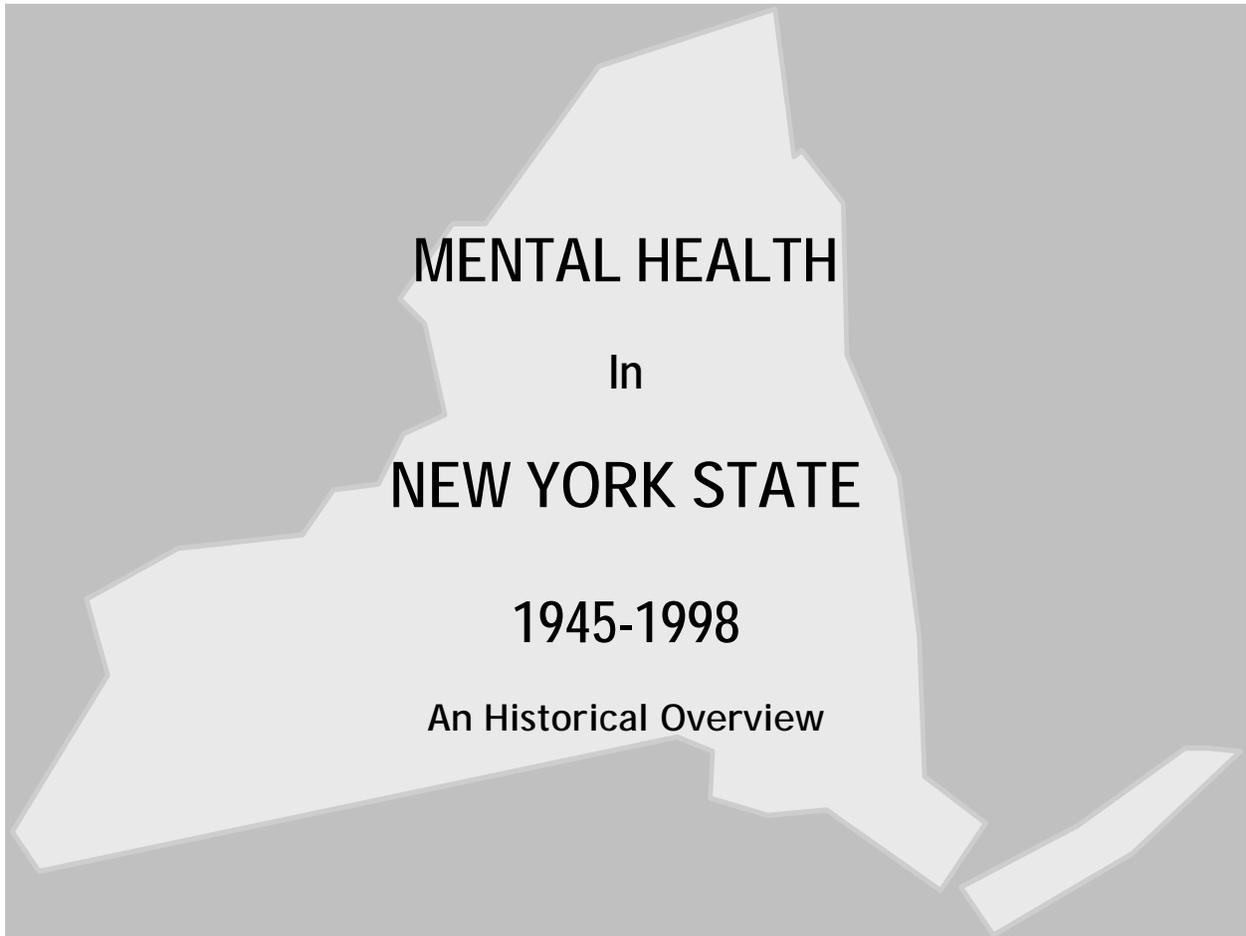




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# Mental Health in New York State, 1945-1998

## An Historical Overview

### Introduction

New York State has for more than one hundred years been a pioneer in the development of mental health treatment and research. Although it was not the first state to construct state-supported institutions specifically for the mentally ill, it was the first completely to relieve county and city governments of the burden of caring for their mentally ill inhabitants; the 1890 State Care Act, which placed all responsibility for the care and treatment of those suffering from mental disorders in the hands of state government, was emulated by a number of other states in subsequent years. The landmark 1954 Community Mental Health Services Act (CMHSA), which was born of the state's desire to divest itself of some of this responsibility, and policymakers' subsequent efforts to compel localities to improve care and to insure that the needs of the seriously mentally ill were being met also anticipated developments in other states and at the federal level.

The reasons for the state's consistent willingness to embrace innovation are obscure, but they may stem in part from the state's large size and, in the New York City metropolitan area, population density. Gerald Grob, the leading historian of mental health policy in the United States, asserts that the development of state mental institutions was but one of many responses to industrialization, urbanization, and immigration, which rendered ineffective the personal relationships and local social institutions that had during the nation's agrarian past cared for the needy.<sup>1</sup> New York State was among the first states to experience these sweeping changes, and as a result the need to devise effective responses to them arose sooner than it did elsewhere. In addition, New York State's demographic characteristics may have exacerbated the problems arising from past policy decisions; for example, policymakers' support for community-based mental health programs was in large part rooted in their awareness that New York State had the largest number of institutionalized people in the nation and fear that state hospital populations and costs would continue swelling.

New York State has also been unusually rich in the cultural resources and political will needed to develop and implement bold reforms. Grob notes that most nineteenth-century efforts to alter American mental health policy originated in the populous Northeast, which dominated the nation's cultural and intellectual life.<sup>2</sup> Although New York State does not seem to have had a nineteenth-century agitator as prominent as Dorothea Dix, the Massachusetts activist who fought to compel state governments to assume responsibility for the care of the mentally ill, it has had more than its share of individuals and organizations dedicated to improving the care of the mentally ill. A number of important national advocacy organizations such as the National Committee for Mental Hygiene (a forerunner of the National Association for Mental Health) were headquartered in New York City and were thus well placed to influence state policy decisions. In addition, New York State has long been known as a laboratory of political reform. Mental-health advocacy groups working in the state have consistently found governors and state legislators to be far more receptive to change than their counterparts in many other parts of the

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<sup>1</sup>Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Cambridge: Harvard University Press, 1994), 40, 43, 47-48.

<sup>2</sup>Grob, *The Mad Among Us*, 43.

United States. However, the state's politicians, like their counterparts elsewhere, have seldom been motivated solely by the desire to do good. Advocates of change have consistently been most successful when they have been able simultaneously to appeal to lawmakers' altruism, fiscal conservatism, and yearning for efficient solutions to bedeviling social problems; for example, the postwar push for community-based treatment and preventative care won adherents because it held out the promise of simultaneously slashing expenditures and reducing human suffering.

The report that follows presents an overview of the complex and often tense relationships that existed between and within the mental health professions, voluntary agencies and political activists, and state and federal politicians. It does not pretend to be definitive, and it deliberately avoids two powerful historiographical traditions that guide many studies of mental health treatment and policy. The first of these traditions, which began taking shape in the late nineteenth century and came of age in the 1940's and 1950's, asserts that state mental institutions are miserable warrens of neglect and suffering. The second, which emerged in the 1960's and continues to inform the arguments of many historians and sociologists, views mental institutions and the very concept of mental illness as means of controlling those who refuse to accept the mental and moral discipline of modern civilization. It seeks primarily to identify the individuals and organizations that shaped mental health policy in New York State, to assess how they interpreted the problems that confronted them, to uncover the mechanisms through which policy was implemented, and, in instances in which policy decisions were particularly ill-informed or inappropriate, to point out these failures. Important as they are, questions of whether state mental hospitals were (or are) inherently bad and whether policymakers were (or are) consciously or unconsciously trying to shore up the social order are in many respects tangential to this endeavor.

### **The Policy Revolution, 1945-65**

Between the enactment of the State Care Act and the passage of the CMHSA, the government of New York State was almost exclusively responsible for the care of the mentally ill. However, a number of important changes took place during this sixty-year period. During the first decades of the twentieth-century, a growing number of Progressive-era psychiatrists were no longer content to see themselves as state hospital-based purveyors of custodial care and began envisioning a broader role for themselves. Rejecting the nineteenth-century belief that mental illness was biologically based and typically incurable and that psychiatrists' chief responsibility was to furnish humane custodial care, they sought to reestablish psychiatry's ties to the medical profession and adopt its therapeutic orientation. They also sought to bring their expertise to bear upon a broad array of social problems such as alcoholism and venereal disease. Seeing these ills as manifestations of mental disorder, they asserted that safeguarding individual and social mental hygiene would ultimately eradicate these vexing problems. The psychiatrists drawn to the mental hygiene movement, which was spearheaded by the Manhattan-based National Committee for Mental Hygiene (NCMH), were convinced that mental illness had a hereditary component and had little faith in their power to cure it once it had developed.<sup>3</sup> At the

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<sup>3</sup>The NCMH was founded in 1909 by psychiatrist Adolf Meyer and Clifford Beers, a Yale University graduate who had been institutionalized for a short period of time. At first, it devoted most of its energies to improving conditions in state hospitals, but within ten years of its foundation focused chiefly upon preventative programs and comprehensive studies of mental illness and treatment; see Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 147-66. In 1950, the NCMH merged with the Psychiatric Association, the fundraising division of the American Psychiatric

same time, they were confident that those predisposed to develop mental disorders could remain healthy if they learned how to respond appropriately to their environment; as a result, champions of mental hygiene believed that teaching adults and, in particular, children how to negotiate adverse personal and social circumstances could help to prevent many (generally less serious) forms of mental illness.<sup>4</sup> The psychiatrists who gravitated toward the movement were also confident in their ability to work in concert with social workers, psychologists, occupational therapists, and other professionals who could help to improve people's mental adjustment; however, by the 1930's many of them felt that these other professionals were challenging their authority and expertise.<sup>5</sup>

The activities of those drawn to the mental hygiene movement were varied. The leaders of the NCMH and other mental hygiene organizations were like other Progressive-era reformers in that they were convinced that scientific study of social problems would highlight potential remedies and force policymakers and the public to take action. As a result, these groups sponsored a number of local studies of mental illness and treatment options; however, their firm belief that mental illness was preventable often overcame their objectivity.<sup>6</sup> They also undertook an ambitious and remarkably successful effort to convince social workers, parent-education groups, and teachers that children were vulnerable to mental illness and that intellectual accomplishment should not come at the expense of personality development.<sup>7</sup> In addition, mental-hygiene organizations spurred the creation of a number of community-based mental health programs, which were sponsored by Community Chest groups, private foundations such as the Rockefeller Foundation, the Laura Spellman Rockefeller Memorial Fund, the Milbank Memorial Fund and the Commonwealth Fund, the State Charities Aid Association, medical schools, and, in some urban areas, city governments.<sup>8</sup> Information about specific programs is

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Association (APA), and the National Mental Health Foundation, an outgrowth of the federal government's wartime Mental Hygiene Program of the Civilian Public Service, and became the National Association for Mental Health. The association was supported largely through grants from the Rockefeller Foundation; see Theresa R. Richardson, The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada (Albany: State University of New York Press, 1989), 155-57.

<sup>4</sup>Grob, Mental Illness and American Society, 144-45, 166-71. Grob notes that the emphasis that psychiatrists within the mental hygiene movement placed upon the preventability of mental illness kept most of them from embracing the less savory aims of some of the movement's other adherents: compulsory sterilization of the mentally ill and developmentally disabled and harsh immigration restrictions designed to keep southern and eastern Europeans out of the country.

<sup>5</sup>Grob, Mental Illness and American Society, 243-65, details the emergence of psychiatric social work, psychology, and occupational therapy and the increasing tension that characterized their relations with the psychiatric profession.

<sup>6</sup>Grob, The Mad Among Us, 156. For an example of the kind of social research undertaken by those active in the mental hygiene movement, see Elizabeth Greene, George K. Pratt, Stanley P. Davies, and V.C. Branham, Report of a Survey of Mental Hygiene Facilities and Resources in New York City (New York: National Committee for Mental Hygiene and New York City Committee on Mental Hygiene, State Charities Aid Association, 1929).

<sup>7</sup>Sol Cohen, "The Mental Hygiene Movement, the Development of Personality and the School: The Medicalization of American Education," History of Education Quarterly 23 (Summer 1983): 124-25, 128-39. By the 1950's, pedagogical theorists had embraced mental-hygienist ideas so fervently that the movement itself no longer existed within educational circles; the movement was a victim of its own success.

<sup>8</sup>Community Chest organizations were peacetime outgrowths of the War Chest charity federations that were formed in order to relieve domestic hardship during the First World War. Like their parent bodies, they were federations that solicited corporate as well as individual contributions. After the Second World War, many Community Chest federations joined forces with the Red Cross and other organizations that were not chiefly concerned with assisting the needy and became United Funds. The federations' adoption of their current name, the United Way, came sometime afterward. For a brief history of the origins of Community Chests, see Community Surveys, Inc., of Indianapolis, Community Chest: A Case Study in Philanthropy (Toronto: University of Toronto Press, 1957), 20, 266-67. For information about the philanthropic foundations that supported mental-hygiene programs, see Richardson, The Century of the Child, 40-41. The New York State Charities Aid Association, which had since its formation in 1872 worked to improve state asylum conditions, created a New York City Committee on Mental Hygiene in 1927. The association, now known as the State Communities Association, still exists and still takes an active interest in state mental health policy; see, e.g., New York State Communities Aid Association, Mental Health at the Crossroads: The Case for

scant, but they existed in Albany and the New York City and it is probable that child guidance clinics and other mental hygiene initiatives took shape in other cities.<sup>9</sup>

Adherents of the mental hygiene movement also sought to alter public policy, and their success in gaining the attention of New York State's legislators is evident in the name given a state agency created in 1926: the Department of Mental Hygiene (DMH). The responsibilities of the DMH as it was first constituted were very modest: the agency was to "visit and inspect all institutions, either public or private, used for the care and treatment of" people who were mentally ill, epileptic, or mentally retarded.<sup>10</sup> However, in the following year the state's new Mental Hygiene Law gave the agency the responsibilities and overall structure that it would have for the next fifty years. It made the DMH responsible for the administration of all state-owned institutions caring for those with mental disorders and for insuring that all mentally ill, developmentally disabled, and epileptic New Yorkers received appropriate care. One provision of the Mental Hygiene Law further testified to the influence of the mental hygiene movement upon state policy: it mandated the creation of a DMH Division of Prevention, which was to monitor "psychiatric field work [and] after care and community supervision" of individuals discharged from state hospitals and perform other activities needed to avert the development of mental disorders.<sup>11</sup>

At the same time as psychiatric champions sought to expand their professional influence beyond the grounds of state mental hospitals, psychiatric activities within these institutions were changing substantially. The years between the First and Second World Wars witnessed the development of new therapies that initially seemed quite promising: fever therapy, which was developed during the 1920's, the surgical procedure known as prefrontal lobotomy, which emerged a decade later and seemed to promise an end to uncontrollable violence and a cure for at least some patients who were not helped by other therapies, insulin and metrazol shock therapies, which also came into use in the 1930's, and electro-convulsive treatment, which was used in the United States from the early 1940's onward and replaced insulin and metrazol as the shock treatment of choice. Psychiatrists were often extremely ambivalent about these therapies, which were drastic and poorly understood. Shock and surgical treatments sometimes produced modest or pronounced improvements, but even their leading proponents did not understand how or why they worked. This uncertainty aside, the aggressive therapeutic stance that underlay these therapies was a manifestation of psychiatrists' desire to prove themselves to be competent physicians.<sup>12</sup>

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Psychiatric Rehabilitation (Albany: New York State Communities Aid Association, 1991). For the development of Charities Aid Associations across the nation, see Grob, The Mad Among Us, 131-32. For information about the New York City Committee on Mental Hygiene, see Greene, Pratt, Davies, and Branham, Report of a Survey of Mental Hygiene Facilities and Resources in New York City.

<sup>9</sup>Between 1945-59, the Community Chest of Albany and city social welfare organizations sponsored a program for children with emotional problems; see Stanley P[owell] Davies, Toward Community Mental Health: A Review of the First Five Years of Operations under the Community Mental Health Services Act of the State of New York (New York: New York Association for Mental Health, 1960), 63-64. As of 1939, the New York City's school system had a Bureau of Child Guidance that served children living in four of the city's boroughs; see Central Hanover Bank and Trust Company, Department of Philanthropic Information, The Mental Hygiene Movement: From the Philanthropic Standpoint (New York: Central Hartford Bank & Trust Co., 1939), 52.

<sup>10</sup>The DMH was created as a result of the constitutional reorganization of New York State government approved by the electorate in November 1925; see New York State Constitution (1925), art. 5, § 2, § 11. The DMH's inspection duties had formerly been assigned to the State Mental Hospital Commission and the State Commission for Mental Defectives, which ceased to exist in the wake of the government's reorganization.

<sup>11</sup>Mental Hygiene Law, Laws of New York (1927), Ch. 426, § 4.

<sup>12</sup>Grob, Mental Illness and American Society, 296-306.

As important as these therapeutic innovations were, they were not the only developments shaping psychiatrists' attitudes about state mental institutions. A number of phenomena taking place outside of the mental health field posed great difficulties for state hospital administrators and grave problems for their patients. The economic hardships of the Great Depression resulted in pervasive overcrowding, staff shortages, and deterioration of facilities' physical plants. These problems worsened throughout the Second World War, which siphoned resources and personnel away from state hospitals and other institutions serving the civilian population. After the war ended, this constellation of problems gave rise to a concerted professional and public campaign for improvement of hospital conditions.<sup>13</sup> Reformers had long been critical of the level of care furnished in most state mental hospitals, but after the end of the Second World War their condemnation of state institutions became increasingly vocal. Albert Deutsch, author of the classic postwar polemic, The Shame of the States, and other reformers who penned exposés of institutional conditions began calling not only for dramatic improvements in hospital conditions but a fundamental reevaluation of the role of state facilities in the care and treatment of the mentally ill.<sup>14</sup> Their writings, which almost uniformly depicted state hospitals as dens of great and pointless suffering, to this day exert lingering influence upon popular and scholarly conceptions of mental institutions.

Postwar lay reformers were not alone in questioning the existence of state mental hospitals. Psychiatrists themselves called for nothing less than a revolutionary change in the treatment of the mentally ill. The profession's prewar efforts to broaden its responsibilities and loosen its ties to state institutions came to full fruition as a growing number of its practitioners began denouncing mental hospitals. Psychiatrists who had treated military personnel suffering from combat-related mental illness found that this patient cohort responded best to immediate, short-term care furnished outside of the asylum environment. In addition, many of them shared the public's shock and revulsion at the dilapidation and overcrowding that existed in many state facilities. The combination of wartime therapeutic successes and disgust at existing institutional conditions led a growing number of psychiatrists to see traditional mental hospitals as inherently detrimental to patients. Convinced that the mental illnesses found in the civilian population were essentially identical to those suffered by military personnel and that state institutions were impeding effective treatment, they began stressing the environmental dimensions of mental disease and the efficacy of outpatient-based therapy and preventative care.<sup>15</sup>

The psychiatric profession's postwar shift toward environmental models of mental illness should not be exaggerated. Some practitioners remained convinced that mental disorders were biological in origin or that they were largely incurable, and the American Psychiatric Association (APA) and other psychiatric professional organizations endured bitter battles over theories of etiology, personality formation, behavioral motivation, and treatment models during the late 1940's and 1950's. Furthermore, even die-hard environmentalists embraced Thorazine and other new psychiatric drugs that appeared in the mid-1950's and shared the profession's belief that these new medicines would facilitate outpatient treatment.<sup>16</sup> Nonetheless, those dissatisfied with the traditional inpatient hospital and somatic theories about the etiology of mental illness were very much in the ascendant, and their influence is manifest in post-war legislative

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<sup>13</sup>Gerald N. Grob, From Asylum to Community: Mental Health Policy in Modern America (Princeton: Princeton University Press, 1991), 161-65.

<sup>14</sup> Albert Deutsch, The Shame of the States (New York: Harcourt, Brace, [1948]).

<sup>15</sup>Grob, From Asylum to Community, 8-23, 71-77.

