FROM MORAL TO IMMORAL TREATMENT: THE FAILURE TO FUND THE TREATMENT OF THE SERIOUSLY MENTALLY ILL IN TEXAS AND THE NATION, 1860 to 2018

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ABSTRACT

This study presents a case study of the treatment of serious mental illness in one state, Texas, and its largest city and county, Houston, and Harris County. It also examines critical factors leading to the federal government's involvement in the treatment of severe mental illness from the 1960s through the early 1980s. This new role for the federal government inaugurated a massive deinstitutionalization movement fueled by new federal funding streams and federal court decisions that dramatically altered the treatment of severe mental illness in the United States. Across the country, states released patients from their psychiatric hospitals often to highly inappropriate facilities or the streets. The new federally funded community mental health centers focused on treating new, less ill patients from the community rather than treating those exiting the state hospitals. The number of state hospital beds dropped from a high of 550,000 in 1955 to less than 40,000 today. The result has been the criminalization of mental illness resulting in the imprisonment of over 350,000 severely mentally ill citizens, and the recognition that the largest mental health facility in every state is the largest county or city's jail. While other studies have chronicled this history on the national level, this fast-growing state and local community show the fate of the mentally ill who need more services than medication and counseling. For those lacking appropriate treatment, their illness often causes them to commit crimes leading to their arrest and jail. From its history of moral treatment in asylums that removed the mentally ill from jails, Texas and the nation have moved to the immoral treatment of jailing and imprisoning the mentally ill for the illnesses they cannot control. The failure of Texas and the nation to fund appropriate systems for the treatment

of mental illness in the wealthiest nation and one of its wealthiest states points to the dramatic need for change in our health care system.

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ABBREVIATIONS

AMSAII	Association of Medical Superintendents of American Institutions for the Insane
AMA	American Medical Association
AMH	*Action for Mental Health*
APA	American Psychiatric Association
BMCO	Behavioral Managed Care Organization
BTSH&SS	Board of Texas State Hospitals and Special Schools
BUCM	Baylor University College of Medicine
CMHC	Community Mental Health Center
COs	Conscientious Objectors
CPZ	Chlorpromazine
CQI	Continuous Quality Improvement
CSU	Crisis Stabilization Unit
DISRP	Delivery System Reform Incentive Payment
DSHS	Texas Department of State Health Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive Therapy
ER	Emergency Room
GLT	Gammel's Laws of Texas
HB	House Bill
HCPC	Harris County Psychiatric Center
HCPH	Harris County Psychiatric Hospital
HEW	Department of Health Education and Welfare
HHSC	Health and Human Service Commission
HSPI	Houston State Psychiatric Institute for Research and Training
ID	Intellectually Disabled
JCMIH	Joint Commission on Mental Illness and Health

LBB	Legislative Budget Board
MBHO	Managed Behavioral Healthcare Organization
Meadows	Meadows Mental Health Policy Institute of Texas
MHMRA	Harris County Mental Health and Mental Retardation Authority
MHNC	Mental Health Needs Council
Mid-Houston	Mid-Houston Community Mental Health Center
NAMI	National Alliance on Mental Illness
NIH	National Institute for Health
NIMH	National Institute of Mental Health
NPC	NeuroPsychiatric Center
R.A.J.	Federal District Court Lawsuit against the Texas State Mental Hospitals
SAMSHA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBOC	Texas State Board of Control
SK&F	Smith, Kline and French
SMI	Serious Mental Illness
SSI	Supplemental Security Income
TDMHMR	Texas Department of Mental Health and Retardation
THHSC	Texas Health and Human Services Commission
TMA	Texas Medical Association
TMC	Texas Medical Center
TNA	Texas Neurological Association
TRIMS	Texas Research Institute of Mental Sciences
TSLA	Texas State Lunatic Asylum
UC	Uncompensated Care
UT-Houston	University of Texas Medical School in Houston
UTMB	University of Texas Medical Branch
UTMSI	University of Texas Mental Sciences Institute

