradual decarceration and excarceration will lead to deepening a retributive system by means of programs billed as "alternatives to incarceration," such as boot camps and parole sanctions.

Another critique of the attrition model can be found in the backlash to deinstitutionalization in its aftermath, by those who claim that people who have been deinstitutionalized often find themselves inappropriately placed in other institutions like prisons and jails. This builds on arguments heard by various activists and organizations such as NAMI (National Alliance for Mental Illness), that people with mental health issues are over-represented in the prison system and should not be placed in jail or prison in the first place. Too often what such calls end up doing is suggest that people with disabilities or mental health issues are inappropriately placed in prisons and jails, which implies that there are others who are somehow appropriately placed there. In other words, it re-inscribes the notion that there are those who really need to be placed in spaces of incarceration, while those who are young and/or disabled do not. In relation to the attrition model, we can see this as another example by which the calls for decarceration of one specific population do not necessarily lead to abolition of the system and its mindset, and ends up strengthening the logic and net effect of the carceral system.

Deinstitutionalization and the Rise in Incarceration

In the public's eye, the first half of the twentieth century is conceived as an era of relative stability in terms of incarceration, with a later explosion in the growth of prisons and jails, a phenomenon commonly referred to as "mass incarceration." However, as Harcourt suggests, if mental hospitalization and institutionalization were also covered in such analysis, the "rise in incarceration" would have reached its peak in 1955, when mental hospitals were at their highest capacity.[12] Put differently, the incarceration rates in U.S. prisons and jails today (about 700 of every 100,000 people) are less or equal to the levels of incarceration during the early part of the twentieth century, when over 600 of every 100,000 people were in psychiatric

hospitals alone.

This relationship, of a reversal of trends between the mental health and the criminal system, is hardly new, however. As early as 1939, Penrose suggested that social control evolves from incarcerating people to treating people, therefore suggesting an inverse relationship between mental health and the prison system.—[13] Since then, this hypothesis has been tested numerous times with inconsistent results. Overall, studies suggest that in relation to arrests, this hypothesis may be corroborated, as the percentage of mental patients with prior arrests increased from the 1940s to the 1970s. But studies of imprisonment seem more inconclusive, suggesting that some inmates end up in jail after being arrested, but not as often in prison.—[14]

Taking incarceration in its broadest terms, i.e. in relation to both prisons and institutions, would also entail deconstructing the categories that are used by criminologists, psychiatrists, and social scientists. The point is not to try and find the most accurate way of measuring "the mentally ill" in prisons and jails, but to ask questions that take into account the blurry line between criminality and medicalization—and the constructed nature of both.

I do not agree with the public outcry following deinstitutionalization (heard by sociologists, activists, and the media) that most people, particularly those labelled as mentally ill, became homeless and were increasingly re-incarcerated in jails and prisons in urban areas in the U.S. I believe this narrative reduces a much more complex process and puts the blame on an easy target—deinstitutionalization—instead of neoliberal policies that led simultaneously to the growth of the prison system and to the lack of financial support for disabled and poor people to live in affordable and accessible community housing.

In addition, the assumption that these are the same people, i.e. that people were deinstitutionalized and ended up in prison, should also be challenged, as the demographics of these populations are quite distinct. Over the years, the gender distribution of inmates in mental hospitals tended to be either equal or tended towards an over-representation of women. However, in terms of imprisonment, the majority of those newly imprisoned are male. There are differences in terms of age and race as well. Although

13
Lionel Penrose, "Mental disease and crime: Outline of a comparative study of European statistics," British Journal of Medical Psychology, 18 (1939): 1-15

14
Liska, Allen E., Fred E. Markowitz, Rachel Bridges Whaley, and Paul Bellair, "Modeling the Relationship between the Criminal Justice and Mental Health Systems," American Journal of Sociology 104, no. 6 (1999): 1744-75.

there is some evidence to suggest that during deinstitutionalization the proportion of those identified as non-whites had increased for those admitted to mental hospitals, they only compromised about a third at its highest point.—[15] As should now be clear to anyone at least somewhat familiar with the prison system in the U.S., non-whites are extremely over-represented. Conversely, in general terms, the inmate population in mental hospitals tended to be more white, older, and more equally distributed by gender than those incarcerated in prisons.—[16] Therefore, we are not speaking about the same population or group of people (who exited hospitals and institutions and entered prisons), but of ways in which the social control function of incarceration retained its importance, but for differing populations.