<sup>16</sup>Grob, From Asylum to Community, 146-50.

developments.<sup>17</sup> Even before the end of the Second World War, reform-oriented mental health professionals such as Robert Felix, the head of the Public Health Service's Division of Mental Hygiene, began lobbying for federal funding of treatment of and research concerning mental illness.<sup>18</sup> The efforts of Felix and others gave impetus to the 1946 National Mental Health Act (NMHA), which sanctioned the disbursement of funds to researchers studying the etiology and treatment of mental illness, to institutions educating mental health professionals, and to states desiring to establish or maintain local mental health programs. The NMHA also provided for the establishment of a new division of the National Institute of Health, the National Institute for Mental Health (NIMH), which would be responsible for evaluating grant applications and monitoring funded projects; the NIMH was formally established in 1949, and Robert Felix served as its head from 1949-64.<sup>19</sup> The Hill-Burton Act, also passed in 1946, provided funds for construction of mental hospitals and psychiatric wings in general hospitals and thus further increased federal involvement in mental health care.<sup>20</sup>

Federal developments were paralleled by those taking shape at the state level. Although mental health was rarely their top concern, state politicians shared professional and broader public concerns about institutional conditions, and they were also concerned about the cost of caring for the mentally ill. Those in New York State, which had by far the largest number of institutionalized patients, were particularly eager to alter the manner in which care was provided and funded. Community treatment and prevention programs took shape in almost every state during the 1950's, and state funding for such programs rapidly outstripped federal support.<sup>21</sup> In New York, legislation enacted in 1949 created the New York State Mental Health Commission (SMHC) within the DMH. The SMHC, which was to meet annually between 1949-54 and to submit to the legislature a final report outlining its recommendations in February 1954, was charged with creating a master plan for state mental health programs. Components of this master plan were to include, among other things, facilitating the recruitment and training of needed mental health personnel, planning and developing needed in- and outpatient services for children and adults, sponsoring needed research, and coordinating the activities of public and private agencies working in any given community.<sup>22</sup>

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<sup>17</sup>Grob, From Asylum to Community, 24-43, 124-46. As Grob points out, the psychiatric profession was syncretistic, and few of its practitioners denied that both somatic and environmental factors contributed to mental illness; psychiatrists differed as to which set of factors was most important.

<sup>18</sup>Grob, From Asylum to Community, 44-53.

<sup>19</sup>Grob, From Asylum to Community, 53-56. The status and responsibilities of the NIMH have changed substantially. In 1953, the Public Health Service, of which the NIH and the NIMH were part, was made part of the newly created Department of Health, Education, and Welfare (HEW; renamed the Department of Health and Human Services after the creation of the Department of Education in 1979). The NIMH was severed from the National Institute of Health (NIH) and given bureau status in 1967, but in 1973 it was again made part of the NIH. At the same time, it was made part of HEW's newly-created Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Following the ADAMHA Reorganization Act of 1992, which abolished the ADAMHA and replaced it with the Substance Abuse and Mental Health Services Administration (SAMHSA), the NIMH became part of SAMHSA and its research activities were transferred to the NIH. See National Institute of Mental Health, NIMH Legislative Chronology, available [online]: <<http://www.nimh.nih.gov/about/legichro.htm>> [ 23 April 1998].

<sup>20</sup>Grob, From Asylum to Community, 166.

<sup>21</sup>Grob, From Asylum to Community, 59.

<sup>22</sup>Act of April 7, 1949, Laws of New York, ch. 733, § 1-2, § 6. As it existed in the wake of the 1949 legislative changes, the SMHC was chaired by Dr. Newton Bigelow (later director of the Marcy State Hospital) and consisted of the state commissioners of health, education, social welfare, and correction; Dr. Ernest M. Gruenberg served as its executive director, Hyman C. Forstenzer as assistant director, and Luther E. Woodward as coordinator of community mental health services in the New York City metropolitan area; see Davies, Toward Community Mental Health, 2. The SMHC apparently enjoyed a de facto existence before it received its legal recognition and mandate: in 1947, it began receiving federal funds allocated in accordance with the 1946 Mental Health Act; see Davies, Toward Community Mental Health, 2-3.

The SMHC ultimately concluded that public demand for community-based mental health care was increasing, that such care was in egregiously short supply in every part of the state, that the availability of such care varied widely from one locality to the next, that there was no single local government agency accountable for community mental health programs, and that the efforts of various state agencies to establish programs for populations in need led to local-level confusion. These findings and politicians' ever-present concerns about the escalating cost of supporting the state's mental hospitals, which cared for roughly one-fifth of the nation's 559,000 psychiatric inpatients, helped to propel passage of New York State's Community Mental Health Services Act (CMHSA), the first legislation of its kind in the United States.<sup>23</sup> State politicians who feared that funding community-based services would place further pressure on the state budget were ultimately persuaded to support the act by the mounting expense of inpatient treatment and predictions that state hospital admissions would increase and that community-based care would be cheaper than treatment furnished in state institutions, and psychiatrists' assertions that community-based care was more humane and effective.<sup>24</sup>

The CMHSA encouraged but did not compel the governments of counties and of cities of more than 50,000 people to establish community mental health boards (CMHB's); New York City was exempted from these guidelines and instructed to create a single CMHB for all five boroughs.<sup>25</sup> By law, CMHB's were composed of the locality's ranking health and welfare officials and at least two physicians and headed by psychiatrists; other local officials and representatives from community service groups were allowed to sit on them.<sup>26</sup> CMHB's were to assume responsibility for identifying and planning to meet the mental health needs of their communities and administering all locally-based in- and outpatient preventative, treatment, rehabilitation, and educational/consultative programs. In effect, the act gave CMHB's a sweeping mandate but little concrete direction. The CMHSA also sought to induce localities to act by compelling the state to reimburse half of a given CMHB's approved expenditures.<sup>27</sup> The CMHSA capped the reimbursement that a given CMHB could request at \$1.00 per capita of the general population it served. Although this figure sounds low, the intent of those who drafted the reimbursement provision was to double the existing level of care in the best-served parts of the state.<sup>28</sup> At the same time, legislators passed a bond act designed to raise \$350,000,000 for construction of new state hospital facilities and the planned community mental health centers; the act, which attached mental health construction bonds to an existing bond act designed to provide bonuses to World War II veterans and their families, was subsequently approved by voters.<sup>29</sup>

The move toward community-based and -controlled mental health care was given added momentum by changes in the operations of state mental hospitals. The open hospital movement, which emerged in Great Britain in the late 1940's and early 1950's and, in the wake of British presentations at the 1954 World Association for Mental Health conference in Toronto, began shaping inpatient mental health care in the United States during the mid- to late 1950's. Its

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<sup>23</sup>Grob, *The Mad Among Us*, 234; Grob, *Mental Illness and American Society*, 317.

<sup>24</sup>Grob, *From Asylum to Community*, 171-72.

<sup>25</sup>*Community Mental Health Services Act*, *Laws of New York* (1954), ch. 10, § 190-a, subd. 1-2.

<sup>26</sup>*Community Mental Health Services Act*, *Laws of New York* (1954), ch. 10, § 190-b subd. 1 and subd. 3.

<sup>27</sup>*Community Mental Health Services Act*, *Laws of New York* (1954), ch. 10, § 190-c and § 191-a, subd. 1.

<sup>28</sup>*Community Mental Health Services Act*, *Laws of New York* (1954), ch. 10, § 191-a. On the goal of doubling care levels, see Davies, *Toward Community Health*, 8.

<sup>29</sup>*Mental Health Construction Bond Act*, *Laws of New York* (1954), ch. 8, § 2. Act of 5 February 1954, *Laws of New York*, ch. 9, § 1, § 3, created the War Bonus and Mental Health Bond Account, which was financed through a combination of income tax revenue and a one-half cent per pack tax on cigarettes.

adherents believed that state institutions as they then existed infantilized patients and intensified their mental illnesses.<sup>30</sup> They argued that that involuntary commitment and institutional regimentation, no matter how gentle, robbed patients of decision-making abilities and other skills they needed to function in society. They also urged that commitment to mental hospitals be largely voluntary and that hospitals allow patients the greatest possible control over their own movements and behavior; high walls, tight schedules, and security checks were to be replaced by open facilities that allowed patients to choose how and where they would spend their time. Lastly, proponents of the open hospital envisioned a smaller treatment role for the hospital, stressing that institutionalization should be of short duration and that it should become part of an array of in- and outpatient programs designed to allow the mentally ill to return to society as soon as possible.<sup>31</sup> As Gerald Grob notes, their ultimate goal was "to blur the demarcation between . . . hospital and community."<sup>32</sup>

New York State mental health officials and professionals found the open hospital concept highly attractive. In 1957, DMH Commissioner Paul H. Hoch sent six state mental hospital administrators to Britain to study open facilities. All six became adherents of the concept, and by late 1959, seventy percent of the patients at the Central Islip State Hospital, eighty percent of those at the Brooklyn State Hospital, and ninety percent of those at the Hudson River and Middletown State Hospitals resided in open wards.<sup>33</sup> Hoch and other New York State professionals who advocated the creation of open hospitals were aided by the New York City-based Milbank Memorial Fund, which had since 1922 provided money for public health projects and studies in New York State and had become interested in mental health issues during the 1930's. The fund financed the 1957 hospital administrators' tour of British facilities and held annual conferences at which American, Canadian, and British mental health professionals detailed their efforts to create effective prevention, treatment, and rehabilitation projects. In turn, high-ranking New York State mental health officials helped guide the fund's activities: Commissioner Hoch and Hudson River State Hospital head Dr. Robert C. Hunt sat on its Technical Board.<sup>34</sup>

New York State advocates of the open hospital identified several obstacles that stood in their way. They felt that the courts were overly concerned about the possibility that lowering the number of involuntary commitments might increase the crime rate, and they believed that the

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<sup>30</sup>Grob, *From Asylum to Community*, 140-41, 144-46.

<sup>31</sup>See, e.g., Robert G. Hunt, "Ingredients of a Rehabilitation Program," in Milbank Memorial Fund, *An Approach to the Prevention of Disability from Chronic Psychoses: The Open Mental Hospital within the Community* (New York: Milbank Memorial Fund, 1958), 9-27.

<sup>32</sup>Grob, *From Asylum to Community*, 145.

<sup>33</sup>The six administrators sent to Britain were: Dr. Nathan Beckenstein, head of Brooklyn State Hospital; Dr. Robert C. Hunt, head of Hudson River State Hospital; Dr. Francis J. O'Neill, head of Central Islip State Hospital; Dr. Hyman Pleasure, head of Middletown Hospital; Dr. Herman B. Snow, head of St. Lawrence State Hospital; Dr. C.F. Terrence, head of Rochester State Hospital. It is unclear as to just how many patients at the St. Lawrence and Rochester State Hospitals were in open wards; however, Dr. Pleasure reported that sixty-five percent of those at St. Lawrence were in such wards even before he went to Britain and that even more patients were placed in open wards after he returned. For the views of the six psychiatrists who went to Britain and their subsequent efforts to emulate their British counterparts, see "Reports of Group Visits to Great Britain's Community-Based, Open Mental Hospitals," in Milbank Memorial Fund, *Steps in the Development of Integrated Psychiatric Services: Report of the Third Meeting of the Advisory Council on Mental Health Demonstrations* (New York: Milbank Memorial Fund, 1960), 14-36.

<sup>34</sup>Information about the Milbank Memorial Fund and its activities can be found in Ernest M. Gruenberg and Frank G. Boudreau, "Preface," in *An Approach to the Prevention of Disability from Chronic Psychoses*, 5, and Grob, *From Asylum to Community*, 89, 169. Grob asserts that the fund began supporting mental health projects in the 1940's, but a 1939 overview of the mental hygiene movement indicates that the organization's concern with mental health developed at least a decade earlier; see Central Hartford Bank & Trust Co, *The Mental Hygiene Movement*, 57.

general public's lack of knowledge about the nature of mental illness was impeding progress. They also perceived another hurdle specific to New York State: the 1890 State Care Act, which made treatment of the mentally ill the exclusive responsibility of the state. In 1957, Robert Hunt charged that:

"The state [had] . . . in effect established a system that allows everyone else to be irresponsible. Local government, general hospitals, practicing physicians, individual citizens, and patients long since abdicated to the state all responsibility for caring for their fellow man when he becomes mentally ill. In New York State local officials can . . . dispose of a problem case with no cost whatever [sic] to any local agency or to the family. They may actually make a profit by removing a name from the welfare rolls."<sup>35</sup>

Not all advocates of community mental health care believed that local politicians were obsessively stingy.<sup>36</sup> However, Hunt's argument continually resurfaced in subsequent decades. In 1965, the New York State Planning Committee on Mental Disorders, which was composed of state officials, mental health professionals, CMHB members, and representatives from interested private groups, argued that "choice of treatment facility should be based on the needs of the patient" and implied that ending "exclusive State fiscal responsibility for State hospital care" would result in more appropriate treatment.<sup>37</sup> In 1976, the Assembly Joint Committee to Study the Department of Mental Hygiene noted that "the presence of a State facility in a county [could] inhibit the development of local programs because it [was] easier and less costly for the locality to use the State facility."<sup>38</sup>

Not surprisingly, the enthusiasm of Hoch, Hunt, and other New York State mental health professionals for community health care programs far exceeded the rate of program development. Community-based programs took shape gradually and CMHB personnel benefited from the creation in 1956 of the Association of Community Mental Health Boards (ACMHB), which from 1957 onward sponsored annual conferences intended to allow CMHB members to share their experiences.<sup>39</sup> However, progress did not occur at the speed that reformers wanted. Stanley Davies, who in 1959 conducted a study of CMHB's for the New York Association for Mental Health, underscored the slow rate of change.<sup>40</sup> Davies visited thirty of the thirty-one

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<sup>35</sup>Hunt, "Ingredients of a Rehabilitation Program," 16.

<sup>36</sup>In 1959, Dr. William Carson, the chair of the St. Lawrence County CMHB, asserted that he was "constantly amazed" that many of his colleagues seemed to regard "elected officials, particularly boards of supervisors [..] as backwoodsmen without any thought except guarding the county treasury" and stressed that officials generally wanted what was best for their communities; see New York State Department of Mental Hygiene, Association of Community Mental Health Boards, Fourth Annual Conference of Community Mental Health Boards (Albany, NY: Department of Mental Hygiene, 1959), 69-70.

<sup>37</sup>New York State Planning Committee on Mental Disorders, A Plan for a Comprehensive Mental Health and Mental Retardation Program for New York State, vol 1., Report of the Mental Health and Mental Retardation Sections of the State Planning Committee (Albany, NY: , 1965), 8.

<sup>38</sup>New York State Assembly, Assembly Joint Committee to Study the Department of Mental Hygiene, Mental Health in New York: A Report To Speaker Stanley Steingut from the Assembly Joint Committee to Study the Department of Mental Hygiene (Albany: New York State Assembly, 1976). It is important to note that local officials in certain areas may have had another reason for relying upon state facilities: fear that the hospitals would be shut down. Rural state hospitals brought money and jobs into the villages and small towns adjacent to them, and local officials might have feared that community mental health programs would ultimately lead to hospital closure.

<sup>39</sup>[New York State Department of Mental Hygiene, Association of Community Mental Health Boards], Second Annual Conference of New York State Community Mental Health Boards. [Albany: Department of Mental Hygiene, 1957], 11.

<sup>40</sup>Davies was Director of Special Studies for the New York State Association for Mental Health at the time he carried out the study. At various times, he had been associate director of the New York State Charities Aid Association, executive secretary of the New York State Committee on Mental Hygiene, general director of the Community Service Society of New York City, president of the New York State Association for Mental Health, a board member of the National Association for Mental Health,

counties that had CMHB's or community mental health programs in place in late 1959, and found that there were 171 outpatient mental health clinics in operation (seventy-nine of which were in New York City), general psychiatric wards in eighteen hospitals, thirty-six consultative and educational programs, and four rehabilitation programs.<sup>41</sup> The sole responsibility of the CMHB's in the thirteen rural counties, which he defined as those that had less than 200,000 inhabitants, was the administration of all-purpose part- or full-time clinics; in six of these counties, these clinics did not exist prior to the formation of the county CMHB.

In explaining why the pace of change was so slow, Davies pointed to a number of issues. Funding was a persistent problem, and CMHB's that operated in rural areas often found it particularly difficult to secure adequate funds. Rural CMHB's also found it hard to induce qualified psychiatrists, psychologists, social workers, and other needed personnel to move away from cities.<sup>42</sup> In addition, those that were established in counties without existing social-welfare and child-services agencies were besieged by people with needs and problems that fell outside of the CMHB's legal mandate.<sup>43</sup> Urban-area CMHB's, which typically inherited control of programs that were already in existence and worked with voluntary organizations seeking state reimbursement, encountered a different set of problems. Local governments that had financed community initiatives and voluntary mental-health programs were eager to secure state funds, and urban CMHB's were beset by reimbursement demands as soon as they were formed. These demands and the administrative functions that these CMHB's were forced to perform almost immediately after they came into existence often consumed all of their time and resources, and they were unable to fulfil the planning component of their mission. In addition, CMHB's that assumed control over or, as was more common, established service contracts with existing programs sometimes found that program personnel saw them as usurpers.<sup>44</sup> The CMHB governing community health programs in New York City, which furnished the highest level of local services in New York State, encountered particular difficulties. Demand for reimbursement was such that the city's CMHB quickly reached the maximum established by the CMHSA and could not establish any other programs.<sup>45</sup>

Davies also discovered that the availability of care continued to vary widely from one part of the state to the next, and he identified another difficulty stemming from the provisions of the CMHSA: localities that did not wish to establish a CMHB were under no obligation to do so, and a number of counties, almost all of which were rural, had witnessed failed attempts at persuading county officials and the broader public that community-based mental health services were needed. Stressing that the solution to this problem lay in the education of citizens and local politicians, Davies did not argue that communities should be compelled to create CMHB's or to allocate funds for community programs.<sup>46</sup> However, in highlighting the role of citizen resistance in retarding the creation community programs he identified a problem that in future decades

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president of the Family Service Association of America, and president of the Mental Health Materials Center; see New York State Department of Mental Hygiene, *New York State Association of Community Mental Health Boards, Sixth Annual Conference of New York State Community Mental Health Boards* (Albany: Department of Mental Hygiene, 1961), 53.

<sup>41</sup>Davies, *Toward Community Mental Health*, 9-10. The Chemung County CMHB refused to allow Davies to assess its activities. CMHB's existed in Albany, Broome, Cayuga, Chemung, Dutchess, Erie, Greene, Jefferson, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Putnam, Rockland, St. Lawrence, Saratoga, Schenectady, Suffolk, Ulster, Warren, Washington, Wayne and Westchester counties and in the New York City.

<sup>42</sup>Davies, *Toward Community Mental Health*, 11-13.

<sup>43</sup>Davies, *Toward Community Mental Health*, 32.

<sup>44</sup>Davies, *Toward Community Mental Health*, 14-15, 22.

<sup>45</sup>Davies, *Toward Community Mental Health*, 204-05.

<sup>46</sup>Davies, *Toward Community Mental Health*, 24.

would continue to bedevil advocates of locally-based prevention, treatment, and rehabilitation: the public's ongoing ignorance about mental illness and persistent preference for segregation of the mentally ill in isolated institutions.

Davies did not explicitly single out one other factor that helped to retard the development of community mental-health programs: the imprecision of the CMHSA as to priorities and target clienteles. Responsibility for making such assessments was placed in the hands of individual CMHB's with the laudable intent of allowing each community to create programs and policies that best met its unique circumstances and needs. However, assigning primary responsibility for effecting radical changes in mental health policy to inexperienced local organizations virtually guaranteed that progress would be slow. State officials became increasingly aware that CMHB's were in need of guidance, and in 1959 the DMH created ten Regional Mental Health Advisory Committees (RMHAC's) that were charged with helping CMHB's plan, implement, and administer programs.<sup>47</sup> In 1962, the DMH created the positions of Associate Commissioner for Community Services and Assistant Commissioner for Community Services in an effort to facilitate the development of local programs.<sup>48</sup> In 1965, it underwent a structural reorganization that made the newly created Division of Local Services one of its three main operating divisions.<sup>49</sup>

The lack of coordination between state and local efforts nonetheless persisted. The obstacles encountered by CMHB's and their champions within the DMH were many and their origins complex. The difficulty of coordinating local and state initiatives and creating a comprehensive array of in- and outpatient services was the subject of the 1961 annual conference of the Milbank Memorial Fund. At the conference, future Commissioner of Mental Hygiene Dr. Lawrence R. Kolb argued that research- oriented and teaching hospitals, long noted for furnishing high levels of care to the mentally ill, could nonetheless act in ways that were counterproductive. Their admissions policies were guided in part by the need for exemplary teaching and research cases, and as a result some patients who were in great need of care were turned away. Such policies often resulted in a poor fit between the hospital and community it served and also served students and researchers poorly: those exposed only to these carefully selected cases failed to grasp the actual distribution of mental illness within communities or to appreciate the role of community-based programs in aiding the mentally ill.<sup>50</sup> Others present at the conference highlighted the persistence of staffing shortages, localities' reluctance to fund

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<sup>47</sup>The RMHAC's, which consisted of CMHB and state hospital administrators, were: New York City Region (Bronx, Kings, New York, Queens, and Richmond counties); Albany Region (Albany, Rensselaer, Saratoga, Schenectady, Warren, and Washington counties); Binghamton Region (Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schoharie, and Tioga counties); Buffalo Region (Allegany, Cattaraugus, Chautauqua, Erie, and Niagara counties); Catskill Region (Orange, Rockland, Sullivan, and Ulster counties); Hudson River Region (Columbia, Dutchess, Greene, Putnam, and Westchester counties); Long Island Region (Nassau and Suffolk counties); Rochester region (Cayuga, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Tompkins, Wayne, Wyoming, and Yates counties); St. Lawrence Region (Clinton, Essex, Franklin, Jefferson, Lewis, and St. Lawrence counties); and Syracuse Region (Fulton, Hamilton, Herkimer, Madison, Montgomery, Oneida, Onondaga, and Oswego counties).