INTRODUCTION

In 1982, Susan Sheehan published the Pulitzer Prize-winning book *Is There No Place on Earth For Me?* It is the true story of a brilliant woman to whom Sheehan gave the pseudonym Sylvia Frumkin, and who suffered from medication-resistant schizophrenia. Sheehan met Frumkin at the Creedmoor Psychiatric Facility in Queens, New York, in 1978. For the next two years, she closely followed Frumkin's chaotic life in and out of different programs at Creedmoor. The chaos encompassed not just Ms. Frumkin, but also her family, those who sought to help her, and other patients with whom she came in contact in and out of the hospital. The case is a tragedy, for it showed, nearly forty years ago, that for her and many of those suffering from severe mental illness (SMI), there was no appropriate place. When Sheehan concluded her book in December 1981, she wrote

> I hope that by the time this book is published in April she [Sylvia Frumkin] will be living in that apartment and that it will please her, because I want there to be a decent place on earth for Sylvia Frumkin, my subject and my friend, and for the many thousands of other people like her.[1]

Unfortunately for Ms. Frumkin, whose real name was Maxine Mason, that wish did not come true. She died in 1994 at the age of 46 at the Rockland Psychiatric Center in New York. Her last years proved as challenging as her earlier ones, and she never found a place for herself.[2]

The reality is that forty years ago, there were more resources available for Maxine Mason than there would be today. Allen Francis, M.D. (b. 1942), former chair of the

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[1] Susan Sheehan, *Is There No Place on Earth For Me?* (New York: Vintage Books A Division of Random House, 1983): 334.

[2] Susan Sheehan, "Postscript: The Last Days of Sylvia Frumkin," *The New Yorker* (February 20 and 27, 1995): 200-211.

department of psychiatry at the Duke University School of Medicine and the psychiatrist who chaired the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) Task Force that created the standard manual for the classification of mental disorders used from 1994 to 2013, presented this grim reality in 2015:

> There has probably never been a worse time and place to have a severe mental illness than now in the U.S. Because we have criminalized psychiatric disorders, 350,000 patients have inappropriately been made prisoners. Instead of receiving treatment, they are routinely jailed for minor nuisance crimes that could have been avoided if they had access to care. An additional 250,000 mentally ill persons are homeless because of our failure to provide them with anything approaching adequate housing.[3]

The most recent estimate by the Treatment Advocacy Center in September of 2016 put the number of severely mentally ill in prison or jail at 383,000.[4]

In the 1970s and 1980s, state psychiatric hospitals still provided the bulk of the treatment for Ms. Frumkin and others suffering from severe mental illness. However, as journalist Alisa Roth states in her new book, *Insane: America's Criminal Treatment of Mental Illness*,

> Today, the country's largest providers of psychiatric care are not hospitals at all, but rather the jails in Chicago, Los Angeles, and New York City. Across the country, correctional facilities are struggling with the reality that they have become the nation's de facto mental health providers, although they are hopelessly ill equipped for the job. They are now contending with tens of thousands of people with mental illness who, by some counts, make up as much as half their populations."[5]

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[3] Allen Francis, "Is this the Country we want to be?" *Psychiatric Times* 32, No. 11 (November 2015): 1.

[4] "Serious Mental Illness Prevalence in Jails and Prisons," *Treatment Advocacy Center*, Accessed August 31, 2019*, https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695.*

[5] Alisa Roth, *Insane: America's Criminal Treatment of Mental Illness* (New York: Basic Books, 2018): 2.

This immoral treatment of the mentally ill in jails and prisons in America today is so different from the concept of moral treatment that began in this country a little over two hundred years ago. In 1817, the Quaker community near Philadelphia, Pennsylvania, established the first asylum in the United States based upon treating the mentally ill with kindness in a specially constructed facility that allowed them freedom from chains and locked doors. Called "moral treatment" with "moral" coming from the French term *moral*, meaning psychological or emotional, it served as the basis of care for the mentally ill in America for most of the 19th century. The facilities were asylums, for they were places where the inmates were free from arrest and being locked in jail. The asylums proved successful in treating several patients, but eventually, states began to build more and larger facilities that could no longer provide the small intimate spaces for the mentally ill. Though some still found their sanity, these programs by the beginning of the twentieth century became long-term holding facilities for those whom society could provide little actual treatment.

From moral treatment that kept its patients free from jail and offered a hope of restoring their sanity, our nation has moved to immoral treatment by failing to fund the treatment of the severely mentally ill and by locking them away in jail and prison for committing crimes that their lack of appropriate treatment leads them to commit. We, as a society, have genuinely allowed the treatment of mental illness to go from moral treatment with its care and concern, to immoral treatment through the criminalization of mental illness.