The Need for Conversion Plans while Decarcerating

Creating new and meaningful uses for the evacuated buildings after their closure is paramount. In the 1970s, Blatt et. al. pushed the idea that for deinstitutionalization to be successful, a full conversion model from an institutional to a community-service model should be achieved.[17] There are unfortunately many examples in which former developmental centres and psychiatric hospitals closed down as part of the deinstitutionalization movement were converted into prisons shortly afterwards. Some facilities created smaller units on the grounds of the old institutions in which people with the same disability labels lived. Such examples illustrate the need to explicitly determine what will happen with the physical remains of the closed institutions, as well as the involvement of activists and the community in such decisions.

Conversion plans also have to take into account fiscal matters. In the case of state-run institutions and mental hospitals, there are two compounding issues at play. The first is that states are often reluctant to close institutions since they are funded by municipal and state bonds.[18] Secondly, even when they close down, the budget of each institution does not seem to go directly into community services. This of course creates a budgetary issue, as monies that were utilized for the care of people with disabilities either disappear from the budget altogether or go to the upkeep of institutions, even those

15 Henry J. Steadman, John Monahan, Barbara Duffee, Eliot Hartstone, and Pamela Clark Robbins, "The Impact of State Mental Hospital Deinstitution-alization on United States Prison Popu-lations, 1968–1978," Journal of Crime, Law & Criminology 75 (1984): 474.

16 Bernard E. Harcourt, "From the Asylum to the Prison: Rethinking the Incarceration Revolution," Texas Law Review 84, no. 7 (2006): 1751-1786.

17 Burt Blatt, Robert Bogdan, Douglas Biklen, and Steven J. Taylor, "From Institution to Community: A Conversion Model," in Educational Programming for the Severely and Profoundly Handicapped, ed. E. Sontag, J. Smith and N. Certo (Reston, VA: Council for Exceptional Children, 1977).

18 Ibid.

with a very small number of residents. Miller claims that in New York State and Pennsylvania, while thousands of patients were left with little housing or treatment options in the community, the budget for the depopulated hospitals actually increased at the beginning stages of deinstitutionalization. He sums up the situation by remarking that although most "mental patients" left the institutions in past decades, the staff, resources, and budgets remained institutionalized.[19]

Closure Does Not Mean Abolition

The closure of repressive institutions such as mental hospitals and prisons can be conceptualized as a necessary but insufficient action on the road to abolition. The most important element in institutional closure is to ensure that people do not end up re-incarcerated in other institutions. The mere closure of prisons and large state institutions for people labelled intellectually or psychiatrically disabled did not necessarily entail a radical change in policy, attitudes, or the lived experiences of those incarcerated. In this light, closure in itself is still embedded within the same circuits of power that created such institutions, unless there is an epistemic shift in the way community, punishment, dis/ability, and segregation are conceptualized.

Elsewhere, I have suggested that the forces of incarceration of disabled people should be understood in relation to the prison industry and the institutional-industrial complex, in the form of a growing private industry of nursing homes, boarding homes, for-profit psychiatric hospitals, and group homes.–[20] As an example, figures show that there is no correlation between the increase of the non-governmental institutional-industrial complex and the percentage of those "needing" these services. Between 1977 and 2009, the total number of residential settings in which people with developmental disability labels received residential services grew from 11,008 to an estimated 173,042 (an increase of 1,472%), while total service recipients increased from about 247,780 to an estimated 439,515 individuals (77.4%).–[21] Because most of these newer settings are much smaller than the massive institutions of previous decades, they are not typically counted as "institutional" placements, but due to their size as well as

19
Miller, Last One over the Wall, 159-167.

20
Liat Ben-Moshe, "Disabling Incarceration: Connecting Disability to Divergent Confinements in the USA," Critical Sociology 39, no. 3 (2013): 385-403.