<sup>48</sup>New York State Department of Mental Hygiene, Summary Statement of Reorganization of Department of Mental Hygiene, October 1, 1962 (Albany: Department of Mental Hygiene, 1961), [4]. The actual implementation of the reorganization plan seems to have occurred somewhat later. Dr. Leonard Lang served as Associate Commissioner for Community Services for a short time; he was subsequently made Commissioner for Mental Hospitals. Lang was replaced by Dr. Alan D. Miller, who also vacated the office shortly after being appointed: he was made Commissioner for Mental Hygiene in February 1966 and remained in that post until his retirement in 1974.

<sup>49</sup>New York State Department of Mental Hygiene, 1965 Annual Report (Albany, NY: Department of Mental Hygiene, 1965), 7.

<sup>50</sup>Lawrence R. Kolb, "Problems of Integration . . . in New York City: The Voluntary Hospitals and Psychiatric Care in the Metropolitan Area," in Milbank Memorial Fund, Decentralization of Psychiatric Services and Continuity of Care: Proceedings of the Thirty-Eighth Annual Conference of the Milbank Memorial Fund (New York: Milbank Memorial Fund, 1962), 67-68, 70.

programs, and the dearth of rehabilitative programs designed to ease the return from the mental hospital to society.<sup>51</sup>

Despite these difficulties in implementation, the New York State CMHSA anticipated developments taking place in other states. California, New Jersey, and Minnesota passed similar laws in 1957, and mental health authorities in other states began implementing similar programs without benefit of legislative mandate.<sup>52</sup> New York State's new mental health policy also set the course changes that took place on the federal level. In the early 1950's interested members of Congress, federal officials working within the NIMH and the Department of Health, Education, and Welfare (HEW), and mental health professionals active in the APA and the American Medical Association (AMA) agreed that the federal government should take a more active role in financing and directing mental health care. In 1955, they established the Joint Commission on Mental Illness and Health (JCMIH), which was sponsored by APA and AMA but supported in part by federal funds. The JCMIH issued its final report, entitled Action for Mental Health, in 1961. Action for Mental Health outlined a comprehensive plan that called for federal support for construction and staffing of community mental health centers. Neither the AMA nor the APA unconditionally accepted the recommendations of the JCMIH, which nonetheless guided the development of federal mental health policy.<sup>53</sup> In 1963, the Community Mental Health Centers Construction Act (CMHCCA), which authorized funds to help defray the costs of constructing (but not staffing) local clinics, was enacted; federal support for staffing, which was administered by HEW, was passed in August 1965. The CMHCCA also established federal funding for the care and training of the mentally retarded and developmentally disabled, whose circumstances were of particular concern to President John F. Kennedy, other members of the Kennedy family, and a growing number of citizen advocates.<sup>54</sup> However, the CMHCCA, which constituted a radical break from previous national mental health policy in both the kind of facilities it supported and the degree of direct federal involvement that it represented, did not clearly define the functions and target clientele of the community centers or their relationship to other local health-care institutions.<sup>55</sup> In its imprecision, it strongly resembled New York State's CMHSA.

The CMHCCA reinforced New York State's move toward community-based provision of mental health care. Under its provisions, funds were made available for every state that devised plans for community mental health programs and facility construction, designated an agency to execute them, and appointed a broadly representative advisory council to guide state policy. In New York State, DMH Commissioner Paul Hoch applied for a planning grant from the NIMH and after approval of his request in May 1963 appointed a Planning Committee on Mental Disorders (PCMD) composed of DMH and other state officials, CMHB members, representatives of professional organizations, and leaders of voluntary advocacy groups. Hoch also ordered all of the RMHAC's to appoint regional planning committees that would report to

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<sup>51</sup>Dr. Marvin E. Perkins, "Problems of Integration . . . in New York City," in Milbank Memorial Fund, Decentralization of Psychiatric Services, 76-77; Dr. Harold C. Miles, "Problems of Integration . . . in Monroe County," in Milbank Memorial Fund, Decentralization of Psychiatric Services, 81-84; Dr. C.F. Terrence, "Problems of Integration . . . in Monroe County," in Milbank Memorial Fund, Decentralization of Psychiatric Services, 85-88.

<sup>52</sup>Grob, From Asylum to Community, 173-75.

<sup>53</sup>Grob, From Asylum to Community, 187-214. Grob notes that one of the most vocal critics of the JCMIH's recommendations was New York State DMH official and Psychiatric Quarterly editor Newton Bigelow, who argued that doing as JCMIH advocated and turning large state mental hospitals into chronic care facilities was in effect defining certain patients as hopeless cases and simply warehousing them.

<sup>54</sup>Grob, From Asylum to Community, 233-34, 248.

<sup>55</sup>Grob, From Asylum to Community, 235-238.

the PCMD.<sup>56</sup> In order to take full advantage of the federal funds that the CMHCCA made available, in summer 1964 Governor Nelson Rockefeller made the DMH solely responsible for meeting the needs of New York State's mentally retarded and developmentally disabled citizens. As a result, Commissioner Hoch created a Mental Retardation Section within the PCMD and urged all of the RMHAC's to appoint developmental-disability experts to the regional committees.<sup>57</sup> New York State was one of the first to receive CMHCCA funds, and as of 1966 it had gotten \$6,600,000 for construction of community centers and another \$1,500,000 for construction of facilities for the mentally disabled.<sup>58</sup>

However, New York State's increasing expenditures upon mental health center construction and staffing were not propelled solely by the availability of federal funds. Elected officials buoyed by the booming economy and promises that community mental health care initiatives would in the long run save money created a number of new funding initiatives. In April 1963, roughly six months before the CMHCCA became law, legislation established the New York State Mental Hygiene Facilities Improvement Corporation (MHFIC), a public-benefit corporation run by the DMH commissioner and two trustees appointed by the governor.<sup>59</sup> The MHFIC, which began its work in January 1964, was empowered to plan, undertake, and direct construction and rehabilitation of facilities for the mentally ill, the mentally retarded, and the developmentally disabled, and it was given control over all local, state, and federal monies intended for these purposes. The MHFIC could also purchase or lease real estate and buildings needed for the creation, expansion, or renovation of mental health facilities.<sup>60</sup> At the same time, the Housing Finance Authority (HFA), which had been established to promote the construction of affordable housing, was given the power to furnish loans for the construction of schools and hospitals; as of 1966, the HFA had loaned \$600,000,000 for mental health facility construction.<sup>61</sup> The same piece of legislation also created the Mental Health Services Fund, which was financed out of the surplus monies that the MHFIC returned to the state comptroller at the end of the year and helped to support personnel training and research activities.<sup>62</sup>

In the wake of the CMHCCA's passage, New York State devoted even more funds to facility construction. In early 1965, Governor Nelson Rockefeller announced plans for a mammoth construction initiative. Five hospitals designed to replace outdated facilities, twelve hospitals exclusively for children, and eight state schools for the developmentally disabled were planned; in the following year, work began upon four of the hospitals and nine new rehabilitation

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<sup>56</sup>New York State Planning Committee on Mental Disorders, A Plan for a Comprehensive Mental Health and Mental Retardation Program for New York State: Report to the Governor, vol. 1, Report of the Mental Health and Mental Retardation Sections of the State Planning Committee, (Albany: 1965), vii. A complete listing of all of the members of the PCMD, which was originally named the State Mental Health Planning Committee, can be found on p. 3-4. Lists of members of various task forces and regional committees can be found in subsequent volumes of the report.

<sup>57</sup>Planning Committee on Mental Disorders, A Plan for a Comprehensive Mental Health and Mental Retardation Program, vol. 1, Report of the Mental Health and Mental Retardation Sections of the State Planning Committee, viii.

<sup>58</sup>New York State Department of Mental Hygiene, Control of Mental Disorders in New York State, (Albany: Department of Mental Hygiene, 1966), 9; New York State Department of Mental Hygiene, 1967 Annual Report (Albany, NY, 1967) [8].

<sup>59</sup>Act of 30 April 1963, Laws of New York, ch. 932, § 1-2.

<sup>60</sup>Act of 30 April 1963, Laws of New York, ch. 932, § 2. Section 2 created Article 2-B of the Mental Hygiene Law. § 29-a of Article 2-B established the MHIC. § 29-c charged it with planning, constructing, and improving facilities or contracting with third parties to perform these functions and empowered it to purchase all materials and supplies needed to run facilities; § 29-c also prohibited localities from altering building plans that the MHFIC approved. § 29-g gave the MHIC sole responsibility for facility construction funds.

<sup>61</sup>Act of 30 April 1963, Laws of New York, ch. 932, § 18; New York State Housing Finance Authority, A Report to Governor Nelson A. Rockefeller (Albany: Housing Finance Authority, 1966, [5]).

<sup>62</sup>Act of 30 April 1963, Laws of New York, ch. 932, § 23.

wings at existing facilities.<sup>63</sup> In 1965, new state legislation enabled local governments to seek state reimbursement of up to one-third of the capital costs and one-half of the operating costs incurred by community mental health centers and psychiatric wings within public hospitals; this legislation also raised the expenditure ceiling for community mental health programs, which had been raised to \$1.20 per capita in 1960, to \$1.40 per capita and waived this limit for communities that met certain qualifications.<sup>64</sup> However, the legislative developments of 1963 and 1965 should not be seen as signs that state government was consciously seeking to micro-manage community-based mental health care. State expenditures for construction, equipment, and training certainly increased, but policymakers were convinced that the programs housed within state-financed buildings should be controlled largely by local authorities. A pamphlet sent to local officials during the latter half of the 1960's stressed that even though the MHFIC would design, construct, and equip facilities and the HFA would finance construction, municipalities would be responsible for their maintenance and operation; after the bonds that had financed construction were retired, localities would also assume ownership of the facilities that the HFA and the MHFIC had built.<sup>65</sup>

The Department of Mental Hygiene also moved to take advantage of various sources of federal funds that became available as a result of programs created or expanded during the administration of Lyndon Johnson. In 1966, it published a handbook detailing the monies available to state and local mental-health programs through the NIMH and other divisions of HEW, the Department of Labor, and the Office of Economic Opportunity; the guide also outlined federal funding sources for programs serving the developmentally disabled.<sup>66</sup> However, the most significant new federal programs were Medicare, a federally-funded health insurance program for senior citizens, and Medicaid, a health insurance program for the needy jointly financed by the federal, state, and local governments. Both of these programs, which were enacted in 1965, covered some forms of mental health treatment and greatly altered the care given mentally ill persons. The framers of these laws sharply limited Medicare and Medicaid reimbursement for care furnished in state mental hospitals; in keeping with prevailing opinion, they believed that state facilities placed far less emphasis upon treatment than psychiatric wings situated in general hospitals. They also made impoverished mentally ill persons under the age of sixty-five ineligible for Medicaid coverage. These stipulations had unanticipated and dramatic consequences. Mental hospital administrators across the nation began moving the aged mentally ill, who had long constituted a substantial proportion of the institutionalized population, out of state hospitals. Some mentally ill senior citizens were sent to psychiatric facilities attached to general hospitals, but the great majority ended up in nursing homes. New York State was not an exception to this trend, which was often detrimental to those moved out of state facilities and yet beneficial to those who remained within.<sup>67</sup> In subsequent years, the DMH realized that its rush

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<sup>63</sup>New York State Department of Mental Hygiene, Control of Mental Disorders in New York State, 4, 12.

<sup>64</sup>Act of 28 June 1965, Laws of New York, ch. 647, § 1-2, § 5.

<sup>65</sup>New York State Health and Mental Health Facilities Improvement Corporation, Improved Health Facilities for Your Community: How the State Can Assist in Construction (Albany, New York State Health and Mental Health Facilities Improvement Corporation, n.d).

<sup>66</sup>New York State Department of Mental Hygiene, Catalog of Selected Federal Programs for Financial Assistance and Grants, (Albany, New York State Department of Mental Hygiene, 1966).

<sup>67</sup>On the provisions of Medicare and Medicaid and their effects on treatment of the mentally ill elderly, see Grob, From Asylum to Community, 267-70. Grob notes that the transfer of the aged mentally ill to nursing homes freed up resources that were then used to improve care for the patients who remained. However, those sent to nursing homes encountered widely varying levels of care and a dearth of psychiatric services. The mortality rate of mentally ill senior citizens increased among those transferred, suggesting that nursing home care was often inadequate; see Grob, The Mad Among Us, 266, 289-90.

to move mental patients into nursing homes was in some respects ill-considered: by the mid-1970's, nursing home operators who had in the past had negative experiences with former state hospital patients and local social welfare agencies that had no desire to fund any of the costs associated with nursing home care heartily resisted the DMH's efforts to place discharged patients in such facilities.<sup>68</sup>

The unexpected consequences of Medicare and Medicaid regulations were not offset by dramatic successes in the creation of community-based mental health facilities. As of early 1967, one hundred centers across the nation had received CMHCCA funds, forty-seven centers had been granted monies for staffing, and twenty-six centers were receiving federal support for both construction and staffing. The pace of center development fell far short of the projections of CMHCCA proponents, who envisioned the relatively rapid creation of some 2,000 centers nationwide. Gerald Grob argues that the slow growth of community centers at the federal level was in part the result of increased competition for funds within HEW and persistent shortages of qualified mental-health personnel. He also underscores the impact of the escalating conflict in Vietnam, which increasingly occupied the attention of President Johnson and the public at large and drained money from social welfare programs, upon federal mental health expenditures.<sup>69</sup>

Grob also highlights the shortcomings inherent in the centers themselves. Beliefs about etiology and treatment held by the staffers of many centers remained nebulous, ensuring wide variation in the scope and kinds of therapies that the centers offered.<sup>70</sup> Furthermore, centers focused increasing attention and resources upon those who had less serious forms of mental illness. In part, this shift was due to the increasing role that psychologists played in furnishing treatment. Psychologists tended to reject somatic explanations of the etiology of mental illness, and they were relatively uninterested in furnishing care to the most seriously mentally ill, were employed in ever-greater numbers in community centers. Relations between psychiatrists and psychologists had been tense since the 1930's, but in the 1960's psychologists' challenges to psychiatry's pre-eminence in the field of mental health at last came to fruition.<sup>71</sup> However, psychologists were not alone in their dislike of treating the acutely mentally ill. Psychiatrists who worked in the centers often saw themselves chiefly as providers of psychotherapy, a therapeutic tool that was resource-intensive and most efficacious when used with educated patients who had relatively minor mental disorders.<sup>72</sup>

Other factors hampered the effectiveness of the centers. Programs designed to help to smooth the transition from institutionalization to life in the larger community often fit poorly with the community center model and were not always eligible for government funding.<sup>73</sup> As a result, these essential components of the new mental health system envisioned by champions of community programs were few and far between. In addition, the CMHCCA's insistence that centers be controlled locally rendered them vulnerable to increasing community demands for services such as substance abuse treatment and counseling designed to help people resolve personal problems.<sup>74</sup> From 1968 onward, federal laws mandating that centers treat substance abuse, a growing public concern, compelled the centers to provide such care. Local control of

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<sup>68</sup>New York State Department of Hygiene, Task Force Report: The Department of Mental Hygiene's Inability to Access Community Skilled Nursing and Health Related Facilities (Albany: New York State Department of Hygiene, 1974), [1]-[2], [4]-[5].

<sup>69</sup>Grob, From Asylum to Community, 249-50.

<sup>70</sup>Grob, From Asylum to Community, 251-52.

<sup>71</sup>Grob, From Asylum to Community, 285-86; Grob, The Mad Among Us, 264.

<sup>72</sup>Grob, From Asylum to Community, 252-53.

<sup>73</sup>Grob, From Asylum to Community, 262-63.

<sup>74</sup>Grob, The Mad Among Us, 264.

centers also gave rise to the same problem that New York State experienced in the wake of the CMHSA: lack of coordination between different treatment programs. Lastly, it set the stage for bitter internal struggles that beset many centers as a result of the social, cultural and political upheavals of the late 1960's and early 1970's.<sup>75</sup>

### **Mental Health Besieged, 1965-77**

From the mid-1960's onward, the problems associated with the slow development of community mental health centers, the inherent shortcomings of the centers themselves, and excessively optimistic discharge policies became increasingly apparent. Politicians and the general public were increasingly critical of the the poorly planned revolution in mental health treatment and policy. However, this criticism had little immediate effect: even as the flaws inherent in the nation's developing mental health policy became too great to ignore, the commitment of state and federal policymakers to community mental health and dramatic reduction in state inpatient censuses intensified. At the same time, society's opinions about mental health and psychiatry changed dramatically as a result of the intense cultural, political, and social ferment that characterized the latter half of the 1960's and early 1970's. People on opposite ends of the political spectrum denounced the very concept of mental health. Psychiatrists, who had formerly been seen as compassionate experts, were instead frequently denounced as ruthless oppressors bent on singling out and crushing the individuality of those who rejected the dominant values of society.

The mental health professions were both instigators and victims of these upheavals. Some psychologists, social workers, and environmentally-oriented psychiatrists were sympathetic to Lyndon Johnson's social welfare initiatives and made commitment to social activism a key component of their professional identities: if mental illness were caused by poor social conditions, then combating racism, poverty, and other social ills was a logical and necessary part of mental health work. Members of the Group for the Advancement of Psychiatry, a liberal professional organization formed in the late 1940's by William Menninger and other sociodynamic psychiatrists, had since the early 1950's advocated psychiatric involvement in social reform causes. During the late 1960's, a growing number of those working in the field embraced the reform-oriented ethos of what Gerald Grob terms "community psychiatry." A smaller number went even further and pronounced themselves champions of the overthrow of capitalism and technocracy.<sup>76</sup>

The pronouncements of the Group for the Advancement of Psychiatry and proponents of community psychiatry focused unwelcome attention upon the profession as a whole. Extremist right-wing organizations had long denounced mental health programs as covert attempts to facilitate the spread of Soviet communism, and their attacks increased as psychiatrists and others voiced their support for the civil rights and anti-war movements, anti-poverty programs, and other causes.<sup>77</sup> By the late 1960's and early 1970's, mainstream conservatives, who were increasingly convinced that the mental health field was composed almost exclusively of their political enemies, were also suspicious of psychiatry. President Richard Nixon sought to eviscerate the CMHCCA and other federal supports for mental health care on the grounds that

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<sup>75</sup>Grob, *From Asylum to Community*, 254-55.

<sup>76</sup>Grob, *The Mad Among Us*, 197-98; Grob, *From Asylum to Community*, 241-44, 281.

<sup>77</sup>Grob, *From Asylum to Community*, 280.

they had been intended only as pilot measures; however, his efforts to dismantle federal mental health policy were foiled by the courts.<sup>78</sup>

Contrary to the accusations made by reactionaries and conservatives, the majority of psychiatrists refused to embrace social activism. A growing number of those within the profession remained convinced that mental illness was a neurobiological disorder; from the late 1960's onward, psychiatrists have abandoned sociodynamic theories and placed increasing emphasis the somatic dimensions of mental disorder. Others were supporters of the civil rights movement and other liberal goals but were firmly convinced that citing their credentials when supporting political causes was unprofessional. The activists within the profession were a small group.<sup>79</sup> Outside of the profession, however, the influence of this group far exceeded their numbers. This phenomenon is perhaps most evident in the popularity of one of its subgroups: leftist and libertarian practitioners who sought to strip their own profession of its legitimacy. R.D. Laing, a left-wing Scottish practitioner who was an active member of Britain's Campaign for Nuclear Disarmament, asserted that schizophrenia and other serious mental illnesses were in fact logical responses to a society that had become delusional and self-destructive and that defining a person as mentally ill was a means of maintaining the hegemony of the existing order. Laing's ideas were in many respects an outgrowth of the environmental theories of mental illness that had emerged in the immediate postwar period; he simply carried the belief that mental illness was influenced by social conditions to an unprecedented extreme.<sup>80</sup> The work of Thomas Szasz, a Hungarian-born professor at the SUNY Upstate Medical Center at Syracuse University, also won widespread acceptance. A libertarian who believed that psychiatry was nothing more than a covert means of extending the power of the state over its citizens, Szasz argued that mental illness did not exist; those suffering from "mental illness" were in fact abdicating their responsibility to make moral choices.<sup>81</sup>

The writings of scholars outside of the psychiatric profession gave added force to the assault on psychiatric legitimacy, and their influence is to this day evident within a number of academic disciplines. In 1965, the English translation of French philosopher Michel Foucault's Madness and Civilization first appeared.<sup>82</sup> Foucault argued that the altruism that had been associated with psychiatry since the eighteenth century was a facade: psychiatrists were not humane helpers of the mentally ill but coercive figures seeking to force asylum inmates to internalize the moral discipline of bourgeois society. In later writings, Foucault elaborated upon these ideas. Taken together, his writings constitute a history of Western civilization that stresses the shift away from external feudal constrictions on behavior toward modern efforts to induce individuals to internalize the values of the modern state and police their own thoughts and actions. He asserted that the function of insane asylums and prisons is to compel the compliance

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<sup>78</sup> Grob, The Mad Among Us, 281-83.