How did we, as a nation, become a place where we punish people for illnesses they cannot control? How have we regressed from a society that cared and attempted to

help the mentally ill to one that locks them away in a jail or prison? This study seeks to find answers to those questions by documenting changes at the national, state, and local levels with Texas and Harris County, Texas, providing the documentation for the latter two. Chapter I draws from recent first-hand newspaper and journal accounts to present the status of the treatment of those with a severe mental illness in the United States today. Chapter II examines the way historians and other writers have considered the changes in the treatment of severe mental illness over time. Chapters III and IV look at the changes nationally from the 1940s through the early 1980s when the federal government became directly involved in the provision of mental health treatment through the community mental health acts and through federal court decisions that changed the treatment of mental illness at all governmental levels. Chapter V documents the first hundred years of the history of the treatment of mental illness in Texas, primarily through institutions. Chapters VI and VII examine the implications of the implementation of community mental health programs, the effect of federal court decisions, and the change in political leadership at the state level in Texas. Chapters VIII and IX show how the changes at the national and state level influenced the treatment of severe mental illness in Harris County, Texas, and its largest city, Houston.

In conclusion, chapter X points to lessons learned from this study of Texas and the nation to show why we, as a society, allow our governments to ignore the severely mentally ill and allow the criminalization of mental illness. It also looks at the implications of this study as it pertains to aspects of the funding of mental illness and to how we as a nation should treat mental illness in the future. Though this study focuses on

the treatment of severe mental illness, the lack of treatment of those with less than severe mental illness is also a problem today.

My interest in this topic grew out of my life's work as an administrator of agencies serving emotionally disturbed children. From my education as a social worker and my early days of work at a small residential children's agency in Illinois in the mid-1970s, deinstitutionalization was the primary focus of public policy. Jerome G. Miller, who headed the Illinois Department of Children and Family Services at the time, had gained a national reputation for closing institutions with little worry about what would become of those leaving them. In Massachusetts, Pennsylvania, and Illinois, he closed facilities with the idea that whatever came next had to be better than being in an institution. Unfortunately, the wholesale closures left many individuals in inappropriate settings. I spent much of my career developing community-based services for children. Some of these programs worked well, while others such as foster care where children can move continually from one home to another, often leave children unconnected to others. With new skills in historical research, I began to search for the origins of this mass rush to close institutions. I also wanted to learn what had happened to the individuals previously served in those facilities. I chose to examine this movement and its impact on those served by focusing on the severely mentally ill, who are the least prepared to live on their own, and the most incapable of living in communities where their needs were not understood.

Mental illness affects many individuals and families; unfortunately, it is an illness with such a stigma, that it often remains hidden. I hope that shedding light on the illness

and our failure to treat it will begin to open our eyes to the real tragedy our society perpetuates daily.

I. THE SERIOUSLY MENTALLY ILL: THOSE WE CHOOSE TO IGNORE

Few of us talk about mental illness. The stigma about the disease is so significant that unless an individual or a family is dealing with a crisis that becomes public knowledge, few others know about it. Nevertheless, in America, it is such a common illness that one of five adults (44.7 million) had a mental illness in 2016. Within that number, one out of 25 adults (10.4 million) in the United States suffers from a serious mental illness (SMI) to the point of not having the ability to perform essential functions in one or more areas of their lives. Thirty-one percent of children received mental health services in 2016,[1] and twenty percent of children between the ages of 12 and 17 have had, or currently have a "seriously debilitating mental disorder."[2]

With that prevalence, mental illness is something that afflicts many more of us than we realize, especially given that many families keep mental illness a secret from neighbors, co-workers, and even from other family members. My family has such secrets. My grandfather stabbed my grandmother and, 16 years later, his second wife, both in the middle of the night while they were sleeping. Both wives survived and remained married to him. I am not sure what treatment he received after the first incident, but after the second, he spent several months in a veteran's hospital for treatment of his mental illness.

[1] Substance Abuse and Mental Health Services Administration, *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52), Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (2017): 3, accessed on October 12, 2017 https://www.samhsa.gov/data/report/key-substance-use-and-mental-health-indicators-united-states-results-2016-national-survey.

[2] Thomas Insel, "Posts by Former NIMH Director Thomas Insel: Mental Health Awareness Month: By the Numbers," *National Institute of Mental Health*, May 15, 2015, accessed on March 29, 2017, https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2015/mental-health-awareness-month-by-the-numbers.shtml.