21
Larson et al., Residential Services, 2010.

daily routines and other aspects of life in these settings, many people with disabilities, family members, and advocates consider them to be "smaller institutions" within the community.

Institution as Mindset

Instead of incarcerating people and segregating them, certain movements such as anti-psychiatry, deinstitutionalization, and prison abolition propose radical new ways of treatment, care, and governance that do not require the segregation of people from their peers. I contend, therefore, that deinstitutionalization could be characterized not only as a process or an exodus of oppressed people outside the walls of institutions and into community living, but as a radical anti-segregationist philosophy. In a similar vein, Self-Advocates Becoming Empowered, a national advocacy group of people with developmental disabilities, states that: "An institution is any facility or program where people do not have control over their lives. A facility or program can mean a private or public institution, nursing home, group home, foster care home, day treatment program, or sheltered workshop."—[22] For those who have been incarcerated, an institution is not just a place, but a mindset.

The goal of a non-carceral society is not to replace one form of control, such as a hospital, institution, or prison, with another, such as psychopharmaceuticals, nursing homes, or group homes in the community. The aspiration is to fundamentally change the ways we interact with each other, the ways we respond to difference or harm, the ways normalcy is defined, and the ways resources are distributed and accessed.

Abolition Versus Reform

Earlier criticisms of institutions and hospitals included various scholarly accounts and exposés by journalists, professionals, and scholars from the early 1960s: Senator Robert Kennedy's unannounced visit to state schools; Blatt and Kaplan's damning photographic depiction of institutional back wards for people labelled mentally retarded, which was published as Christmas in Purgatory and

22 Self Advocates Becoming Empowered, http://www.sabeusa.org/wp-content/uploads/2014/02/POSITION-STATEMENT-Institutions.pdf

also in Look Magazine; and Geraldo Rivera's exposé on Willowbrook State School, which attracted national coverage. In addition, several influential books were published in the early 1960s that exposed mental hospitals as coercive warehouses for the indigent, such as Thomas Szasz's The Myth of Mental Illness (1961), and Erving Goffman's Asylums (1961). A year later, Ken Kesey's bestselling novel One Flew over the Cuckoo's Nest came out to widespread acclaim. Although a fictional portrayal, it was this novel above all, and its subsequent film adaptation in 1975, that instigated the popular critique of psychiatric hospitals.

These exposés and depictions showed that institutions were beyond reform and presented them as inhumane warehouses, often alluding (in this post-WWII era) to concentration camps in their imagery and textual references. Overall, however, these early exposés did not do much to change the fate of those institutionalized, at least not immediately. Blatt and Kaplan published Christmas in Purgatory in 1966, and in 1979 Blatt revisited these institutions and found no great improvement; they were just mildly cleaner "snake pits."[23] In his book Acts of Conscience, Steven Taylor constructs a historiography of mental institution exposés from the turn of the century, focusing on the 1940s onward. He presents the work of such well-known reformers as Dorothea Dix and Clifford Beers, who brought on the beginning of the mental hygiene movement, which resulted in the construction of mental health hospitals. Later, such exposé-driven reforms resulted in a change in the degree of squalor presented in the institutions, but the institutions essentially remained intact.[24] It was not until the shift was made towards the elimination of such institutions that a real change in the institutional mindset was effected. It was the coupling of these exposés with the ideology of normalization, self-advocacy, and anti-psychiatry that ultimately led to a change in perspective—from an institutional to a community-based model—and eventually calls for the closure of all such institutions.