<sup>79</sup> Grob, From Asylum to Community, 281.

<sup>80</sup>Rael Jean Isaac and Virginia C. Armat, Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill (New York: Macmillan, Free Press, 1990), 27-32, furnish a summary of Laing's ideas. However, their work must be read with a certain degree of caution. They make no pretense of hiding their intense anger at deinstitutionalization, which they see as the end product of a determined legal and psychiatric assault upon social order, family rights, and human decency. Their sympathies clearly rest with the families of the seriously mentally ill, whom they see as burdened and abused by unresponsive courts and mental health professionals.

<sup>81</sup>Thomas Szasz, The Myth of Mental Illness: Foundations of a Theory of Personal Conduct (New York: Harper & Bros., Hoeber, 1961).

<sup>82</sup>Michel Foucault, Madness and Civilization: A History of Insanity in the Age of Reason, trans. Richard Howard (New York: Pantheon, 1965).

of those who resist integration into the state's moral and behavioral regime.<sup>83</sup> Foucault's assessment of the inner meaning of madness and other forms of social deviance to this day carries immense weight in the social science and humanities; although Foucault's popularity has waned in Europe and North America, scholars remain divided as to the accuracy and value of his work, his ideas continue to guide many sociologists, historians, and policy analysts.

A number of sociologists working independently of Foucault also stressed the coercive dimensions of mental health diagnosis and treatment. Erving Goffman's Asylums, which was published in 1961, extended Bruno Bettelheim's arguments about the devastating impact of Nazi concentration camps upon the human psyche to mental hospitals. Goffman asserts that the two were alike in that they were "total institutions" that isolated inmates from society, strictly regulated their behavior, and stripped them of all sense of individuality and dignity. In this respect his arguments differ little from those advanced by Paul Hoch, Robert Hunt, and other psychiatric champions of the open hospital movement and community-based mental health care. However, Goffman also had a jaundiced view of psychiatry and its undergirding assumptions. He concluded that the real function of mental hospitals was to sustain the psychiatric profession and its belief in the medical model of diagnosis and treatment: "to get out of the hospital, or to ease their life within it, they [patients] must show acceptance of the place accorded them, and the place accorded to them is to support the occupational role of those who appear to force this bargain."<sup>84</sup>

Other sociologists argued that psychiatry was concerned less about insuring the continued existence of their own profession than about enforcing social order. Sociologists had long been sensitive to the ways in which societies defined and stigmatized aberrant behavior, but in the turbulent political and social climate of the 1960's the study of deviancy became explicitly political. A growing number of them turned their attention to the study of social deviance and found signs of authoritarian social control everywhere they looked. Thomas Scheff and other scholars asserted that psychiatric diagnoses such as schizophrenia were little more than labels attached to those who refused to conform to dominant societal values; in turn, those labeled as deviant came to see themselves as such and became even more insistent upon acting abnormally.<sup>85</sup>

The arguments of Laing, Szasz, Goffman, Scheff, and others critical of psychiatry and mental institutions gained wide currency from the mid-1960's onward, and their impact upon popular culture is readily evident. During the 1950's, books and films had generally depicted psychiatrists as humane and competent professionals, but from the early 1960's onward writers and filmmakers took a much harsher view of them. Acclaimed novels such as One Flew Over the Cuckoo's Nest (1962) and A Fine Madness (1964), documentaries such as The Titicut Follies (1967) and fictional films such as Diary of a Mad Housewife (1970) and the highly-regarded motion-picture version of One Flew Over the Cuckoo's Nest (1975) framed them as malevolent and dictatorial. The press, which had long played an important role in creating public concern about conditions within mental institutions, also became increasingly assertive in challenging the

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<sup>83</sup>See Michel Foucault, Discipline and Punish: The Birth of the Prison, trans. Alan Sheridan (New York: Random House, Vintage Books, 1979).

<sup>84</sup>Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (Garden City, NY: , 1961), 364, quoted in Grob, From Asylum to Community, 284.

<sup>85</sup>Thomas J. Scheff, "Schizophrenia as Ideology," Schizophrenia Bulletin no. 2 (Fall 1970): 15-20. Interestingly, the Schizophrenia Bulletin was published by the NIMH.

authority and expertise of state hospital administrators and other members of the psychiatric profession.<sup>86</sup>

However, the effects of the assault upon psychiatry and mental health were most evident within the reform and radical movements that flourished during the latter half of the 1960's. Many of those drawn into these movements readily embraced Laing and Scheff, who were openly sympathetic to leftist causes; the work of Szasz, who never hid his contempt for the New Left, also captivated them.<sup>87</sup> To many drawn into the nascent youth subculture, psychiatry and mental hospitals were little more than an effort to force teenagers and young adults to accept the achievement- and acquisition-oriented ethos of consumer capitalism. However, not all of these activist young people were willing to discard the concept of mental health entirely. In cities across the United States, they established alternative services that sought to cast aside the traditional hierarchical relationship between caregiver and client and treat young people's drug use, sexual behavior and emotional distress with sympathetic concern. Some of these programs were started by altruistic laypeople, others by young psychologists and social workers dissatisfied with existing institutions and programs, and still others through the cooperative efforts of lay and professional people. These activists often contended not only with the hostility of established mental health providers but with the distrust of young people and political radicals, who often suspected them of being police informants or covert supporters of "the Establishment." In addition, they often experienced considerable internal conflict: the pressures associated with commitment to a precarious venture, their ambivalent relationships with both the larger society and the youth subculture, and their attempts to improvise more egalitarian and emotionally honest ways of living sometimes led them to turn upon one another.<sup>88</sup> Many of these programs, which almost always placed far greater emphasis upon resolution of emotional difficulties than upon treatment of serious mental illness, perished shortly after they were started, but others were eventually incorporated into existing networks of community mental health and welfare services.<sup>89</sup>

The hostile attitude of leftist radicals toward the profession of psychiatry and institutionalization was echoed by adherents of the other social movements that emerged during the late 1960's and early 1970's. The resurgent feminist movement was sharply critical of the ways in which mental health providers treated women. In the highly influential The Feminine Mystique, Betty Friedan sharply criticized psychiatrists who tried to treat what she called "the problem with no name" with tranquilizers and psychotherapy; Friedan, whose arguments centered upon educated middle-class homemakers, argued that the "problem" was little more than a frustrated yearning for challenging work.<sup>90</sup> Friedan believed that psychiatrists were acting out of ignorance, but other feminists asserted that mental health professionals were knowingly coercive. Writers such as Phyllis Chesler and psychologist Naomi Weisstein asserted that

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<sup>86</sup>Grob, From Asylum to Community, 292; Grob, The Mad Among Us, 275.

<sup>87</sup> One person who was not captivated by Szasz's work was DMH Commissioner Paul Hoch, who tried to have fired Szasz from the Upstate Medical Center and apparently succeeded in insuring that he had no allies on the faculty; see Issac and Armat, Madness in the Streets, 40.

<sup>88</sup>See Ted Clark and Dennis T. Jaffe, Toward a Radical Therapy: Alternate Services for Personal and Social Change, Social Change Series, ed. Victor Gioscia (New York: Gordon & Breach, Interface, 1973), for discussion of the goals of and problems faced by the founders of a New Haven, CT alternative service.

<sup>89</sup>The extent to which the alternative mental health service movement existed in New York State is unclear. The movement was by its very nature community-based and separate from existing channels of care and funding, and may be hard to document. However, examination of community mental-health and social-service organizations may provide clues to their existence; for example, the Equinox program located in the city of Albany is apparently an outgrowth of efforts to provide alternative counseling and welfare services to troubled young people.

<sup>90</sup>Betty Friedan, The Feminine Mystique (New York: Norton, 1963; reprint, New York: Bantam Doubleday Dell, Dell 1983).

psychiatrists had long sought to force women to accept their subordination and punished women who were aggressive, uncooperative, or sexually unorthodox.<sup>91</sup> At roughly the same time, those involved in the nascent gay rights movement launched stinging assaults on the abuses that the profession, which until 1973 defined homosexuality as a form of mental illness, had inflicted upon gay men and lesbians.<sup>92</sup> Attitudes toward mental health within these movements varied in ways similar to that seen within the youth subculture as a whole: some feminists and gay activists denounced the very concept of mental health as a political weapon, while others sought to create mental health programs that would support women and gay people as they struggled to overcome their internal and external oppression.

Former mental patients also began denouncing psychiatrists and mental institutions. Former patients had in previous decades organized on their own behalf: Clifford Beers, who had been institutionalized in private and state facilities for a short period of time, was the driving force behind the creation of the NCMH, and groups of former patients started self-help programs such as the Manhattan-based Fountain House program.<sup>93</sup> However, the ex-patient movement of the 1960's was notable for its sweeping attacks upon the legitimacy of psychiatry and the very concept of mental illness. Groups such as New York City's Mental Patients Liberation Project and publications such as the Madness Network News declared that psychiatry was a bulwark of the established social order and mental institutions were inhumane. Those active in the movement sponsored numerous demonstrations, boycotts, and sit-ins (including a month-long occupation of the offices of California governor Jerry Brown) in an effort to draw attention to their cause. Politically active former patients were aided by mental health professionals sympathetic to their cause. In 1973, radical therapists and former patients held the first annual North American Conference on Human Rights and Psychiatric Oppression, and the group sponsored annual meetings well into the 1980's. However, tensions between the therapists and former patients eventually became too great to surmount and many patient liberation groups ultimately broke with their supporters in the mental health professions.<sup>94</sup>

Civil libertarians were also influenced by the popularity of Laing, Szasz, and Scheff, and as a result began paying closer attention to the practices of mental health professionals.

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<sup>91</sup>Phyllis Chesler, Women and Madness (Garden City, NY: Doubleday, 1972); Naomi Weisstein, "'Kinder, Küche, Kirche' as Scientific Law: Psychology Constructs the Female," in Sisterhood is Powerful: An Anthology of Writings from the Women's Liberation Movement, ed Robin Morgan (New York: Random House, Vintage Books, 1970), 205-19. This interpretation of the work of the mental health professions remains powerful: see Hannah Lerman, Pigeonholing Women's Misery: A History and Critical Analysis of the Psychodiagnosis of Women in the Twentieth Century (New York: Harper Collins, Basic Books, 1996).

<sup>92</sup>Not all segments of the psychiatric profession supported efforts to have homosexuality removed from its comprehensive listing of mental illnesses, the Diagnostic and Statistical Manual of Psychiatric Disorders; to this day, some members of the profession regard homosexuality as a mental disorder. However, the APA asserted after a 1973 referendum vote that homosexuality was not a mental illness and that it would no longer be classed as such. For an analysis of the bitter conflict that the issue, which gay and feminist activists forced the APA to address, produced, see Ronald Bayer, Homosexuality and American Psychiatry: The Politics of Diagnosis, 2d. ed. (Princeton: Princeton University Press, 1987), 101-55.

<sup>93</sup>The Fountain House program was started in the 1940's by a group of former patients of the Rockland State Hospital who felt that they had been cut adrift after discharge. The program was initially an informal support group, but in 1948 it purchased a Midtown brownstone and created a halfway house. In 1955, it hired professional staffers to oversee the program. Fountain House has always emphasized the importance of work in restoring clients' self-confidence. Staffers and clients work side by side at the same tasks, and in 1960 Fountain House started a job-placement program notable for its policy of insuring that mental illness-related absenteeism will not affect employers: if a Fountain House resident cannot go to work on any given day, one of the program's staffers will substitute for him or her. Fountain House also has a striking open-door policy: any person who has been part of the program is welcome to return at any time if he or she feels the need to do so. See Issac and Armat, Madness in the Streets, 289-90.

<sup>94</sup>Issac and Armat, Madness in the Streets, 58-60, 163-74. The ex-patient movement continues to exist; see Support Coalition International, Support Coalition International, available [online]: <[http://www.efn.org/~dendron/home/home/home\\_main.html](http://www.efn.org/~dendron/home/home/home_main.html)> [1 June 1998], for information about the movement as it currently exists.

Organizations such as the American Civil Liberties Union and the American Bar Association had in past years devoted increasing attention to the legal issues raised by commitment procedures, but their efforts were limited largely to outlining the law as it then existed and recommending limited changes. As Gerald Grob asserts, these efforts nonetheless had the effect of drawing attention to patient rights and implying that these rights were being violated. This perception was heightened by the proceedings of the Senate Judiciary Committee's Subcommittee on Constitutional Rights, which in 1961 began investigating commitment procedures in the District of Columbia even though there was little evidence that abuses existed; the subcommittee was chaired by Sam Earvin, a Southerner who may have wanted to look tough on civil rights without having to contend with racial issues.<sup>95</sup> New York State and a number of other states responded to initiative such as these by reforming their commitment laws. New York State's new commitment law, which passed in April 1964 and went into effect the following September, greatly reduced the state's reliance upon courtroom commitment hearings, which were widely regarded as humiliating public ordeals. The law also mandated that every involuntary commitment decisions be subject to periodic review and created the Mental Health Information Service, an advocacy and legal advisory service for patients and their families.<sup>96</sup> In 1967, California went even further, enacting legislation that prohibited those who were neither dangerous nor gravely ill from being involuntarily committed for more than seventeen days.<sup>97</sup>

These changes were not sufficient to prevent judicial scrutiny of institutionalization. By the late 1960's and early 1970's, lower federal and state courts, which had traditionally been content to leave mental health policy to psychiatrists, became increasingly willing to intervene when it seemed that patients' civil liberties were being violated. In 1966, Judge David Bazelon of the District of Columbia Circuit Court of Appeals issued a ruling, Rouse v. Cameron, that set the law on a collision course with state commitment procedures. Bazelon asserted that individuals sent to mental hospitals by criminal courts had a right to therapeutic treatment and that denial of such treatment constituted cruel and unusual punishment, denial of due process, and violation of equal protection of the law. Later that year, Bazelon issued another ruling that established patients' right to treatment in the least restrictive setting suited to their condition. Two years later, the Massachusetts Supreme Court followed Bazelon's line of argument and ruled that patients who had been sent to mental hospitals after being deemed incompetent to stand trial for criminal offenses had a right to expect treatment.<sup>98</sup> In New York State, the Court of Claims ruled in 1968 that a man who had been held in Matteawan State Hospital for more than fourteen years because he had allegedly violated his parole had been treated unjustly and awarded him some \$300,000 in damages.<sup>99</sup> In the years that followed, many other state and federal courts ruled that some commitment practices violated the Eighth and Fourteenth Amendments. This trend culminated in the U.S. Supreme Court's 1975 decision in O'Connor v.

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<sup>95</sup>Grob, From Asylum to Community, 289-90, 370. Earvin may have had another reason for focusing on the issue: his late brother-in-law had for a time served as president of the APA.

<sup>96</sup>Act of 22 April 1964, Laws of New York, § 3, § 18. The Mental Health Information Service, which still exists, is an arm of the Appellate Division of the New York State Supreme Court. It has from the outset been completely independent of the DMH.

<sup>97</sup>Issac and Armat, Madness in the Streets, 121-24. The idealists and budget-cutters who championed this law were dismayed to find that it did not lead to a dramatic decrease in the number of patients involuntarily placed in state institutions for lengthy periods of time; the law's provision for involuntary commitment of the gravely ill was used to keep many patients in state hospitals.

<sup>98</sup>Grob, From Asylum to Community, 291; Grob, The Mad Among Us, 274-75; Ann Braden Johnson, "Unravelling of a Social Policy: The History of the Deinstitutionalization of the Mentally Ill in New York State" (Ph.D. dissertation, New York University, 1986), 282..

<sup>99</sup>Whitree v. State of New York, 56 Misc 2d 693 (Court of Claims, 1968), 711.

Donaldson. The court did not find that mental patients had a right to treatment, but it unequivocally stated that people who were not dangerous to themselves or others and who were capable of living independently or with assistance from willing family and friends could not be institutionalized against their will.<sup>100</sup> In addition, a number of lower court rulings, including New York City Health and Hospitals Corporation v. Stein, afforded mental patients the right to refuse treatment if they so chose.<sup>101</sup>

In the wake of these decisions, public-interest lawyers, who had during the 1960's begun working with African-Americans, Latinos, women, and other groups traditionally ill-served by the law, started to defend the rights of the mentally ill and the developmentally disabled. In New York State, the New York Civil Liberties Union (NYCLU) initiated a new campaign upon behalf of mental patients. Led by David Ennis, who had little prior knowledge about the inner workings of the mental health system apart from reading of the works of Thomas Szasz, the campaign was also supported by Brooklyn lawyer Morton Birnbaum, the author of a 1960 American Bar Association Journal article that had heavily influenced David Bazelon.<sup>102</sup> The NYCLU initiated New York State Association for Retarded Children v. Rockefeller, the landmark case more popularly known as Willowbrook. Although the court's 1973 ruling stopped short of asserting that people in New York State facilities for the mentally ill, the mentally retarded, and the developmentally disabled had a right to treatment, it found that overcrowding at the Willowbrook State Hospital, a facility for the mentally retarded and the developmentally disabled, violated patients' right to protection from harm and ultimately handed down a consent decree that mandated that all Willowbrook patients were to be placed in community residences.<sup>103</sup> The Willowbrook case gave added impetus to the discharge of patients from state facilities: at least some DMH and other state health officials were afraid that state hospital administrators might eventually have to contend with a Willowbrook-type ruling.<sup>104</sup> In response to this fear, the department may have assigned discharge quotas to administrators of state mental hospitals in an effort to reduce the inpatient census and avert unfavorable legal rulings.<sup>105</sup>

Other factors hastened the decline in hospital populations in New York State and other states. New federal programs made it possible for increasing numbers of mentally ill people who were incapable of supporting themselves to live independently or to be housed in other institutions. Medicaid and Medicare, which resulted in the transfer of large numbers of the aged mentally ill to nursing homes from the mid-1960's onward, were expanded in 1966 to subsidize alternative forms of care for the mentally ill. At the same time, other new Social Security

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<sup>100</sup>Johnson, "Unravelling of a Social Policy," 280-81.

<sup>101</sup>Johnson, "Unravelling of a Social Policy," 285. The other cases establishing this right were Wyatt v. Stickney, a landmark 1972 federal case that also affirmed the right to treatment, and Winters v. Miller, which afforded institutionalized Christian Scientists the right to refuse psychotropic drugs.

<sup>102</sup>Johnson, "Unravelling of a Social Policy," 273-76.

<sup>103</sup> Johnson, "Unravelling of a Social Policy," 274, 284. Other legal cases also affected the operation of state hospitals. Public interest lawyers filed a number of federal suits that succeeded in barring the use of patient labor that was not compensated at prevailing wage levels. These suits were laudable in that they sought to force hospitals to honor labor laws and to prevent them from retaining patients who were well enough to be discharged but capable of performing important tasks. However, these suits also increased the patient inactivity that hospital critics deplored. For a discussion of these suits, see Issac and Armat, Madness in the Streets, 137-39.

<sup>104</sup>See, e.g., New York State Department of Mental Hygiene, Task Force Report: The Department of Mental Hygiene's Inability to Access Community Skilled Nursing and Health Related Facilities (Albany: New York State Department of Mental Hygiene, 1974), [6].