Wounded by machine-gun fire in World War I, I assume my grandfather's illness was probably post-traumatic stress disorder (PTSD). He was able to return home to his family and to work after both instances. I also have a cousin who has had schizophrenia since his teenage years. His mother cared for him until her death, and while he continues to live by himself, an older brother who lives nearby checks on him daily, takes him his food, and makes sure that he takes his medication. My wife's grandmother spent most of her life in a state psychiatric hospital during the first half of the twentieth century. We do not know her diagnosis; my wife never knew her grandmother, and her situation was never a topic of discussion within the family.

Defining Mental Illness

While all mental illnesses have significant implications for those who suffer from them, those with the diagnosis of an SMI are the most affected. The Substance Abuse and Mental Health Services Administration (SAMSHA) of the United States states that an adult with an SMI is a person 18 years or older who had at

> any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment.[3]

Psychiatrists identify several different mental illnesses, including some that may or may not be as severe, depending upon the effect of the illness on the person's ability to function. The most severe mental illness is schizophrenia, which affects 1.1 percent of the

[3] "Mental and Substance Abuse Disorders," Substance Abuse and Mental Health Service Administration (SAMSHA), last modified March 8, 2016, accessed on October 20, 2016, http://www.samhsa.gov/disorders. While SAMSHA only identifies by name the three listed illnesses, the agency recognizes that any mental illness, which causes serious functional impairment to the point that it interferes with life activities including serious personality disorders, are serious mental illnesses.

population. Its onset usually comes in the late teens or the early twenties, and it decidedly affects the life of the young person and his/her family. A person suffering from schizophrenia experiences delusions, hallucinations, such as hearing voices or seeing things that others do not observe and has disorganized speech and behavior, among other symptoms.[4]

Mood disorders are another type of mental illness. These disorders include bipolar disorder considered an SMI, which affects 2.6 percent of the adult population in America. Patients with this illness have extreme swings in mood from mania, where they experience a euphoric high, become hyperactive, and sleep little, to a deep depression where they collapse into a depressive state. The second SMI in this category is major clinical depression, from which 6.9 percent of the adult population in America suffers. Persons with clinical depression have little interest in life, their mood is depressed, they have no energy, have trouble sleeping, or sleep all of the time, they feel worthless, have trouble concentrating, and often their thoughts are of death or suicide.[5] Psychiatrists also identify dysthymia, a depressive disorder suffered by 1.5 percent of American adults; while not as severe as major depression, it is a persistent, long-term state of depression with brief interludes of a normal mood. People with this illness "tend to be chronically miserable."[6] Cyclothymia is a milder form of bipolar disorder that affects between 0.4 to 1 percent of adults in America. Persons with it have less severe mood swings from

[4] Nancy C. Andreasen, *Brave New Brain: Conquering Mental Illness in the Era of the Genome* (New York: Oxford University Press, 2001): 193. "Mental Health by the Numbers," National Alliance on Mental Illness, (2019), accessed July 23, 2019, https://www.nami.org/learn-more/mental-health-by-the-numbers.

[5] Andreasen (2001): 225-230. "Mental Health by the Numbers,"

[6] Andreasen (2001): 230. Katie Hurley, "Persistent Depressive Disorder (Dysthymia)," (2019), accessed July 23, 2019, https://www.psycom.net/depression.central.dysthymia.html.

depression to mania, but it is also a persistent illness.[7] An illness that has elements of both schizophrenia and bipolar disorder called schizoaffective disorder is a chronic illness with symptoms of delusions and hallucinations as well as swings in mood from depression to mania. It affects 0.3 percent of the population in the United States.[8]

Borderline Personality Disorder (BPD) is a condition that accounts for 20 percent of the psychiatric hospitalizations in the United States.[9] Individuals who are suffering from BPD struggle to regulate their emotions. For long periods, they feel intense emotions that make it quite difficult for them to return to normalcy. They have difficulty with "impulsivity, poor self-image, stormy relationships and intense emotional responses to stressors." As they struggle to bring their emotions under control, their actions can often lead to self-harm.[10] The illness is "characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior." It affects 2 percent of the adults in the United States, with "75 percent of the cases diagnosed among women" who have often suffered some trauma.[11]

Another type of mental illness identified by psychiatrists are anxiety disorders that affect 18.1 percent of adults in the United States each year.[12] With these illnesses, the

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[7] Andreasen (2001): 234. Dina Cagliostro, "Cyclothymia," (May 5, 2019), accessed July 23, 2019, https://www.psycom.net/depression.central.cyclothymia.html.