The resistance to institutionalization and psychiatric hospitals arose from a broader social critique of medical authority and a new understanding of human value—especially with regards to people with disabilities—as seen in the principles of normalization, anti-psychiatry, the ex-patients' movement, and the People First or

23 Burton Blatt, Andrejs Ozolins, and Joe McNally, The Family Papers: A Return to Purgatory (New York: Longman, 1979).

24 Steven J. Taylor, Acts of Conscience: World War II, Mental Institutions and Religious Objectors (Syracuse: Syracuse University Press, 2009).

self-advocacy movement. The anti-medical view of mental "illness" propounded by Thomas Szasz and R. D. Laing was reaffirmed by social scientists such as Thomas Scheff and others who supported "labelling theory." It is also echoed in the writings of sociologists such as Erving Goffman and Wolf Wolfensberger, who showed that once a person had been placed in an institutional setting they will act accordingly—[25] (i.e. disabled, institutionalized etc.).
Of course, the most vocal critics of psychiatry were those who had been psychiatrized themselves, including those who self-identify as psychiatric survivors, or consumers or ex-patients (some identify as all, some only as one category, although they are often lumped together), as well as anti-psychiatry activists.

While all these critics share an understanding of the constructed nature of mental illness, some advocates would take this critique to its absolute: the abolition of psychiatry. For instance, activist Judi Chamberlin critiques the mantra that is often cited by activists and professionals that "mental illness is like any other illness," or that the way to combat the oppression of those psychiatrized is in fighting against stigma. Given current laws in relation to involuntary hospitalization, mental "illness" cannot be characterized as being like cancer or a heart attack, according to Chamberlin. Rather, altered states such as anger and pain should not be characterized as illness, but as a consequence of a system of power and inequality that denies people their basic human needs. In addition, stigma is not perceived by Chamberlin to be the force that most oppresses those who are psychiatrized. Psychiatry itself is that force.—[26]

Another example of the shift in perspective from reform to abolition is the establishment of The American Association for the Abolition of Involuntary Mental Hospitalization (AAAIMH) in 1970 by Thomas Szasz, Erving Goffman, and George Alexander (then Dean of the Law School at the University of Santa Clara in California). Szasz, more than any other scholar and perhaps most activists in the anti-psychiatry movement, was never really interested in reforming psychiatry as a medical field, but rather in its total abolition. He claimed that there is no such thing as voluntary commitment to a psychiatric hospital because you are not the person who decides when you get out. Once you are committed, your release is always determined by

25 Wolf Wolfensberger, The origin and nature of our institutional models. (Syracuse, N. Y.: Center on Human Policy Syracuse University Division of Special Education and Rehabilitation, 1974); Erving Goffman, Asylums; essays on the social situation of mental patients and other inmates (1st ed.). (Garden City, N.Y.: Anchor Books, 1961).

26 Judi Chamberlin, On Our Own: Patient-Controlled Alternatives to the Mental Health System (National Empowerment Center, 1977).

medical experts, regardless of how you entered the hospital. So if you cannot get out voluntarily when you choose, how can it be called voluntary commitment? Thus, for Szasz, modern psychiatry always stands for coercion.

In the literature on deinstitutionalization of individuals with labels of "mental retardation," it seems that no theory or concept was more influential in the 1960s and 1970s than the principle of normalization.—[27] The concept of normalization came from Europe, especially Scandinavia, where it was originally suggested by Niels Erik Bank-Mikkelsen and Bengt Nirje, and popularized in the U.S. by Wolf Wolfensberger. Nirje defined normalization as:

> [M]aking available to the mentally retarded patterns and conditions of everyday life, which are as close as possible to the norms and patterns of the mainstream of society. This principle should be applied to all the retarded, regardless whether mildly or profoundly retarded, or whether living in the homes of their parents or in group homes with other retarded.—[28]

The idea that people with developmental disabilities should be raised in and live in normalized settings resembling those of their peers, as suggested by the principle of normalization, may seem trivial to us now, but it was an idea that was fiercely resisted at its time, and is not universally accepted to this day. It was a paradigm shift that seemed almost unimaginable in the 1960s and early 1970s because the prevailing solutions of the era were focused on improving or reforming institutional living by creating smaller settings that are better managed or geographically less remote, or by diverting more money to segregated housing and special education programs. The notion that people with disabilities should not be segregated in the first place was a tremendous paradigm shift in the field.