<sup>105</sup>New York State Assembly Legislative Committee, Mental Health Subcommittee on Community Aftercare, From the Back Wards to the Back Alleys (Albany: New York State Assembly, Mental Health Subcommittee on Aftercare, 1978), 5. It is unclear as to whether the existence of these quotas, which were alleged to have been in force from 1968 onward, can be documented: the subcommittee's report claims only that it received "many reports" about their existence.

programs were created: Old Age Assistance, Aid to the Permanently and Totally Disabled (ATPD), and Old Age and Survivor Insurance. The states took advantage of these programs, which made matching funds available to them, and discharged increasing numbers of patients from state facilities. Deinstitutionalization accelerated even further in the wake of the 1972 legislation that created two new Social Security programs, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI and SSDI were designed to guarantee the mentally and physically disabled a minimum income and to remove the stigma long associated with relief payments; by placing them under the umbrella of Social Security, policymakers hoped that these programs would be regarded as entitlements and thus preserve the dignity of recipients. States, which were concerned less with safeguarding the self-worth of the indigent disabled than with shifting the cost of caring for the disabled to the federal government, rushed to secure SSI and SSDI dollars. All of those receiving ATPD benefits before 31 December 1973 were guaranteed SSI benefits, and the states responded by enrolling as many of the seriously mentally ill as they could. In addition, SSI's status as an entitlement meant that the application process could begin before a patient was discharged from a state institution, and hospital personnel often took an active part in helping patients secure SSI benefits.<sup>106</sup>

However, SSI, which gradually superseded ATPD and was funded wholly by the federal government, had unanticipated and profound effects upon the treatment of the mentally ill. Ann Braden Johnson notes that the SSI program's emphasis upon the rights and dignity of recipients prevented it from mandating that they seek treatment. In addition, those living in publicly-owned halfway houses designed to ease the transition from the institution to society were not eligible for SSI. Patients who had no desire to continue treatment were not forced to do so, and those who did want to do so at times found it difficult to obtain care. As a result of this combination of program requirements and treatment scarcity, many former state mental patients who received SSI ended up living in nursing homes, single-room occupancy hotels (SRO's), or in the nursing homes and private proprietary homes for adults (PPHA's) that sprang up like mushrooms in the wake of the program's creation.<sup>107</sup> This phenomenon may best be described as reinstitutionalization: life in many PPHA's and nursing homes is every bit as regimented and stultifying as life in the state hospital back wards. Television and print journalists who no longer find the state hospitals rich sources of scandal have not been disappointed by these institutions, some (but not all) of which are characterized by listless and overmedicated residents deprived of all recreation other than television, overworked and sometimes abusive staffers, and administrative corruption.<sup>108</sup>

Mental health care in New York State was also affected by a number of less predictable national developments. The economic stagnation and inflation of the 1970's affected almost every aspect of New York State government, and the DMH encountered its share of cost-cutting initiatives and efforts to ensure its fiscal responsibility. Policymakers' concerns about squandering of resources were almost invariably wedded to criticism of the failures of community mental health programs, which politicians and advocacy organizations saw as inadequate, lacking oversight, and resistant to citizen involvement. The DMH, which remained generally optimistic about the possibility of treating most mental illnesses in community-based outpatient settings, tried to respond to these concerns. In 1973, it created the Office of Citizen Participation in an effort to facilitate public involvement in the creation of community mental

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<sup>106</sup>Johnson, "Unravelling of a Social Policy," 414-15.

<sup>107</sup>Johnson, "Unravelling of a Social Policy," 416-19.

<sup>108</sup>Johnson, "Unravelling of a Social Policy," 386-95, 482-84, 487-89.

health programs, and in 1974 established a citizen advisory council charged with drafting recommendations for mental health, mental retardation, and substance abuse treatment.<sup>109</sup> During its 1975 reorganization, it created a new office dedicated to oversight of expenditures and gave greater power to its Office of Evaluation and Inspection.<sup>110</sup>

State policymakers sought to resolve other problems that beset the agency. In 1973, the state sought to improve community services and ensure adequate care for the severely mentally ill who had been discharged from state institutions by passing the Unified Services Act in 1973. The Unified Services Act, which had the backing of the DMH, strongly encouraged CMHB's to devise plans for the treatment of the mentally ill living that tied local services to those provided by the state. Unified services plans had to coordinate state and local programs and to ensure that "all population groups [were] covered, that there [was] coordination and cooperation among local providers of services, . . . and that there [was] continuity of care among all providers of services."<sup>111</sup> Localities were not compelled to devise unified services plans, but those that chose not to still had to create comprehensive local plans; communities that failed to draft approved unified or local service plans that were acceptable to the DMH would not receive state support.<sup>112</sup> In an effort to induce local governments to create unified services plans, state funding to localities that had such plans approved increased according to a complicated population-based formula.<sup>113</sup> In order to make it easier for CMHB's to devise unified services plans, the DMH created eight regional offices designed to support and guide them.<sup>114</sup> In the following year, the DMH gave the directors of these regional offices sole responsibility for oversight of all local and state mental health programs in their jurisdictions in an effort to improve the fit between state and local programs.<sup>115</sup>

However, local governments were hesitant to devise unified services plans. In the three years following the passage of the Unified Services Act, only the counties of Rensselaer, Rockland, Westchester, and Warren and Washington (which put forth one plan for both counties) put forth plans that the state approved.<sup>116</sup> Niagara County also drew up a plan, but the DMH refused to accept it on the grounds that county officials could not secure the cooperation of one of its largest providers.<sup>117</sup> In February 1976, Governor Hugh Carey placed an eighteen-month moratorium on acceptance of unified services plans and charged the DMH with determining why localities were so slow to respond to the Unified Services Act. DMH Commissioner Lawrence Kolb allotted this investigation to a task force charged with improving mental health services.

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<sup>109</sup>New York State Department of Mental Hygiene, 1974 Annual Report (Albany: New York State Department of Mental Hygiene, 1974), 5.

<sup>110</sup>New York State Department of Mental Hygiene, 1975 Annual Report (Albany: New York State Department of Mental Hygiene, 1975), 5.

<sup>111</sup>Unified Services Act (1973), § 11.12, § 11.13; § 11.13, subd. 4 quoted.

<sup>112</sup>Unified Services Act (1973), § 11.17.

<sup>113</sup>Unified Services Act (1973), § 11.23.

<sup>114</sup>Department of Mental Hygiene, 1974 Annual Report, 4. The eight regions were: Western New York (Chautauqua, Cattaraugus, Allegany, Erie, and Niagara counties); Finger Lakes (Steuben, Chemeung, Schuyler, Seneca, Yates, Livingston, Wyoming, Genesee, Orleans, Monroe, Ontario, and Wayne counties); Central New York (Tioga, Broome, Delaware, Otsego, Chenango, Cortland, Cayuga, Onondaga, and Madison counties), North Country (Lewis, Hamilton, Warren, Jefferson, St. Lawrence, Franklin, Clinton, and Essex counties); Northeast New York (Greene, Columbia, Schoharie, Albany, Rensselaer, Washington, Saratoga, Schenectady, Montgomery, Herkimer, and Oneida counties); Mid Hudson (Rockland, Westchester, Putnam, Orange, Sullivan, Ulster, and Dutchess counties); Nassau-Suffolk, and New York City.

<sup>115</sup>New York State Department of Mental Hygiene, 1975 Annual Report, 5.

<sup>116</sup>New York State Department of Mental Hygiene, Task Force on Mental Hygiene Service Delivery, Toward a New System of Service Delivery of Mental Hygiene Services for the State of New York (Albany: New York State Department of Mental Hygiene, Task Force on Mental Hygiene Service Delivery, [1976]), 25.

<sup>117</sup>Department of Mental Hygiene, 1975 Annual Report, 16, 22.

The task force found that localities were confused by the complex and multi-tiered funding provisions built into the act and intimidated by the prospect of having to coordinate the activities of many different (and sometimes uncooperative) agencies and programs. The permanency of unified services plans, which local authorities regarded as experimental and unprecedented, also gave them; once a locality had put forth an acceptable unified services plan, it did not have the choice of retreating and creating a local services plan if the unified plan proved unsuccessful. Most importantly, local governments were daunted by the prospect of having to increase expenditures for mental health care. Local officials who successfully waded through the Unified Services Act's complex funding formula often realized that a unified services plan would force them to spend more money than they would under a local services plan.<sup>118</sup> As it was, the New York City and Erie and Onondaga counties and other local authorities were reducing mental health expenditures as a result of the economy's downturn.<sup>119</sup> As a result of these problems, the Unified Services Act never produced the results desired by policymakers or the DMH.

Lawmakers, not satisfied with the DMH's efforts to remedy the problems associated with community-based mental health services and state hospital discharge policies, also enacted several pieces of legislation intended to remedy the DMH's shortcomings. From 1975 onward, the department was compelled to take into account the extent to which "consumers, consumer groups, voluntary agencies, and other providers of services" had participated in the development of a given unified services plan when judging whether to approve it.<sup>120</sup> In the following year, the state ordered the DMH to devise a comprehensive plan for the "consolidation [and] realignment of patient care functions" that would simultaneously ensure that patients were receiving adequate care and that resources were not being used inappropriately; the possibility of closing some state hospital facilities was specifically mentioned.<sup>121</sup> At the same time, New York State assumed greater responsibility for the care of the severely mentally ill. In 1974, it passed legislation mandating that all of the costs associated with furnishing aftercare to people who had been patients in state hospitals between 1 January 1969 and 31 December 1973 were to be paid by the state.<sup>122</sup> Another new law made New York State temporarily responsible for paying all public and medical assistance costs incurred by discharged patients who had been institutionalized for at least five years; however, the state's responsibility for costs incurred by a given patient ended after he or she had lived outside of state institutions for five years.<sup>123</sup>

The state's targeting of funds for community care, which was reinforced by the DMH's conscious decision to steer funds away from state hospitals and toward local programs in an effort to discourage use of state facilities, may have resulted in a decline in the quality of care found in state institutions. In 1975, the DMH endured the very public humiliation of having the Creedmoor and Pilgrim Psychiatric Centers stripped of their accreditation. The department was acutely aware that loss of accreditation meant that patients in these facilities were no longer eligible for Medicare and Medicaid reimbursements and publicly proclaimed the need for state facilities to meet accepted standards, but continued to divert funds toward outpatient care, which

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<sup>118</sup>Task Force on Mental Hygiene Service Delivery, Toward a New System of Service Delivery, 26-27.

<sup>119</sup>Task Force on Mental Hygiene Service Delivery, Toward a New System of Service Delivery, 42.

<sup>120</sup>Act of 29 July 1975, Laws of New York, ch. 515, § 1, § 2.

<sup>121</sup>Act of 23 June 1976, Laws of New York, ch. 437, § 1, § 2.

<sup>122</sup>Act of 30 May 1974, Laws of New York, ch. 620, § 1, § 2.

<sup>123</sup>Act of 30 May 1974, Laws of New York, ch. 621, § 1, § 3. Laws making the state responsible for one hundred percent of the costs associated with the outpatient care of the most acutely mentally ill further retarded the development of unified services plans. They led localities to believe that a dual system of care would continue to exist and tempted them to inflate the number of cases eligible for one hundred percent reimbursement; see Task Force on Mental Hygiene Services Delivery, Toward a New System of Service Delivery, 26-27.

was still widely regarded as less expensive and more humane than care furnished in state hospitals; the inpatient facilities that were best funded were recently constructed ones that were explicitly designed to fit into the community-centered treatment model.<sup>124</sup> In 1977, the DMH further proved that it was committed to moving patients out of state facilities: in response to the planning mandate of the previous year, it proposed closing the Marcy and Northeast Nassau Psychiatric Centers and merging the three facilities situated on New York City's Ward's Island. It also held out the possibility of closing other facilities, arguing that some should be closed because they were no longer housing significant numbers of patients and others because localities were overutilizing them.<sup>125</sup>

The DMH's efforts to direct more funds away from inpatient care and toward community-based outpatient programs sparked outright opposition from a number of quarters. The public and private organizations that furnished most community-based mental health care in many instances resisted accepting former state hospital patients, who were typically impoverished and unresponsive to psychotherapy. In addition, many providers of community-based care and treatment felt that the state had not adequately informed them of the impending return of large numbers of acutely ill people to society. In the New York City area, local mental health providers who felt that they had been taken by surprise formed the Coalition of Voluntary Mental Health, Mental Retardation, and Alcoholism Agencies in 1972 and lobbied city and state officials in an effort to avoid being saddled with what they saw as unanticipated and unwelcome responsibilities.<sup>126</sup> It is likely that providers of outpatient care working in other parts of New York State publicly resisted the state's efforts to force them to care for the seriously mentally ill or simply furnished just the bare minimum of care needed to remain eligible for state reimbursement. However, their ability to resist was soon reduced by the 1975 federal Mental Health Act, which sought to force community mental health centers receiving federal funds to screen and treat discharged state mental hospital patients.<sup>127</sup>

The DMH and state policymakers encountered even more resistance from the Civil Service Employees' Association (CSEA) and one of its offshoots, the Public Employees' Federation (PEF). The PEF, which represented most of those employed in state hospital facilities, and the CSEA reacted violently to the news that the DMH was contemplating the closure of hospital facilities and loudly protested the privatization of mental health jobs. The CSEA created a highly publicized task force that concluded that the state was "dumping" the acutely ill onto the streets and into substandard PPHA's and that community mental health care providers would never willingly care for the most seriously ill.<sup>128</sup> During the 1978 gubernatorial election, the union ran a brief but devastatingly effective radio and print advertising campaign that accused the state of sacrificing patient welfare in the name of cost-cutting. This campaign,

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<sup>124</sup>Department of Mental Hygiene, 1975 Annual Report, 10-11.

<sup>125</sup>New York State Department of Mental Hygiene, Proposals for Consolidation--Realignment of DMH Facilities (Albany: New York State Department of Mental Hygiene, 1977), 4.

<sup>126</sup>Johnson, "Unravelling of a Social Policy," 352, 549; The Coalition of Voluntary Mental Health Agencies, Inc., The Coalition of Voluntary Mental Health Agencies at 25: A Casual History of the First Quarter Century, available [online]: <[www.cvmha.org/histoire.pdf](http://www.cvmha.org/histoire.pdf)> [29 May 1998]. The coalition is somewhat vague about the circumstances that led to its creation, asserting that it took shape because the New York City Department of Mental Health did not appreciate member agencies' commitment to "caring and nurturing of clients" and tried to limit their ability to determine how their clients' needs would best be met. The issue of being forced to care for an undesirable client population is never explicitly mentioned, but it is quite possible that the agencies that formed the coalition objected to being forced to assume responsibility for care of the seriously mentally ill.

<sup>127</sup>Grob, The Mad Among Us, 283.

<sup>128</sup>Civil Service Employees Association, Task Force on Mental Hygiene, Deinstitutionalization: State and County Policies and CSEA Response (New York: Civil Service Employee Association, 1977).

which did little to endear state hospital employees and community-based mental health workers to one another, apparently helped to produce a gubernatorial policy decision that thwarted state and DMH efforts to reduce the role of state facilities in mental health treatment. Shortly after the election, Governor Hugh Carey's chief policy advisor, Robert Morgado, drafted a memorandum that strongly recommended that the staff-patient ratio at state hospitals be increased to roughly 1.0, that hospital officials strive to ensure that all discharges were appropriate, and that employee retraining and transfer programs be implemented. In the wake of Morgado's memorandum, staffing levels apparently increased: an Accountants for the Public Interest study found that in 1981 the staff-patient ratio in state psychiatric facilities, which had been .25 in 1955, had increased to 1.38.<sup>129</sup>

Efforts to reduce the hospital population and create outpatient programs for the seriously mentally ill also provoked increasing opposition from private citizens. Advocates of community-based mental health care had since the 1950's been aware that the public could resist their initiatives, but citizen resistance to the depopulation of state mental hospitals became an increasing concern of policymakers during the 1970's.<sup>130</sup> In part, public resistance may have stemmed from economic conditions: voters who had readily approved local mental health levies in more affluent times were in all likelihood less willing to increase their tax burdens when inflation unemployment were on the rise. The discharge of large numbers of acutely mentally ill persons also aroused considerable fear about increases in crime and public disorder. Proposals for the creation of community-based residential programs for the mentally ill aroused increasing opposition from homeowners concerned about their physical safety and their property values. In 1976, the Assembly Joint Committee to Study the Department of Mental Hygiene faulted the past practices of the DMH for aggravating public resistance: in previous years, large numbers of poorly trained and inadequately socialized patients had been released into communities that were wholly unprepared for their return to society.<sup>131</sup> The combination of fear, anger, and ignorance that greeted community-based efforts to care for the seriously mentally ill remains a serious problem for the state, local and voluntary agencies that support community-based mental health care and treatment.

### **Mental Health in the Present Era, 1977-98**

Frustrated by the slow development of community-based mental health programs, the high cost of furnishing inpatient care, and what it saw as the DMH's inefficiency and lack of clearly defined priorities, the state legislature took action in 1977. It completely recodified the Mental Hygiene Law and reorganized the DMH. In the process, New York State's mental health agency acquired the structure that it has to this day; some of its components have of course been

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<sup>129</sup>Accountants for the Public Interest, The Transfer of People Versus Dollars: Intergovernmental Financing for Mental Health Services in the State of New York (New York: Accountants for the Public Interest, 1983), 38-41. Part of the apparent rise in patient-staff ratio was due to the increase in outpatient and alcoholism services. Although those who conducted the study excluded hospital staffers who furnished outpatient care, they made no effort to disaggregate administrative and support staffers employed at state hospitals; some of these workers were responsible solely for outpatient programs. In addition, staffers responsible for inpatient treatment of alcoholism, a problem that was of increasing concern to policymakers, were included in calculation of staff-patient ratios. The figures put forth by Accountants for the Public Interest differ from those put forth by the Office of Mental Health, which stated in 1982 that its staff-patient ratio was .72; see New York State Department of Mental Hygiene, Office of Mental Health, Annual Report 1982 (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1982), 2.

<sup>130</sup>See, e.g., Task Force on Service Delivery, Toward a New System of Service Delivery, 5, and New York State Assembly, Assembly Joint Committee to Study the Department of Mental Hygiene, Mental Health in New York State (Albany, New York State Assembly, Assembly Joint Committee to Study the Department of Mental Hygiene, 1976), 191-204.

<sup>131</sup>Joint Committee to Study the Department of Mental Hygiene, Mental Health in New York, 195-96.

created, merged, phased out, or renamed in subsequent years, but its administrative hierarchies generally resemble those established in 1977. The DMH's obligation to care for and treat the mentally ill, the developmentally disabled, and substance abusers was partitioned and invested in three autonomous offices: the Office of Mental Health (OMH), headed by the Commissioner of Mental Health, the Office of Mental Retardation and Developmental Disability (OMRDD), headed by the Commissioner of Mental Retardation and Developmental Disability, and the Office of Alcoholism and Substance Abuse (OASA), headed by the Director of the Division of Alcoholism and Alcohol Abuse and the Director of the Division of Substance Abuse. The three offices were to consult one another on a regular basis and to work together to care for people who had multiple mental disabilities, but the framers of the law clearly hoped that disaggregating the DMH's responsibilities would streamline the department's administration and reduce waste and inefficiency.<sup>132</sup>

In an effort to insure that the New Yorkers who needed the services provided by the OASA, the OMRDD, and the OMH were given appropriate care and treatment, legislators mandated that "each local government [had to] submit a five-year plan and annual implementation plans and budgets which . . . reflect[ed] local needs and resources" in order to remain eligible for state reimbursement.<sup>133</sup> These local or unified services plans had to conform to the state's long-term plans and had to win the approval of all three offices.<sup>134</sup> In order to facilitate these complex and long-range planning activities, the new Mental Hygiene Law established or reformed a host of councils and committees designed to assist the DMH's three offices. The OMH was aided by the Advisory Council on Mental Health, which consisted of the Commissioner of Mental Health and fourteen other members appointed by the governor; at least seven members had to be former patients or outpatient clients, relatives of current or former patients or clients, or other "consumer representatives." The Advisory Committee on Youth, which was similar in composition to the Advisory Council on Mental Health, aided the OMH in identifying the special mental health needs of children and adolescents.<sup>135</sup> The heads of the state's CMHB's (now called community services boards, or CSB's) were incorporated into the State Conference of Local Mental Hygiene Directors, which was to review proposals for changes in local and state provision of care.<sup>136</sup>

These advisory groups and similar bodies established within the OMRDD and the OASA reported to the Council for Mental Hygiene Planning, which consisted of the heads of the OMRDD, the OASA, and the OMH, and fifteen mental health, mental retardation, and alcohol substance abuse experts and advocacy group representatives appointed by the governor. The council was to supervise planning, devise effective evaluation mechanisms, and ensure that local and state programs were working toward common goals. Its ultimate task was to produce a comprehensive and detailed five-year plan and budget that drew upon local government plans and the work of the various councils and committees that reported to it.<sup>137</sup> In addition, these groups were to help the OMH devise new standards for admission to and discharge from all in- and outpatient mental health facilities, provisions for local review of admission and discharge

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<sup>132</sup>Mental Hygiene Law, Laws of New York (1977), Ch. 978, § 1. Records pertaining to the reorganization of the DMH are held by the New York State Archives.

<sup>133</sup>Mental Hygiene Law, Laws of New York (1977), Ch. 978, § 41.15, subd. b.

<sup>134</sup>Mental Hygiene Law, Laws of New York (1977), Ch. 978, § 41.16.

<sup>135</sup>Mental Hygiene Law, Laws of New York (1977), Ch. 978, § 7.05. In 1982, these two advisory bodies and the OMH's Advisory Committee on Minority Affairs were merged into the Mental Health Services Council, which was given greater influence in shaping OMH policy; see Act of 27 July 1982, Laws of New York (1982), Ch. 724, § 1.

<sup>136</sup>Mental Hygiene Law, Laws of New York (1977), Ch. 978, § 41.10.