[8] "Schizoaffective Disorder," National Alliance on Mental Illness: Mental Health Conditions, accessed October 20, 2016, https://www.nami.org/learn-more/mental-health-conditions/schizoaffective-disorder.

[9] Borderline Personality Disorder," *Psychology Today*, accessed January 4, 2019, https://www.psychologytoday.com/us/conditions/borderline-personality-disorder.

[10] "Mental Health Conditions: Borderline Personality Disorder," National Alliance on Mental Illness, accessed October 20, 2017, https://www.nami.org/learn-more/mental-health-conditions/borderline-personality-disorder.

[11] "Borderline Personality Disorder," *Psychology Today*.

[12] "Facts and Figures," Anxiety and Depression Association of America, (2018), accessed July 23, 2019, https://adaa.org/about-adaa/press-room/facts-statistics.

normal adaptive responses of anxiety and fear become abnormal, appear without warning, and incapacitate the individual seemingly without cause. One type is a panic attack, which is an intense fear reaction to a great danger that is present only in the mind of the individual. If these attacks occur several times, and the person spends much time fearing another attack, he/she may have a panic disorder.[13] Some prevalent types of anxiety disorders are phobias, which includes social phobias, also called social anxiety disorder, which is "the fear of doing things in front of other people that might lead to humiliation or embarrassment," and specific phobias, which are the fear of something specific such as an animal or specific situation. There is usually no rational basis for these fears, but the person reacts with significant anxiety and fear.[14] 2.7 percent of adult Americans have a panic disorder, 6.8 percent suffer from social anxiety disorders, and 8.7 percent have a specific phobia disorder.[15]

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder first identified among soldiers returning from combat. Called by other names in different wars, including shell shock, battle fatigue, and traumatic war neurosis, the individual has flashbacks that take him/her back to the event, and he/she reacts as if he/she was still experiencing the trauma. These flashbacks may be nightmares, or they may occur when triggered by some stimuli that remind them of the experience. Psychiatrists now recognize that PTSD is not just a war-related illness, for any significant trauma in a person's life can cause it. Such traumas

[13] "Panic attacks and panic disorders," Mayo Clinic Patient Care and Health Information, accessed October 20, 2017, https://www.mayoclinic.org/diseases-conditions/panic-attacks/symptoms-causes/syc-20376021.

[14] Andreasen (2001): 302.

[15] "Facts and Figures."

can include major injury produced by accidents, rapes, physical abuse, and natural disasters.[16] PTSD affects 3.5 percent of adults in the United States.[17]

Generalized Anxiety Disorder is a milder anxiety disorder that affects 3.6 percent of adult Americans.[18] The individuals suffering from this illness "feel anxious and worried most of the time and complain of … being keyed up, on edge, restless, easily fatigued, irritable, or tense."[19] Another anxiety disorder is Obsessive-Compulsive Disorder (OCD), which affects 1.0 percent of the adult population in the United States.[20] Persons suffering from this illness are compelled to do repetitive acts "for no obvious reason or to an extreme degree." They are obsessed with thoughts that while senseless to others are troubling to them, and they cannot stop thinking about them. The compulsions and obsessions "become a disorder when they are accompanied by intense and crippling anxiety if [they] are resisted or not adequately satisfied." Persons with OCD may spend all day trying to get dressed just right. They may follow rituals and preoccupations that "seem almost delusional." Some extremes of the illness include hoarding or an extreme focus on orderliness.[21]

Any mental illness needs proper diagnosis and treatment, for untreated mental illness can lead to symptoms that are more significant. It may also lead to death or impairment through self-harm or it can lead to the injury of others. One of the problems for the mentally ill in America today is obtaining proper diagnosis and treatment. Most people with a mental illness in this country will first see their primary care physician.

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[16] Andreasen (2001): 303-308.
[17] "Facts and Figures."
[18] Ibid.
[19] Andreasen (2001): 308.
[20] "Facts and Figures."
[21] Andreasen (2001): 309-310.