In other words, reform-based approaches to deinstitutionalization focused on improving overcrowded conditions, calling for more money in the budget for hospitals and developmental centres, hiring more staff, or making institutions and hospitals more liveable. Although such efforts are still pervasive in the ongoing debate over deinstitutionalization, professional opinion and most of

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One critique of the principle of normalization is that it focuses too much on trying to change the individual so that she will fit into societal standards, which makes this more of a "principle of assimilation." See, for example, M.J. Oliver, Capitalism, Disability and Ideology: A Materialist Critique of the Normalization Principle (1994). But, in the original formulation proposed by Bengt Nirje (1969), the environment is what needs to be changed into being as normalized as possible, not the person.

28
Bengt Nirje, "The Normalization Principle and Its Human Management Implications," in Changing Patterns in Residential Services for the Mentally Retarded, ed. Robert B. Kugel and Wolf Wolfensberger (Washington DC: President's Committee on Mental Retardation, 1969), 181.

the public opinion started demanding the closure of these institutions and devoting all the money and strategic thinking to their alternatives. But it was not until the pendulum swung towards abolition, when professional opinion moved to community living instead of reform (especially in I/DD), that massive deinstitutionalization became possible. Although these ideological shifts did not solely bring about deinstitutionalization and the closure of psychiatric hospitals and large state institutions nationwide, I believe that any significant decrease in institutionalized populations would have been impossible without them.

Decarceration in the Present Tense

Norwegian sociologist Thomas Mathiesen conceptualizes abolition as an alternative in the making: "The alternative lies in the 'unfinished,' in the sketch, in what is not yet fully existing."[29] By definition, then, abolition and decarceration cannot wait for a future constellation when appropriate alternatives are already in place. In fact, this is inherently impossible because alternatives cannot emerge from the existing order but from a process of change that will come as a result of a massive transition. According to Mathiesen, abolition as a goal and a mindset is in fact necessary to come up with new alternatives. Avery Gordon further asserts that the core of abolitionism is its refusal to wait. Slaves or prisoners, and those fighting for their freedom, cannot wait for a new world order to be free of incarceration or bondage. They cannot wait until the right conditions emerge and the desired future begins.[30] This sense of urgency enables abolitionism to become a model for political activity in the here and now. Emancipation is ongoing work and cannot wait until the time is ripe for it.

This characterization of abolition could also be seen in the case of deinstitutionalization activists who insisted on a non-carceral and inclusive world before alternatives to institutionalization were in place in all locales (or anywhere, for that matter). This ideological stance may create a dilemma concerning whether deinstitutionalization proponents should wait until there are sufficient community placements before advocating for institutional closure, or go ahead regardless based on the principle that no one should

29 Thomas Mathiesen, The Politics of Abolition (New York: Halsted Press, 1974), 1.

30 Avery Gordon, Keeping Good Time: Reflections on Knowledge, Power and People (Boulder: Paradigm Publishers, 2004).

live in an institution at any time. Even though concepts like "harm" and "quality of life" cannot be defined, especially from above by professionals, advocates such as Steven Taylor believe that bringing up such ethical questions would lead one to realize that institutional living is unjustifiable if one cares more about those institutionalized than about cost-benefit analysis, even if community settings are imperfect at the present time.—[31]

31 Taylor, "Institutional Closure," 8-9.

The goal of those advocating for community living and community mental health programs, as well as other institutional alternatives, was to close down institutions and refute the institutional and segregationist mindset while the alternatives were not ready-made and indeed could not have been, as such a framework did not exist at that time. Their detractors used it to critique and halt the process of deinstitutionalization, since there were not sufficient placements for people with intellectual or psychiatric disabilities in the community; budgets for community mental health centres were miniscule if available at all. But deinstitutionalization and anti-psychiatry activists contended that until hospitals and institutions closed down, such alternatives and their accompanying budgets would never be transferred to alternatives. By insisting that the time for closure is now, or in other words that there is never an optimal time to make such a change, deinstitutionalization became a reality on the ground.