<sup>137</sup>Mental Hygiene Law, Laws of New York (1977), Ch. 978, § 5.07.

decisions, a state-wide "assessment, evaluation, and reporting system," standard per-patient payment rates for facilities upkeep and programming, and new labor and employment policies governing mental health facilities.<sup>138</sup>

In keeping with its legislative mandate, the OMH devoted increasing attention to planning for future needs. It put forth its first five-year plan in 1978, issued updates in subsequent years, and to this day continues to devise plans in accordance with the 1977 Mental Hygiene Law. It also took other steps designed to increase its accountability to politicians and the public and its ability to perform its mandated tasks. In 1979, it standardized the planning forms and terminology used by localities in order to speed processing and increase the accountability of local officials. A year later, many state and local mental health personnel were using identical service categories in their reports and all local providers were required to employ standard planning, budgeting, and service reporting formats when working with the state.<sup>139</sup> It also sought to standardize patient case records.<sup>140</sup> In addition to reducing the potential for fraud and inefficiency, these changes made it possible for the OMH to compile more detailed statistics about the people it treated.<sup>141</sup>

The OMH also sought to mitigate some of the problems associated with the ad hoc policy of deinstitutionalization. Some of its efforts to do so were mandated by new legislation. Politicians and other policymakers were still convinced that community-based outpatient treatment was far more humane and far less expensive than state hospital care, and they had few alternative options; had they questioned the wisdom of depopulating state facilities, economic circumstances and the newly-established right to refuse treatment would almost certainly have led them to reject the possibility of dramatically expanding state-furnished inpatient care. However, they were displeased by the unplanned and often ill-considered manner in which state facilities had discharged patients. Dismayed that the overwhelming majority of discharged state hospital patients had no further contact with state or voluntary mental health personnel, in 1977 the state legislature compelled the OMH to locate and contact former patients and to formulate individualized treatment programs for those who needed and desired outpatient care. By December 1979, the OMH had identified 11,000 former patients in need of follow-up care and had contacted ninety-eight percent of them.<sup>142</sup> This effort to insure that the seriously mentally ill were not left to fend for themselves developed into an ongoing intensive case management program that exists to this day.

Other OMH initiatives, most notably the Community Support System (CSS) took shape within the agency itself. The CSS, which was implemented in 1978 and which was in all likelihood propelled in part by the desire to make the state eligible for funds from the NIMH's new Community Support Program for the seriously mentally ill, was funded entirely by the state, supervised by the OMH's five regional offices, and maintained largely by local and private

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<sup>138</sup>Mental Hygiene Law, Laws of New York (1977), Ch. 978, § 41.17. The OMRDD and the OASA were to perform the same tasks.

<sup>139</sup>New York State Office of Mental Health, Annual Report 1979, 8, 20; New York State Department of Mental Hygiene, Office of Mental Health, Annual Report 1980 (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1980), 4.

<sup>140</sup>New York State Department of Mental Hygiene, Office of Mental Health, Annual Report 1981 (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1981), 3.

<sup>141</sup>New York State Department of Mental Hygiene, Office of Mental Health, Annual Report 1982 (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1982), 3.

<sup>142</sup>New York State Department of Mental Hygiene, Office of Mental Health, Annual Report 1979 (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1979), 4. In all likelihood, OMH staff shortages and time constraints made it impossible for staffers to perform the lengthy follow-up visits and devise the highly individualized treatment plans that policymakers desired

agencies working under contract.<sup>143</sup> It was designed to furnish community-based outpatient treatment and other services needed by seriously ill people who had been patients in state, local, or private inpatient facilities. Almost eighty percent of the initial allocation of \$15.1 million was targeted at the communities most profoundly affected by hospital discharges of the acutely mentally ill: Erie, Chemung, Niagara, Broome, Oneida, St. Lawrence, Dutchess, Rockland, Westchester, Sullivan, Nassau, and Suffolk counties, and nine areas within the New York City.<sup>144</sup> By 1984, the CSS, which received almost \$50 million in funds, was treating some 20,000 former hospital patients on a regular basis and furnishing sporadic care to another 10,000.<sup>145</sup>

Aware of former patients' difficulties in finding suitable living arrangements, the OMH did as many other state mental health authorities were doing and began financing the establishment and operation of community-based residential facilities. Like its counterparts in other parts of the United States, the office did not become directly involved in the provision of such services; instead, it contracted out to voluntary and for-profit agencies.<sup>146</sup> It began working with a voluntary organization, the Association for Community Living Administrators in Mental Health, to build or subsidize appropriate facilities.<sup>147</sup> The number of beds supported by the OMH grew relatively rapidly but consistently lagged behind need: in 1987, there were only roughly 5,500 such beds in existence.<sup>148</sup> Not surprisingly, the quality of these residences also varied considerably: a 1988 Commission on Quality of Care for the Mentally Disabled study of thirty-two OMH-sponsored residential facilities found that only one-third were completely "safe, nurturing, and rehabilitative," while half fell somewhat short of OMH goals and fifteen percent fell far short of meeting one or more of the OMH's standards concerning the safety, hygiene, health, recreational, and rehabilitative needs of residents. The commission also found that the OMH had failed to create programs for people who were ready to move out of these residences but were not yet capable of leading completely independent lives; as a result, residence administrators had to choose whether to continue housing people who were ready to assume

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<sup>143</sup>On the NIMH Community Support Program, which was intended to improve coordination of services for the mentally ill, see Grob, *The Mad Among Us*, 305. In 1982, the OMH received NIMH funding for ongoing analysis of the effectiveness of CSS programs, and it is likely that these funds were made available under the auspices of the Community Support Program; see Office of Mental Health, *Annual Report* (1982), 15. The 1977 reorganization created five new regional administrative units: Western New York (Chautauqua, Cattaraugus, Allegany, Erie, Niagara, Steuben, Chemeung, Schuyler, Seneca, Yates, Livingston, Wyoming, Genesee, Orleans, Monroe, Ontario, and Wayne counties); Central New York (Tioga, Broome, Delaware, Otsego, Chenango, Cortland, Cayuga, Onondaga, Madison, Lewis, Hamilton, Warren, Jefferson, St. Lawrence, Franklin, Clinton, and Essex counties); Hudson River (Greene, Columbia, Schoharie, Albany, Rensselaer, Washington, Saratoga, Schenectady, Montgomery, Herkimer, Oneida, Rockland, Westchester, Putnam, Orange, Sullivan, Ulster, and Dutchess counties); Nassau-Suffolk; and New York City. It is probable that this change was an effort to improve services in the rural parts of the state. The annual reports that the DMH published during the 1970's suggest that rural areas were persistently underserved; in fact, the old North Country region, which contained the Adirondack State Park, was barely mentioned in the DMH's reports even though it contained the St. Lawrence Psychiatric Center.

<sup>144</sup>New York State Department of Mental Hygiene, Office of Mental Health, *Annual Report 1978* (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1978), 14.

<sup>145</sup>New York State Department of Mental Hygiene, Office of Mental Health, *Annual Report 1984* (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1984), 9.

<sup>146</sup>A 1986-87 NIMH study of state-supported residential programs found that the overwhelming majority of them began in the second half of the 1970's, when federal legislation compelled CMHC's receiving federal funds to furnish appropriate outpatient care for the seriously mentally ill, and mushroomed during the 1980's. The study also found that relatively few agencies were involved in creating and running such programs and that slightly more than half were not-for-profit organizations; see Frances L. Rudolph, Priscilla Ridgway, and Paul J. Carling, "Residential Programs for Persons with Severe Mental Illness: A Nationwide Survey of State-Affiliated Agencies," *Hospital and Community Psychiatry* 42 (November 1991): 1111-14.

<sup>147</sup>Office of Mental Health, *Annual Report 1979*, 9.

<sup>148</sup>New York State Department of Mental Hygiene, Office of Mental Health, *Annual Report 1987* (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1987), 4.

greater responsibility for their own well-being or to cast them adrift and hope that they would be able to fend for themselves.<sup>149</sup>

The OMH also sought to improve standards of care in state inpatient facilities. Since the passage of the 1890 State Care Act, the DMH sought to insure that state facilities served clearly defined regional catchment areas, but the OMH increasingly felt that simply directing all patients from a given region to a single psychiatric center was wasteful and detrimental to patient well-being. From 1980 onward, it began grouping patients according to degree of treatment needed and level of functioning instead of geographic origin; in doing so, it was emulating the organization of other residential facilities that cared for the mentally ill.<sup>150</sup> The public embarrassment of having two state psychiatric centers denied reaccreditation was also a concern: in 1978 it created a Bureau of Accreditation that conducted preparatory reviews of all facilities awaiting accreditation inspections and in 1981 entered into an agreement with the Joint Commission on Accreditation of Hospitals that allowed it to direct most capital funds away from facilities that were being phased out of existence.<sup>151</sup> Efforts to insure that state psychiatric centers remained accredited also led the OMH to increase staffing levels; of course, continuing political pressure from the CSEA and other unions and the Morgado memorandum also guided its actions.<sup>152</sup> Increasing public concern about the abuse of patients, which culminated in a legislative inquiry into the problem, also goaded it into action. It began implementing reporting and investigative programs designed to uncover such problems, and sent employee representatives from state psychiatric centers to classes at Cornell University's School of Industrial and Labor Relations that detailed how to detect and respond to instances of abusive behavior.<sup>153</sup>

However, the OMH's efforts to improve inpatient care standards in large part grew out of its increasing awareness that serious mental illnesses such as schizophrenia could not be cured and that some patients simply could not function in community settings. During the late 1970's and the 1980's, the population of adult patients in state psychiatric centers declined only one to three percent each year, and the OMH acknowledged that the reduction in the inpatient census was due solely to the deaths of elderly patients; had it not been for these deaths, state hospital populations would have increased slightly during these years.<sup>154</sup> The OMH was also faced with the rapid growth of a new type of patient: the chronically ill young male adult. Men between the ages of eighteen and thirty-four made up an increasing percentage of the inpatient census, and the emergence of this patient cohort baffled OMH officials and other mental health professionals.<sup>155</sup> It is not at all surprising that the number of mentally ill young adults increased

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<sup>149</sup>New York State Commission on Quality of Care for the Mentally Disabled, A Review of 32 Office of Mental Health Supervised Community Residences (Albany: New York State Commission on Quality of Care for the Mentally Disabled, 1988), iii, 3-17. New York State was not atypical in this respect. The 1986-87 NIMH study found that only one-third of the agencies that furnished residential care "offered more than one type of program" and that the "continuum of residential services" needed to furnish effective care apparently did not exist; Randolph, Ridgway, and Carling, "Residential Programs for Persons with Severe Mental Illness," 1114.

<sup>150</sup>Office of Mental Health, Annual Report 1980, 6.

<sup>151</sup>Office of Mental Health, Annual Report 1979, 5, Office of Mental Health, Annual Report (1981), 3.

<sup>152</sup>Office of Mental Health, Annual Report 1982, 2.

<sup>153</sup>Office of Mental Health, Annual Report 1978, 7.

<sup>154</sup>Office of Mental Health, Annual Report 1984, 17.

<sup>155</sup>New York State Department of Mental Hygiene, Office of Mental Health, Annual Report 1983 (Albany: New York State Department of Mental Hygiene, Office of Mental Health, 1983), 18. The number of men who were between the ages of eighteen and thirty-four who were in state inpatient facilities increased by eighteen percent in 1983; in contrast, the percentage of those between the ages of thirty-five and forty-four declined by seven percent and those over by twenty-seven percent. Seriously ill young adults also constituted an increasing percentage of those treated at community mental health centers.

at this time: the number of adults between the ages of eighteen and thirty-four swelled as the baby-boom generation came of age. This increase in the absolute number of young adults, not a dramatic rise in the percentage of young adults afflicted by serious mental illness, was most likely responsible for the emergence of this patient cohort.<sup>156</sup> However, the characteristics of this group were in some respects unique: like others their age, acutely ill young adults were suspicious of authority, highly mobile, and unprecedentedly tolerant of illicit drug use. Many refused treatment, tried to run away from their problems (and sometimes ended up on the streets), and descended into alcohol or drug addiction.<sup>157</sup> Legal restrictions, funding shortages, and prevailing treatment philosophies militated against long-term institutionalization of this cohort of patients, but the OMH, other mental health agencies, and policymakers were increasingly forced to acknowledge that some forms of mental illness were hard to treat in outpatient settings and that some people who were capable of living outside of state facilities would never be capable of living independently of some sort of intensive support network.

The OMH also had to contend with a growing number of mentally ill people who were not eligible for any form of outpatient treatment: those who committed serious crimes. The state's prison population increased dramatically during the late 1970's and the 1980's, bringing increasing numbers of mentally ill people into contact with the criminal justice system. The office's increasing responsibility for caring for mentally ill criminals is evident in the rapid expansion of facilities designed specifically for them. In the mid-1970's, the DMH had taken over a reformatory established by the New York City and created the Mid-Hudson Psychiatric Center, which treated those who were deemed incompetent to stand trial or judged not guilty by reason of insanity. In 1977, the OMH established the Central New York Psychiatric Center, which was intended specifically for treatment of mentally ill prison inmates, and started outpatient programs in seven prisons around the state.<sup>158</sup> Between 1977 and 1985, the office also established regional forensic units at the Hutchings, Gowanda, Manhattan, Rochester, and Sullivan Psychiatric Centers.<sup>159</sup> From 1980 onward, the Insanity Defense Reform Act required that the criminally insane be institutionalized for lengthier periods of time and evaluated regularly, thus further increasing the demand for forensic services.<sup>160</sup> As a result, the OMH opened the Metropolitan New York Forensic Center in 1984 and the Kirby Forensic Psychiatric Center in 1985; both of these facilities were intended to relieve persistent overcrowding at the Mid-Hudson Psychiatric Center, which underwent expansion at roughly the same time.<sup>161</sup> Relying in part upon NIMH funding, the OMH also worked with local corrections officers, creating a demonstration program intended to identify and treat suicidal and potentially suicidal

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<sup>156</sup>It is difficult to tell from readily accessible OMH statistics whether the percentage of men being treated in inpatient facilities increased or remained constant; the question certainly bears investigation. The emergence of this patient cohort reflects a decline in the age of first hospitalization or onset of mental illness. In 1981, the OMH anticipated that the inpatient census might increase as the baby boom generation reached its thirties and forties, the age range that had historically produced high rates of hospital admission for schizophrenia and other serious mental disorders; see Office of Mental Health, Annual Report 1981, 21. In 1998, the National Alliance for the Mentally Ill noted that most people who have serious mental illnesses are diagnosed when in late adolescence or early adulthood; see National Alliance for the Mentally Ill, Things You Should Know: NAMI Facts, available [online]: <<http://www.nami.org/about/thing.htm>> [29 May 1998].

<sup>157</sup>Grob, The Mad Among Us, 296-300.

<sup>158</sup>Office of Mental Health, Annual Report 1978, 20. On the origins of the Mid-Hudson Psychiatric Center, see New York State Department of Parks, Recreation, and Historic Preservation, Bureau of Field Services, "A History of Mental Health Care Institutions in the United States and New York State," by Judith Botch, Albany, 1986, section II, part B, [ii], [iv]. (Photocopied.)

<sup>159</sup>Office of Mental Health, Annual Report 1983, 12; New York State Department of Mental Hygiene, Office of Mental Health, Annual Report 1985, 11.

<sup>160</sup>Insanity Defense Reform Act of 1980, Laws of New York,

<sup>161</sup>Office of Mental Health, Annual Report 1984, 8; Office of Mental Health, Annual Report 1985, 11.

county and city jail inmates.<sup>162</sup> This program soon became a full-fledged component of the OMH's forensic responsibilities and helped to spawn a joint OMH-Department of Correctional Services program that trains police officers how to recognize signs of mental illness and how to respond to mentally ill people they encounter while working.<sup>163</sup>

The OMH also implemented a number of new outpatient treatment initiatives that targeted specific groups of New Yorkers. Aware that African-Americans and Latinos were slightly overrepresented in the state's patient population, the OMH sponsored a number of research projects intended to identify the particular needs of mentally ill African-Americans and Latinos and demonstration programs that sought to provide culturally sensitive treatment; the need to furnish such treatment is to this day one of the office's key concerns.<sup>164</sup> The OMH also devoted increasing attention to treating mentally ill senior citizens. Even though the state had since the mid-1960's sought to place patients over the age of sixty-five in nursing homes and other facilities, the elderly remained a substantial part of the inpatient population in state facilities and the OMH continued to find it difficult to find appropriate placements for patients who no longer needed intensive inpatient care.<sup>165</sup> Increasing knowledge about some forms of mental illness that afflict older people and the concomitant formation of new advocacy groups also prodded the OMH into action. In the early 1980's, the degenerative phenomena that had formerly been attributed to arteriosclerosis or to the process of aging itself were increasingly recognized as symptoms of a distinct and progressive disorder known as Alzheimer's disease. The office sought to provide guidance to families caring for those who suffered the disease and to create day and respite care programs for elderly New Yorkers suffering from Alzheimer's disease and other forms of mental illness.<sup>166</sup> From the mid-1980's onward, it also paid increasing attention to the mental health needs of the growing number of people suffering from the newly-defined physical illness known as Acquired Immune Deficiency Syndrome, or AIDS.<sup>167</sup>

With the probable exception of its new forensic programs, the OMH's efforts were guided not only by legislative mandates, public-relations considerations, and internal concerns about patient welfare but by pressure from a growing number of citizen advocacy groups. In 1979, the National Alliance for the Mentally Ill (NAMI), which is a support group for people with serious

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<sup>162</sup>Office of Mental Health, Annual Report 1984, 8.

<sup>163</sup>New York State Office of Mental Health, Local Correctional Suicide Prevention Crisis Service Program, available [online]: <<http://www.omh.state.ny.us/suicide.htm>> [29 May 1998]. New York State Office of Mental Health, Police/Mental Health Coordination Project, available [online]: <<http://www.omh.state.ny.us/police.htm>> [29 May 1998]. The OMH and the Department of Correctional Services were linked in another way: unneeded buildings at the Pilgrim, Gowanda, and Utica Psychiatric Centers and the Craig Developmental Center were in many instances taken over by the Department of Correctional Services and turned into prison facilities; see New York State Governor's Task Force to Identify Mental Health Facilities to be Adapted for Prison Use, A Proposal to Make Adaptive Use of the State's Capital Plant to Meet Prison Space Requirements (Albany: New York State Governor's Task Force to Identify Mental Health Facilities to be Adapted for Prison Use, 1982).

<sup>164</sup>Office of Mental Health, Annual Report 1981, 18; Office of Mental Health, Annual Report 1983, 24; Office of Mental Health, Annual Report 1985, 6. It is hard to determine the extent to which external political pressure led the OMH to assess whether African-Americans and Latinos were being treated appropriately. African-American and Latino advocacy groups demanding better care for the mentally ill members of their communities do not seem to have existed; it is possible that pressure for improved services emanated from chapters of advocacy groups and mental health professionals working in areas with high concentrations of African-American and Latino people. The OMH's current mission statement affirms the agency's responsibility to provide "individualized services which respect . . . cultural differences"; see New York State Office of Mental Health, OMH Strategic Framework, available [online]: <<http://omh.state.ny.us/framewrk.htm>> [1 June 1998].

<sup>165</sup>Office of Mental Health, Annual Report 1980, 10. In 1980, roughly half of the state inpatient population was over the age of sixty-five. However, the percentage of elderly patients ranged from five percent in some new facilities to more than seventy percent in some older rural centers.

<sup>166</sup>Office of Mental Health, Annual Report 1981, 8.

<sup>167</sup>Office of Mental Health, Annual Report 1987, 5.

mental illness and their families, a lobbying organization that sought to increase funding for and levels of care, and a sponsor of research concerning the etiology of mental illness, was founded in Madison, Wisconsin. The NAMI grew rapidly, its membership swelling in large part due to the deep frustration felt by many people who had acutely ill relatives: the absence of appropriate treatment programs for relatives who had been discharged from state facilities or who had repeatedly been hospitalized for long periods of time led many family members to make great personal sacrifices and made many of them feel bewildered and isolated. In the early 1980's twelve New York State NAMI chapters formed the Alliance for the Mentally Ill in New York State, which currently has over seventy chapters and remains dedicated to helping mentally ill people and their families.<sup>168</sup>

Relations between these groups and the OMH and other mental health care providers have not always been ideal: like others who care for chronically ill relatives and lack adequate resources or support, many of those drawn to them were (and are) profoundly dissatisfied with the status quo. Searching for effective alternatives to institutionalization and in many instances convinced that outpatient care was simply not suitable for their relatives, they have often been convinced that state mental health agencies, the state and federal courts, and mental health professionals had failed them; some have openly yearned for a return to long-term institutionalization.<sup>169</sup> As a result, these organizations were at times impatient with and publicly critical of the OMH. However, these groups also sought to work with the OMH and other state agencies, which in the long term probably benefited from their involvement. The OMH's programs for people suffering from Alzheimer's disease were developed in tandem with a new voluntary organization, the Alzheimer Disease and Related Disease Foundation, and in subsequent years the office worked with other citizen advocacy groups when developing new mental health programs.<sup>170</sup> Cooperative efforts such as these may have initially magnified frustrations, but they may also have served to create lasting working relationships between the OMH and the new advocacy groups. In addition, these organizations performed much-needed educational and support functions at little cost to the OMH or other state agencies and pressed legislators to increase funding for mental health treatment and research.