That physician is familiar with the illnesses but does not have the knowledge of a psychiatrist to distinguish between the varieties of illnesses, nor the same understanding of the powerful medications used to treat them that require constant monitoring. Such medications often take weeks to begin to achieve results, and the effects on the person may change over time. If the primary care physician chooses to refer the patient to a specialist, there is limited availability of the specialists to whom insurance companies will pay. Because insurance payments to psychiatrists tend to be quite low, the number of psychiatrists who will accept health insurance payments is not as significant as other specialties. This situation often means that referrals are to social workers, psychologists, or other mental health therapists who may refer to a psychiatrist only those whom they believe need medication. Unfortunately, many individuals may not receive the proper diagnosis, and often, the coordination between therapist and psychiatrist ranges from zero to limited.

The impact of an SMI extends beyond the mentally ill person to his/her family. It taxes the financial and emotional resources of the family members to the point that they cannot provide the support required, placing the individual at the mercy of the greater community, often with poor results. For many centuries, the community viewed the seriously mentally ill whom their families could not hide away as persons tormented by evil spirits. By seeing these persons as less-than-human, communities locked them away under barbaric conditions.

The Plight of the Seriously Mentally Ill Today

The personal stories of the seriously mentally ill and their families provide the best picture of these illnesses that most of us fail to understand. I am grateful that in

2014, the national newspaper, *USA Today*, published a lengthy series entitled "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill." That series, led by their health writer for twelve years, Liz Szabo, won a national award for excellence in medical science reporting. Through personal interviews with individuals suffering from severe mental illness, their family members, persons who seek to help them, and advocates for the mentally ill, she and other reporters working with her captured their stories in their own words. Ms. Szabo has since become the senior correspondent at *Kaiser Health News* and has won several more awards for health care reporting. I draw from her work with *USA Today* and the work of other writers telling these stories to convey an understanding of the real nature of the problems of those suffering from a severe mental illness today.

From two congressional representatives, Ms. Szabo learned that the most significant problem for the mentally ill is the lack of care for persons with an SMI. Congressman Tim Murphy, R-Pa., who is also a child psychologist, states, "We have replaced the hospital bed with the jail cell, the homeless shelter and the coffin."[22] Former Congressman Patrick Kennedy from Rhode Island, who has long advocated for the mentally ill, stated that in America, "mental health is a separate but unequal system. We have a wasteland of people who have died and been disabled because of inadequate care." Kennedy noted that our nation "routinely fails to provide the most basic services for patients with mental illness something the country would never tolerate for patients with cancer or other physical disorders." Kennedy noted that the failure of the nation to

[22] Liz Szabo, "Cost of not caring: Nowhere to go—A man-made disaster," "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill," *USA Today*, May 12, 2014, accessed March 28, 2017, http://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535/.

provide the hospital and community care needed by the mentally ill has led to "overburdened emergency rooms, crowded state and local jails, and left untreated patients to fend for themselves on city streets."[23]

The Criminalization of Serious Mental Illness

The mentally ill, and particularly the seriously mentally ill, make up a disproportionate number of those incarcerated in the criminal justice system. A study in 2012, estimated that there were 356,268 seriously mentally ill persons incarcerated in prisons and jails and approximately 35,000 such patients in state psychiatric hospitals.[24] In a recent blog post from the *Psychiatric Times' Couch in Crisis Blog*, Allen Francis M.D. stated that in 2019, the last number state psychiatric hospital beds remain at "only about 35,000."[25] A person with an SMI in the United is ten times more likely to be in prison or jail than in a state psychiatric hospital. The Urban Institute, drawing from several studies, stated, "Severe mental illness afflicts nearly one-quarter of the US correctional population including individuals in prisons, in jails, and on probation," and also between 15 and 24 percent of the prison population.[26] The Bureau of Justice reported

[23] Liz Szabo, "Cost of caring: Stigma set in stone," in "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill," *USA Today*, July 25, 2014, accessed on March 28, 2017 http://www.usatoday.com/story/news/nation/2014/06/25/stigma-of-mental-illness/9875351/.

[24] E. Fuller Torrey, Mary T. Zdanowicz, Aaron D. Kennard, Donald F. Eslinger, Michael C. Biasotti, and Doris A. Fuller, "The Treatment of Persons with Mental Illness in Prisons and Jails: A Joint Report of the Treatment Advocacy Center and the National Sherriff's Association," (April 8, 2014): 6, accessed August 1, 2016, http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

[25] Allen Francis, "Dungeons and Back Alleys: The Fate of the Mentally Ill in America," *Couch in Crisis Blog*, May 24, 2019, accessed June 5, 2019, https://www.psychiatrictimes.com/couch-crisis.