The emergence of this growing citizen constituency was in part propelled by the mounting fiscal difficulties faced by the OMH and social welfare and mental health agencies across the nation. From the late 1970's onward, the OMH shouldered an increasing share of the cost for the care of the mentally ill. The goal of making county and city governments assume a greater share of the burden was increasingly recognized as unworkable, and federal monies earmarked for mental health research and treatment declined substantially. The federal government's intent to decrease funding for mental health care first became evident during the administration of Jimmy Carter. State policymakers, mental health professionals, and advocacy groups had hoped that the Carter administration would produce significant advances in federal support for mental health: First Lady Rosalyn Carter was a prominent advocate of better care for

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<sup>168</sup>Alliance for the Mentally Ill of New York State, About AMI-NYS, available [online]: <<http://www.crisny.org/not-for-profit/aminys/About.html>> [29 May 1998]; Alliance for the Mentally Ill of New York State, Affiliate List, available [online]: <<http://www.crisny.org/not-for-profit/aminys/affiliate.html>> [29 May 1998].

<sup>169</sup>Families' anger at not being able to have mentally ill relatives placed in state facilities for lengthy periods of time stemmed from a number of sources. A few probably wanted to be rid of troublesome kin. However, others caring for deinstitutionalized family members had good reason to fear violence from their mentally ill loved ones or watched helplessly as family members repeatedly improved as a result of drug therapy administered in inpatient programs and then declined after they were discharged and refused to take their medicines. See Issac and Armat, Madness in the Streets, 272-76, and Johnson, "Unravelling of a Social Policy," 373-75, 433-34, 486.

<sup>170</sup>Office of Mental Health, Annual Report 1981, 8.

the mentally ill, and the creation in 1977 of the highly publicized President's Commission on Mental Health seemed to portend an expansion of federal support for mental health initiatives. However, the federal government's ability to do so was limited by spiraling inflation, the escalating cost of Medicare, Medicaid and other federal entitlement programs, the absence of vocal champions at the NIMH and other government agencies, and the lack of consensus about priorities; the community mental health centers' many responsibilities and the increasing prominence of psychologists and social workers in the mental health field virtually guaranteed that there would be no agreement as to which forms of mental illness or treatment were to be emphasized. These contradictions were reflected in the 1980 National Mental Health Systems Act, which stressed the need for improving linkages between mental health and other forms of health care, increasing provider accountability, improving care for the acutely ill, and safeguarding patients' civil rights but did not detail how these aims were to be accomplished. In addition, the act stressed that the federal government would continue to help shape mental health policy even as federal funding for community mental health centers would eventually cease.<sup>171</sup>

From 1981 onward, the federal government's reluctant disengagement from mental health policy quickly gave way to a determined retreat. Seeking to cut federal taxes and expenditures, President Ronald Reagan sought to dismantle or shrink many social welfare programs. One of the aims of his first administration was to take apart federal mental health and substance abuse programs, cut federal support for them by twenty-five percent, and forward federal monies to the states in the form of block grants that would allow each state to devise its own mental health and substance abuse treatment policies. With the passage of the 1981 Omnibus Budget Reconciliation Act of 1981, which revoked the Mental Health Systems Act, this goal was made into policy.<sup>172</sup> Gerald Grob argues that the Omnibus Budget Reconciliation Act constituted a dramatic rejection of the federal mental health policy that had taken shape during the 1960's. In its wake, American mental health policy was once again the responsibility of the states and of localities. However, the federal government's abdication of responsibility occurred "at precisely the same time that states [and local governments] were confronted with monumental social and economic problems that increased their fiscal burdens" and was as a result particularly disastrous for the mentally ill.<sup>173</sup>

Part of the states' fiscal difficulties stemmed from other federal policy changes. During the Reagan years, the executive and legislative branches of the federal government sought to curb Social Security expenditures. Rejecting the call of the President's Commission on Mental Health, which issued its final report in December 1980, to integrate federal entitlement programs and mental health treatment, both the president and Congress sought to shrink the SSI and SSDI rolls and curb abuse of these programs. Under the provisions of the 1980 Disability Amendments Act, each SSI and SSDI recipient was to undergo a benefits review every three years. Under pressure from the Reagan administration, the Social Security Administration used these reviews to cut large numbers of mentally ill and other disabled recipients from these programs. It created definitions of mental disability that differed considerably from those it had employed in the past and from prevailing professional definitions of acute mental disorder, and its actions resulted in a dramatic decline in the number of mentally ill people receiving SSI and SSDI. Mentally ill people, who constituted roughly eleven percent of recipients, made up some

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<sup>171</sup>Grob, *The Mad Among Us*, 284-86.

<sup>172</sup>Richard Frank and Thomas MacGuire, "Health Care Financing and State Mental Health Systems," in *Health Policy, Federalism, and the American States*, ed. Robert F. Rich and William D. White (Washington, D.C.: Urban Institute Press, 1996), 129.

<sup>173</sup>Grob, *The Mad Among Us*, 286-87.

thirty percent of those dropped from the SSI and SSDI rolls. The vast cuts in SSI and SSDI expenditures, which produced savings far greater than that anticipated by the Reagan administration, ultimately produced a public uproar that compelled the Reagan administration to reverse course.<sup>174</sup> However, the hardships and dislocations that grew out of this policy were no doubt substantial; at least some of those who were denied benefits became homeless and severed all contact with mental health and social service agencies.<sup>175</sup> Decreases in federal support for low-income housing and other social-welfare programs made it even more difficult for mentally ill people to adjust to being removed from the SSI and SSDI rolls.<sup>176</sup>

Federal funding cuts and the state cuts that followed them clearly affected mental health care in New York State. The OMH noted in 1982 that fourteen of the twenty-six community mental health centers that had constructed and staffed under the provisions of the CMHCCA and other federal laws had "graduated from federal funding" and were being supported largely by the state.<sup>177</sup> The state's fiscal difficulties were also noted by the Governor's Select Commission on the Future of the State-Local Mental Health System, which predicted that New York State would eventually face a fiscal nightmare if it did not integrate state and community-based programs more effectively and that it could no longer expect substantial assistance from the federal government.<sup>178</sup> By 1983, funding for a number of OMH programs had been slashed, and the office laid off some personnel and transferred responsibility for the office's Long Island Research Institute to another state agency in hopes of saving money.<sup>179</sup> The office, goaded perhaps by a report from the New York State Division of Audits and Accounts that charged that slipshod OMH managerial practices denied the state some \$4.5 million in Medicaid and Medicare reimbursements every year, also automated its billing procedures and took over responsibility for setting Medicaid reimbursement rates in order to insure that it got as much money as possible from remaining federal sources.<sup>180</sup>

In the wake of federal cutbacks, policymakers in New York State and other states were more firmly committed than ever to community-based provision of mental health. Some still hoped that community programs would be much cheaper than inpatient care at state psychiatric centers, but most were guided by the realization that the current fiscal and legal climate militated against any dramatic expansion of inpatient care and remained convinced that inappropriate institutionalization remained a problem. As a result, the OMH sought improve community-based care for the acutely ill. The office created a program designed to support voluntary agencies' efforts to acquire real property and create residences for mentally ill people and sought to boost funding of community-based service programs.<sup>181</sup> In addition, the OMH used the federal block

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<sup>174</sup>Grob, The Mad Among Us, 300-02. The administration had hoped for a savings of \$218 million by 1985, but the Social Security Administration projected that some \$3.5 billion would be saved by that time.

<sup>175</sup>New York State Governor's Select Commission on the Future of the State-Local Mental Health System, Final Report of the New York State Governor's Select Commission on the Future of the State-Local Mental Health System (Albany: New York State Governor's Select Commission on the Future of the State-Local Mental Health System, 1984), 6. For a complete list of commission members, subcommittee members, and others involved in the Select Commission's work, see pp. i and 45-48.

<sup>176</sup>Frank and MacGuire, "Health Care Financing and State Mental Health Systems," 129.

<sup>177</sup>Office of Mental Health, Annual Report 1982, 2.

<sup>178</sup>Governor's Select Commission on the Future of the State-Local Mental Health System, Final Report, 6.

<sup>179</sup>Office of Mental Health, Annual Report 1983, 5.

<sup>180</sup>New York State Division of Audits and Accounts, Department of Audit and Control, "Re: Audit Report AL-Misc-3-83, Medicare Recovery of Outpatient Service Costs" (20 September 1982); Office of Mental Health, Annual Report 1982, 12, and Office of Mental Health, Annual Report 1983, 22.

<sup>181</sup>Office of Mental Health, Annual Report 1987, 7. The OMH's share of block-grant monies was relatively small: the House Committee on Energy and Commerce concluded that by the early 1990's New York State was directing only ten percent of its block-grant funds to mental health programs. See U.S. Congress, House, Committee on Energy and Commerce, Community

grant funds it received to expand the CSS, and in 1987 streamlined funding for the program by inducing the legislature to merge monies allocated for the CSS with those earmarked to fulfil the state's legal obligation to pay for the aftercare of former state psychiatric center patients.<sup>182</sup>

The OMH also undertook a number highly-publicized efforts to address the problem of homelessness, which grew in part as a result of federal and state cuts in social welfare spending and was particularly pronounced in New York City. The office's drive to furnish care to the homeless was in large part the result of mounting public criticism of past mental health policy: many citizens and politicians had become convinced that almost all former state hospital patients ended up on the streets, that all but a few of them were belligerent, socially disruptive, and potentially dangerous, and that deinstitutionalization was solely to blame for the phenomenon of homelessness and the urban decay associated with it. In reality, only a highly visible subgroup of mentally ill people became homeless and the problem had multiple roots: the shortage of aftercare, the inability of the OMH and other agencies to compel the acutely ill to undergo treatment, the reductions in the SSI and SSDI rolls, alcohol and drug addiction, and New York City real-estate tax and abatement codes that encouraged ruthless (and often illegal) evictions from and demolition of SRO's and other residences inhabited by low-income people.<sup>183</sup>

Aware of the complexity of the problem, the OMH sought to defuse public criticism by addressing the existence of mental illness among the homeless population of the New York City. It cooperated with the Governor's Task Force on the Homeless and, in conjunction with the State Department of Social Services and the New York City Human Resources Administration, created short- and long-term programs for the homeless at the Creedmoor Psychiatric Center.<sup>184</sup> In addition, the OMH, acting in tandem with the Human Resources Administration, placed mental health screening teams in a number of municipal shelters for the homeless; after the Creedmoor facility for the homeless opened in 1985, the OMH screening teams directed those in need of immediate and intensive inpatient care to the city-operated Bellevue Hospital and those requiring less intensive care to Creedmoor.<sup>185</sup> The OMH's efforts did not hold back the swelling tide of public criticism; however, given the multiple causes of homelessness and the simple fact that not all homeless people are mentally ill, no amount of action taken by the OMH would have completely resolved public concern about (and fear of) homeless people.<sup>186</sup>

The financial hardships that the OMH and other mental health authorities endured during the early 1980's became less acute during the second Reagan administration and the administration of George Bush. Advocacy groups and mental health professionals supportive of the reforms outlined by the President's Commission on Mental Health were galvanized into action by dramatic federal funding cuts, and they increasingly made common cause with advocacy groups representing people with other forms of disability. The resulting alliances made it easier for supporters of mental health care expansion and reform to influence the

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Mental Health and Substance Abuse Services Improvement Act of 1992, H. Rept 102-464 to Accompany H.R. 3698, 102d Congress, 2d sess., 1992 (Washington, D.C.: Government Printing Office, 1992), 53

<sup>182</sup>Office of Mental Health, Annual Report 1984, 4-5; New York State Office of Mental Health, Annual Report 1987, 4;

<sup>183</sup>On the roots of the problem of homelessness in New York City, see Johnson, "Unravelling of a Social Policy," 399-410, and Governor's Select Commission on the Future of the State-Local Mental Health System, Final Report, 6.

<sup>184</sup>Office of Mental Health, Annual Report 1983, 4-5.

<sup>185</sup>Office of Mental Health, Annual Report 1985, 32; Office of Mental Health, Annual Report 1987, 27.

<sup>186</sup>The prevalence of mental illness among homeless people has been the subject of protracted debate. Estimates have ranged from twenty to more than fifty percent, and funding considerations may have colored efforts to equate homelessness and mental illness. One New York City mental health worker subsequently recalled that the state labeled homeless people mentally ill because it could use the existing CSS program to finance their care and thus avoided having to pass legislation that would furnish funds through the Department of Social Services; see Johnson, "Unravelling of a Social Policy," 407-09.

formation of policy. In addition, the Social Security Administration implemented a number of desirable changes after it was forced to stop purging mentally ill persons from program rolls. It altered the requirements of SSI (but not SSDI) to allow mentally ill people to remain eligible for partial benefits after they found paid work and expanded Medicaid support for mental health care. These reforms may have stemmed partly from the involvement of the agency's fiscal experts in the work of the President's Commission: as a result, key Social Security personnel became aware that some SSI provisions did not meet the needs of mentally ill recipients.<sup>187</sup>

These changes were accompanied by modest increases in federal spending for mental health research and treatment. These increases were typically implemented with little fanfare: high-profile initiatives such as the 1992 Community Mental Health and Substance Abuse Services Improvement Bill, which sought to make federal funding more equitable and expand community programs, did not become law.<sup>188</sup> Mental health advocacy groups and their friends in the Democratic-controlled Congress soon learned that the most effective way to increase federal mental health expenditures was to bury funding mandates in mammoth budget reconciliation bills that retarded close scrutiny.<sup>189</sup> However, some federal measures explicitly dedicated to improving mental health care did become law. In 1984, Congress succeeded in overcoming the objections of the Reagan administration and bestowed full legal status upon the NIMH's Community Support Program, which for the next five years continued to induce the states to improve services for people with serious and chronic mental illness.<sup>190</sup> In 1986, the State Comprehensive Mental Health Services Plan Act (SCMHSPA), which compelled the states to devise detailed service plans that emphasized improving outpatient-based care for the chronically mentally ill in order to receive federal mental health monies, became law.<sup>191</sup> The planning provisions of the SCMHSPA, which mark a low-profile return to direct federal involvement in the shaping of mental health policy, bear more than a passing resemblance to those contained within the 1977 recodification of the New York State Mental Hygiene Law.

During the presidency of Bill Clinton, the executive and the legislative branches of the federal government have cooperated in increasing both the amount of and the strings attached to the block- grant funds disbursed by the Center for Mental Health Services (CMHS), which is a component of the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).<sup>192</sup> In addition to controlling block-grant monies, the CMHS also administers grant funds targeted for demonstration projects involving mentally ill children, programs for the homeless and people with HIV disease, legal advocacy and information groups serving the mentally ill, and training of mental health personnel. The center is also responsible for compiling statistics concerning mental illness, treatment, and research, and furnishing assistance to those devising programs for select populations (e.g., women, African-Americans, Asian-Americans, Latinos, prison inmates, those living in rural areas) or working with disaster survivors. Most recently, the CMHS has begun the National Mental Health

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<sup>187</sup>Chris Koyanagi and Howard H. Goldman, "The Quiet Success of the National Plan for the Chronically Mentally Ill," *Hospital and Community Psychiatry* 42 (September 1991), 903.

<sup>188</sup>U.S. Congress, House, Committee on Energy and Commerce, *Community Mental Health and Substance Abuse Services Improvement Act of 1992*, H. Rept 102-464 to Accompany H.R. 3698, pp. 2-8, 57-58.

<sup>189</sup>Koyanagi and Goldman, "The Quiet Success of the National Plan for the Chronically Mentally Ill," 903.

<sup>190</sup>Grob, *The Mad Among Us*, 305. In 1989, the NIMH dedicated the Community Support Program solely to measuring the effectiveness of state programs.

<sup>191</sup>*State Comprehensive Mental Health Services Plan Act of 1986*, *Statutes at Large* 100, sec. 501-03, 3794-97.

<sup>192</sup>See note 19 for discussion of the creation of the SAMHSA.

Services Knowledge Exchange Network, an information clearinghouse for mentally ill people, their family members, and others interested in mental-health issues.<sup>193</sup>

Apart from these incremental increases in federal responsibility and funding for treatment, research, and public education, federal mental health policy has undergone little change during the Clinton years. The first Clinton administration's highly publicized national health insurance plan was notable for its relatively generous provisions for mental health treatment. However, in the wake of the plan's rejection by Republicans and many Democrats in Congress and the 1994 elections that gave control of both houses of Congress to the Republican Party, the Clinton administration has been loath to press for dramatic expansions of social welfare programs. Instead, the administration and Congress have sought modest improvements in third-party insurance coverage of mental health treatment. The Mental Health Parity Act (MHPA) of 1996, which went into effect upon 1 January 1998, compelled corporations that offered mental health benefits to their employees to increase annual and lifetime caps to match more closely those set for physical disorders.<sup>194</sup> These changes have at best meant a modest improvement in the insurance benefits of some seriously or moderately mentally ill people, but mental-health professionals and advocacy groups heralded the MHPA as a first step toward equal coverage of mental and physical disorders.<sup>195</sup> The MHPA did not prohibit the states from enacting more stringent parity legislation, and in its wake a number of states did so.<sup>196</sup> However, New York State was among neither the pioneers that had acted in advance of federal legislation nor among those propelled into action by it. At the present time, state lawmakers apparently believe that the MHPA's provisions are sufficient; apart from a bill improving insurance coverage of treatment for serious mental illness, which is at the time of this writing being studied by the New York State Insurance Department, politicians have been loath to press private insurance companies to offer more comprehensive mental health benefits.<sup>197</sup>

New York State legislators have been much more eager to adopt some of the cost-containment strategies devised by commercial and not-for-profit health insurers. In 1991, they compelled counties to devise managed care programs for Medicaid recipients, including those who are mentally ill, and in 1996 subsequent legislation mandated the creation of Special Needs Plans (SNP's) for mentally ill adults and children who receive Medicaid benefits; pending federal approval, the 1996 legislation also gives the state the power to force the mentally ill into these managed care programs.<sup>198</sup> As of late 1997, the OMH, which has played a substantial role in

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<sup>193</sup>Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, [The Center for Mental Health Services Information Page](http://www.samhsa.gov/cmhs/cmhs.htm), available [online]: <<http://www.samhsa.gov/cmhs/cmhs.htm>> [29 May 1998].

<sup>194</sup>[Mental Health Parity Act of 1996, Statutes at Large](#) 110, sec. 701-03, 2944-50. The MHPA, which expires on 30 September 2001, does not compel companies to offer mental-health coverage, apply to those that have fewer than fifty employees, or extend to treatment for substance abuse and chemical dependency. In addition, corporations that could prove that parity implementation would raise their insurance costs by at least one percent could apply for exemptions. The passage of the MHPA also brings to the fore a subject of particular interest to those seeking to document the development of mental health policy and programs: the history of private insurance coverage of mental illness. Information on this aspect of mental health policy is hard to come by, but it seems that mental health benefits began to develop in the 1960's and became more common in subsequent decades.

<sup>195</sup>See, e.g., National Alliance for the Mentally Ill, [The Mental Health Parity Act of 1996](#), available [online]: <<http://nami.org/update/parity96.htm>> [1 June 1998].

<sup>196</sup>See National Alliance for the Mentally Ill, [State Mental Illness Parity Laws](#), available [online]: <<http://www.nami.org/pressroom/statelaws.html>> [1 June 1998].

<sup>197</sup>At present, the only bill that would mandate improved coverage of mental illness is Assembly Bill 1379, which would compel insurers to cover serious mental illness. The bill was sent to the Insurance Department for study in January 1998; see New York State Legislature, Legislative Bill Drafting Commission, [Legislative Digest 1998: January 7 to May 22](#), vol. 2, [Assembly Introduction Record](#), 81.

<sup>198</sup>Act of 12 June 1991, [Laws of New York](#), Ch. 165, § 8; New York State Office of Mental Health, [OMH Quarterly](#) 2 (March 1996), available [online]: <<http://www.omh.state.ny.us/qvol2no2htm#anchor1348229>> [9 June 1998].

determining the provisions of the SNP's, anticipated that the plans designed for adults would be implemented in the summer of fall of 1998 and that those for children and adolescents six months to a year later.<sup>199</sup>

The drive to cut costs also spurred the OMH to close a number of its psychiatric centers. However, declining inpatient populations also drove the closures: the inpatient census declined from 22,724 in 1980-81 to 10,500 in late 1993 and that admissions rates, which had remained constant throughout the 1980's, dropped substantially in 1991-92. In response to this rapid drop in population, the Harlem Valley, Gowanda, Central Islip, Willard, and King's Park Psychiatric Centers all ceased operations during the mid- to late 1990's.<sup>200</sup> The closure of these facilities, coupled with sustained efforts by Mario Cuomo and George Pataki to reduce the number of state employees, produced a dramatic decrease in the number of people employed by the OMH: between 1988 and 1997, transfer programs, retirement incentives, and attrition contributed to a forty-seven percent drop in the agency's workforce. As of late, the OMH anticipates that community-based outpatient programs and the growing number of inpatient psychiatric beds in general hospitals (which are eligible for Medicaid reimbursement) will in the future produce a further decline in the state's inpatient population.<sup>201</sup>

The OMH's closure of facilities and declining workforce gave rise to concern that the welfare of the seriously mentally ill would be sacrificed in the name of cost-effectiveness. In an effort to insure that psychiatric-center closures do not produce the problems associated with deinstitutionalization in the 1970's and that efforts to pare the OMH workforce and close facilities that it operates are not propelled solely by the desire to reduce mental-health spending, the Community Mental Health Reinvestment Act (CMHRA) of 1993 mandates that the savings realized from the closure of Harlem Valley, Gowanda, Central Islip, Willard, King's Park, and any other state psychiatric centers be directed to community-based treatment, residential, and support programs for people with severe mental illnesses.<sup>202</sup> Although Governor Mario Cuomo initially objected to the CMHRA on the grounds that it would tie the hands of his successors and the CSEA was opposed to any facility closures, the Mental Health Action Network, an informal coalition of politicians, mental health professionals and advocacy groups that pressed for the law's passage and shaped its provisions, successfully overcame this opposition and secured its passage. Despite Governor Pataki's efforts to undercut it, the CMHRA remains in effect.<sup>203</sup>

### Conclusion

In some respects, the course of mental health treatment and policy in New York State and in the United States from the late nineteenth to the late twentieth century has been circular. Psychiatrists and advocacy groups representing families of the mentally ill now concur that serious mental illnesses are biologically rooted. In the future, the mountain of studies into the neurochemical dimensions of mental illness may alter the very manner in which it is conceptualized: the New York City chapter of the NAMI asserts that "mental illness" is a

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<sup>199</sup>New York State Office of Mental Health, OMH Quarterly 3 (December 1997), available [online]: <<http://www.omh.state.ny.us/qvol3no3.htm#anchor1482785>> [9 June 1998].

<sup>200</sup>New York State Office of Mental Health, Statewide Comprehensive Plan for Mental Health Services 1994-1998 (Albany: New York State Office of Mental Health, 1993), 1-2.

<sup>201</sup>New York State Office of Mental Health, OMH Quarterly 3 (June 1997). Available [online]: <<http://www.omh.state.ny.us/qvol3no2.htm>> [9 June 1998].

<sup>202</sup>Community Mental Health Reinvestment Act of 1993, Laws of New York, ch. 723, § 2, § 12, subd. a-i, § 24. The relevant provisions of the act expire on 31 March 2000.

<sup>203</sup>For the circumstances leading to the creation and passage of the CMHRA, see Robert N. Swidler and John V. Tauriello, "New York State's Community Mental Health Reinvestment Act," Psychiatric Services 46 (May 1995): 496-500.

misnomer and that "neurobiological disorder" is a more appropriate and precise way of classifying disorders such as schizophrenia, and the term seems to be gaining favor.<sup>204</sup> Although the OMH continues to assert that its actions should be guided by "the expectation that each person can recover from mental illness," advocacy groups such as the NAMI and most members of the psychiatric profession have become markedly pessimistic about curing serious mental disorders.<sup>205</sup> The federal government's retreat from extensive involvement in the shaping of mental health policy and the increasing latitude given the state also calls to mind the decades before the Second World War.

However, these apparent similarities obscure as much as they reveal about the trajectory of mental health policy. The federal government has since the mid-1980's resumed some responsibility for mental health policy and compels states seeking federal funds to adhere to certain requirements concerning care of the seriously mentally ill and development of community-based programs. The OMH and its counterparts in many other states preside over a decentralized system of care and treatment that consists of both local and state agencies and which is supported by a combination of state, local and federal monies. The office also strives to meet the needs of a much broader client population: the expansion of mental health treatment to cover those suffering less serious forms of mental illness or having difficulty coping with difficult life circumstances that began during the Progressive era and blossomed from the 1960's onward has compelled it to develop its programs accordingly. In devising these programs, the OMH continues to rely upon psychiatrists, the traditional providers of care and treatment of the mentally ill, but it also works with psychologists, social workers, and other mental health professionals who no longer defer to psychiatric expertise. State inpatient institutions, which once housed most of the mentally ill, have become but one of several kinds of facilities providing care and treatment, and it is highly unlikely that they will once again predominate: even if the state had the money needed to reconstruct the extensive network of hospitals that once existed, the numerous court cases that established patients' right to refuse treatment would militate against the recreation of the old mental health system.

Changing attitudes toward treatment also work against the reestablishment of the old state hospital-centered system. The hope of finding easy and permanent cures for serious mental illness has been discarded, but few mental health professionals and advocacy groups believe that simple custodial care such as that formerly furnished on the back wards of state hospitals is desirable. Recognizing that serious mental illness is chronic and that those who suffer from it are likely to suffer relapses from time to time, they have instead focused upon trying to ensure that mentally ill people can function to their fullest potential and to reduce the dislocations that the illness produces. Of course, these hopes do not always coincide with reality: in many instances, the quality of life in PPHA's and other institutions that developed as state hospital systems were being dismantled is little better than that found in the back wards of the old state facilities, and community-based programs in many areas remain fragmented and ill-equipped to prevent those with serious mental illness from falling through the gaps in the safety net.

The mental health system of New York State resembles the integrated network envisioned by the drafters of the 1954 Community Mental Health Services Act much more closely than it does the centralized hospital system created by the 1890 State Care Act. However, it continues to exhibit many of the problems highlighted by its critics from the mid-

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<sup>204</sup>National Alliance for the Mentally Ill/ New York City, NAMI/ NYC, available [online]: <<http://www.schizophrenia.com/ami/>> [1 June 1998].

<sup>205</sup>Office of Mental Health, OMH Strategic Framework.

1950's onward: lack of cooperation between state and local providers, gaps in provision stemming from the state's efforts to tailor policy to maximize reimbursements from the federal government, and an unfortunate tendency to lose track of the most acutely ill. Recent policy initiatives spearheaded by the OMH, state lawmakers, and federal authorities have sought, with varying degrees of success, to address these problems, and it seems that this relatively modest goal will in the immediate future continue to animate state and federal policy reforms: given the immense difficulty of radically restructuring such a complex system and the seeming absence of the political will needed to do so, it seems likely that most efforts at changing the mental health system will focus upon correcting its more readily identifiable and (apparently) remediable flaws.

1998 by Bonita L. Weddle

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# Timeline

## Mental Health Policy in New York State, 1900-1998

**1890's-1930's:** Psychiatrists, who over the course of the nineteenth century become distant from the medical profession, seek to reestablish their medical credentials. No longer content to see themselves as providers of humane custodial care, they adopt an aggressive therapeutic stance.

**1909:** The National Committee for Mental Hygiene (NMCH) is founded and headquarters in Manhattan. The NCMH spearheaded the mental hygiene movement, which was pessimistic about curing mental illness but convinced that it could be prevented. The aims of the movement fit well with psychiatrists' efforts to broaden their influence, but by the 1930's the movement's efforts to involve psychologists and social workers in mental health treatment make many psychiatrists feel that their status and authority is under attack. Psychiatrists attracted to the mental hygiene movement refrained from embracing the demands for compulsory sterilization of the mentally ill and developmentally disabled and harsh immigration restrictions put forth by some active in the movement.

**1920's:** Fever therapy is introduced in mental hospitals. Many psychiatrists are ambivalent about its use.

**1920's-1940's:** The mental hygiene movement's preventative activities focus upon schools. After the Second World War, concepts of personality development and child guidance become so deeply ingrained in American pedagogical theory that the movement as a result of own success.

**1926:** The New York State Department of Mental Hygiene (DMH) is created in wake of 1925 constitutional reorganization of state government. The DMH's sole responsibility is to inspect state and private institutions caring for the mentally ill, the developmentally disabled, and epileptics.

**1927:** The New York State Mental Hygiene Law is enacted. The DMH is given almost all responsibility for the care and treatment of the mentally ill, the developmentally disabled, and epileptics. The Mental Hygiene Law also underscores the influence of the mental hygiene movement upon state policymakers: it mandates the creation of a DMH Division of Prevention.

**1930's:** Insulin shock and metrazol shock therapies and surgical technique of prefrontal lobotomy are developed. As was the case with fever therapy, many psychiatrists are hesitant to embrace them.

**1930's- 1945:** Conditions in state mental institutions deteriorate as a result of Depression-era financial hardships and the resource and personnel demands of the war. Physical plants deteriorate and overcrowding is common.

**Late 1930's-Early 1940's:** Electroconvulsive therapy, which replaces insulin and metrazol shock therapies, is introduced into the United States. Psychologists are of two minds about its value.

**1941-1945:** The experience of treating military personnel suffering from combat-related mental illness leads many psychiatrists to emphasize the social dimensions of mental disorder. The recognition that patients suffering from war-related disorders respond best when given immediate care in outpatient-based settings leads the profession to hypothesize that mentally ill civilians might best be treated outside of traditional mental institutions.

**Late 1940's--Early 1950's:** Exposés of hospital conditions produce a widespread public and professional demand first for reform and then for dismantling of state hospitals.

**Mid-1940's:** Fountain House, a Manhattan-based support group, is started by a group of former patients of the Rockland State Hospital. In 1948, the organization purchases a Midtown brownstone that serves as a residence for program members.

**1946:** The federal Hill-Burton Act, which allocates monies for state hospital renovation and construction, is enacted.

**1949:** The National Institute of Mental Health (NIMH), a new component of the Public Health Service's National Institute of Health, comes into existence.

**1949:** The New York State Mental Health Commission is formed. The commission is charged with meeting annually to determine the outlines of a new state mental health policy designed to reduce the state's inpatient census, which is the largest in the nation.

**1954:** The New York State Community Mental Health Services Act is passed. The act encourages localities to establish community-based mental health programs and to apply for state reimbursement of up to fifty percent of the cost of these programs.

**Mid-1950's:** The development of psychiatric drugs such as Thorazine and new tranquilizers reinforce psychiatric confidence in the effectiveness of outpatient treatment and their ability to cure mental illness. Even die-hard champions of environmental models of mental illness are enthusiastic.

**Mid-1950's:** The open-hospital movement, which developed in Great Britain and emphasizes patients' need to govern their own movements, comes to the United States. In 1957, DMH commissioner Paul Hoch becomes interested and sends seven state hospital

administrators to Britain to study the movement. All seven return adherents of the principle of allowing patients the greatest freedom of movement.

- 1955:** The Federal Mental Health Study Act funds the activities of the Joint Commission on Mental Illness and Health, a study group established by the American Medical Association and the American Psychiatric Association.
- 1956:** The DMH creates the Association of Community Mental Health Boards in order to foster communication between and innovation among community mental health boards (CMHB's), the local authorities responsible for creation and administration of community-based mental health programs.
- 1959:** The DMH creates ten Regional Mental Health Advisory Committees in an effort to assist CMHB efforts to devise suitable programs.
- 1961:** The Joint Commission on Mental Illness and Health issues its final report, Action for Mental Health. The lack of consensus and focus within the commission, which is dominated by social and behavioral psychiatrists, is evident, and APA is divided about its recommendations.
- 1963:** The Federal Community Mental Health Centers Construction Act makes available federal funds for construction of community centers; between one- and two-thirds of the cost of each center is paid for by the federal government. States have to submit plans, designate an agency responsible for executing them, appoint a broad advisory council and develop a construction program. In subsequent years, the federal government allocates some funds for staffing centers and training necessary personnel.
- 1963:** The New York State Mental Hygiene Facilities Improvement Corporation is established and given control of disbursing all local, state, and federal funds targeted for facility construction. The state's Housing Finance Authority, the agency responsible for issuing loans for health facility, public housing, and state university construction projects, is empowered to issue loans for construction of mental health facilities.
- 1965:** Medicare, a federally-supported health insurance program for senior citizens, and Medicaid, a health insurance program for the needy funded jointly by local and federal government, are established. Both contain provisions for mental health treatment, but care furnished in state hospitals is explicitly not covered and mentally ill people under the age of sixty-five are ineligible for Medicaid benefits. These provisions result in the transfer of large numbers of the elderly mentally ill from state hospitals to nursing homes, a shift that increases mortality rates among mentally ill senior citizens.
- 1967:** The NIMH is given full bureau status.
- Late 1960's-1970's:** Academic attacks on mental health and psychiatry, including some launched from within, proliferate:

- R.D. Laing, a left-wing Scottish psychiatrist and Thomas Szasz, a libertarian professor of psychiatry at the SUNY Upstate Medical Center at Syracuse University, launch concerted and highly influential assaults upon psychiatry.
- French philosopher Michel Foucault's studies of insane asylums, penal institutions, and other modern Western phenomena stress that psychiatry and other developments commonly seen as "enlightened" are in fact tools of the modern Western state, which induces people to internalize its codes of thought and behavior.
- Sociologists such as Erving Goffman assert that psychiatrists are concerned above all else with preserving their own professional identity.

**Late 1960's-1970's:** The mass political movements of the era are often hostile to the concept of mental health.

- The New Left sees it as a tool of "the Establishment" and embraces the arguments of Laing, Szasz, and Goffman; however, a few drawn to the New Left attempt to create more responsive alternatives to traditional mental health treatment.
- Feminists assert that psychiatrists wittingly or unwittingly seek to compel women to accept their subordination.
- Gay-rights activists, who in 1973 successfully force the American Psychiatric Association to assert that homosexuality is not a mental disorder, denounce the suffering that psychiatrists have caused lesbians and gay men.
- A nascent patient-liberation movement denounces psychiatry and mental institutions as instruments of oppression.
- Conservatives angered by the pronouncements of the minority of psychiatrists who are active in the civil rights and anti-war movements denounce mental health as a covert means of advancing a liberal or radical political agenda.

**Late 1960's-1970's:** The definition of mental illness, which has gradually broadened as a result of the mental hygiene movement and psychiatric efforts to expand the scope of their influence, expands to include minor mental disorders and difficulty in coping with life crises. This expansion is in part propelled and reinforced by the increasing involvement of psychologists, social workers and other non-psychiatric personnel in treating mental illness. During the 1960's, these professionals successfully challenge the hegemonic position of the psychiatric profession.

**Late 1960's-1970's:** The problems associated with the policy of mass discharges from state hospitals, which is increasingly referred to as deinstitutionalization, become increasingly evident: lack of continuity of care and failure to meet the needs of the seriously mentally ill.

**Late 1960's-1970's:** State and federal courts rule that the mentally ill have the legal right to refuse treatment and cannot be involuntarily committed to mental institutions unless they

pose a clear and present danger to themselves or others. Other court rulings force New York State and other states to improve the quality of care in the institutions they operate.

**1970's:** Economic difficulties affect the DMH and hamper its ability to maintain and expand programs.

**1972:** Two new federal Social Security programs, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), dramatically alter care for the mentally ill. Designed to preserve recipients' dignity, they do not mandate that mentally ill recipients seek treatment. These benefits enable those who might otherwise have no place to go other than a state hospital to live independently, sometimes at the cost of ensuring that they are housed, fed, and clad decently.

**1973:** New York State Unified Services Act seeks to improve coordination between state and local agencies by encouraging localities to devise service plans that harmonize state and local efforts. Owing to the complexity of its funding provisions, local lawmakers' reluctance to embrace untried reform measures or increase spending on mental health programs, the act does not produce desired results: only five counties put forth acceptable unified services plans.

**1973:** The NIMH is made part of the Department of Health and Human Services' newly created Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Its research functions are transferred to the National Institute of Health.

**1974:** The New York State Legislature enacts laws mandating that the state furnish appropriate care for those discharged from state hospitals.

**1975:** The Creedmoor and Pilgrim Psychiatric Centers are stripped of their accreditation. Although deeply embarrassed, the DMH continues to channel resources away from the state's psychiatric centers.

**1975:** The Federal Mental Health Act, which Congress passes over the veto of President Gerald Ford, compels federally funded community mental health centers to care for the seriously mentally ill.

**1977:** The New York State Mental Hygiene Law is recodified and the DMH's responsibilities broken down and assigned to three autonomous offices: the Office of Alcohol and Substance Abuse, the Office of Mental Retardation and Developmental Disability, and the Office of Mental Health (OMH). The recodification also compels local mental health authorities and the three successor offices of the DMH to draw up five-year service plans and to issue annual progress reports.

**1977:** Jimmy Carter forms the President's Commission on Mental Health.

**1978:** The OMH creates the Community Support System, a program designed to furnish treatment and support services to the seriously mentally ill. This program may be an effort to secure funds from the NIMH's newly-created Community Support Program for the seriously ill.

**1978:** The Civil Service Employees Association, the labor union representing many state hospital employees, sponsors a radio and print advertising campaign that accuses the state of "dumping" the mentally ill onto the streets or into substandard custodial facilities. The highly effective campaign, which runs during the gubernatorial election, results in an executive-office policy directive that instructs the OMH to increase staffing levels in state psychiatric centers.

**1979:** The National Alliance for the Mentally Ill (NAMI), a new advocacy group for people with serious mental illness and their families, is formed in Madison, WI. Branches quickly take shape in New York State. The NAMI is but one of several new advocacy groups that shape the direction of mental health policy.

**1980's:** The OMH creates new initiatives designed to meet the specific needs of mentally ill African-Americans and Latinos. In response to the emergence of Alzheimer's disease as a distinct mental illness, it increases outpatient programs for the elderly. Escalating prison populations lead it to create new facilities for the treatment of mentally ill criminals, outpatient programs in several state correctional facilities, and training programs for state and local law enforcement officers. From the mid-1980's onward, it also devotes increasing attention to the mental health needs of people with AIDS.

**1980:** The New York State Insanity Defense Reform Act increases the OMH's responsibility for caring for and evaluating criminals deemed not responsible by reason of insanity.

**1980:** The National Mental Health Systems Act, which asserts that the federal government will continue to shape mental health policy but will assume less of the burden of paying for treatment, is passed during the last months of Jimmy Carter's presidency.

**1981:** The President's Commission on Mental Health issues its final report, albeit without fanfare.

**1981:** The administration of Ronald Reagan abdicates responsibility for setting federal mental health policy. The 1981 Omnibus Budget Reconciliation Act repeals the provisions of the National Mental Health Systems Act, cuts federal mental health and substance abuse allocations by twenty-five percent, and converts them to block grants disbursed with few strings attached. New York State, which uses block-grant monies to fund community-based programs, and other states have to cut mental health programs.

**Early 1980's:** Seeking to cut federal expenditures, the Reagan administration directs the Social Security Administration to pare the SSI and SSDI rolls. Social Security administrators respond by developing definitions of mental illness that diverge from

those used in the past and those employed by mental health professionals. They also project a savings of \$3.5 billion dollars, a figure far larger than that predicted by the administration's budget personnel, who had anticipated a \$218 million savings. The mentally ill were disproportionately affected by program cuts: they constituted eleven percent of SSI and SSDI recipients and roughly thirty percent of those purged from the rolls. The resulting dislocations ultimately produce a public outcry that compels the administration and Social Security to back down.

**Mid-1980's:** Federal support for mental health treatment increases as advocacy groups protest against funding cuts and Democrats in Congress bury funding allocations in omnibus budget bills.

**1986:** The federal State Comprehensive Mental Health Plan Act compels states to devise detailed service plans that emphasize the needs of the seriously mentally ill in order to remain eligible for federal block grant funds. In its emphasis upon planning, it closely resembles New York State's efforts to insure that seriously ill people receive adequate care.

- 1992:** The federal Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act abolishes the ADAMHA and replaces it with the Substance Abuse and Mental Health Services Administration (SAMHSA). During the Bush and Clinton administrations, the SAMHSA emphasizes information provision and administration of block grants, which have more restrictions than they had in the past.
- 1993:** The New York State Community Mental Health Reinvestment Act mandates that all savings realized from the closure of unneeded state psychiatric centers be funneled to community mental health programs. The act is propelled in part by the OMH's intention to close several facilities.
- 1993:** The Clinton administration's efforts to create a national health insurance program are notable for their relatively generous provisions for mental health care. However, the plan is rejected by Republicans and many Democrats in Congress and the administration shies away from advancing any other bold policy initiatives.
- 1996:** The federal Mental Health Parity Act compels companies that offer mental health insurance benefits to their employees to insure that coverage of mental and physical illness is reasonably equitable.