[26]Kideuk Kim, Mariam Becker-Cohen, and Maria Serakos, "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis," *Urban Institute*, March 2015: 1. Accessed June 10, 2017, http://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf.

a total correctional population in the United States in federal and state prisons, local jails, and on probation or parole of 6,741,400 on December 31, 2015, with 1,526,800 incarcerated in prisons and 728,200 in jails.[27] Given those numbers, over 1.6 million persons in the total correctional population have a serious mental illness, and between 229,020 and 366,432 of those in prisons have a serious mental illness. No specific analysis for those with an SMI in local jails is available. However, assuming a similar range to those in prison of between 15 and 24 percent yields 109,230 to 174,768 with an SMI in local jails. The jails of the larger cities and counties have become the most extensive mental health facilities across the nation as they provide psychotropic medications and psychotherapy to the incarcerated mentally ill patients.[28]

Looking beyond those with serious mental illness, a study in 2005 found more than half of the individuals in federal and state prisons and local jails were suffering from some form of mental illness. That study identified 705,600 (56 percent) in state prisons, 78,800 (45 percent) in federal prisons, and 479,900 (64 percent) in local jails as having a mental health problem.[29] A more recent estimate, in 2014, by Dean Aufderheide, a clinical and forensic psychologist stated, "50 percent of males and 75 percent of female inmates in state prisons, and 75 percent of females and 63 percent of male inmates in jails, will experience a mental health problem requiring mental health services in any

[27] Danielle Kaeble and Lauren E. Glaze, "Correctional Populations in the United States, 2015," Bureau of Justice Statistics, December 29, 2016, NCJ 250374, accessed on June 10, 2017, https://www.bjs.gov/content/pub/pdf/cpus15.pdf.

[28] Alisa Roth, *Insane: America's Criminal Treatment of Mental Illness* (New York: Basic Books, 2018): 2.

[29] The definition of mental illness, noted in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, U.S. Department of Justice, is an occurrence within the previous 12 months of a symptom or recent history of mental illness. The basis of this study was data from interviews of federal and state prisoners in 2004 and persons held in local jails in 2002. Doris J. James and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," *Bureau of Justice Statistics Special Report,* NCJ213600, September 2006, accessed August 1, 2016, http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

given year."[30] Though the jail experience contributed to the problems, the mental illness they suffered before incarceration likely contributed to their jailing in the first place.

The National Alliance on Mental Illness (NAMI), a grassroots organization created by family members of persons diagnosed with mental illness, reported the jailing of 2 million people with mental illness each year. Of that number, 15 percent of the men and 30 percent of the women have an SMI. The mentally ill are more likely to encounter a police officer than medical help when they suffer a crisis.[31] Forty percent of persons suffering from a serious mental illness are arrested one or more times in their lives.[32] While some jails provide mental health services, NAMI notes that 83 percent of jail inmates do not receive treatment for their mental illness, which only makes their illness worse. The mentally ill spend more time in jails than those without mental illness and have a greater risk of becoming victims of abuse both in jail and outside.[33]

Jails and prisons have become the placement of last resort for the mentally ill. Cook County, Illinois Sheriff Tom Dart oversees one of the largest jails in the nation. He estimates that 30 percent of the 12,000 inmates in the Cook County Jail in Chicago have a serious mental illness, and he describes his estimate as "a horrifically conservative number." He notes that "they end up here (the criminal justice system), because we are the only system that can't say no." Dart describes one of the inmates as a "self-mutilator"

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[30] Dean Aufderheide, "Mental Illness in America's Jails and Prisons: Toward a Public Safety/Public Health Model," *Health Affairs Blog*, April 2, 2014, accessed October 20, 2016, http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safetypublic-health-model/.

[31] "Jailing People with Mental Illness," *National Alliance on Mental Illness*, accessed March 30, 2017, http://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness.

[32] Ron Honberg, " Foreword to A Guide to Mental Illness and the Criminal Justice System," *National Alliance on Mental Illness Department of Policy and Legal Affairs*, accessed March 30, 2017, http://www.pacenterofexcellence.pitt.edu/documents/Guide_to_Mental_Illness_and_the_Criminal_Justice_System_NAMI.pdf .

[33] "Jailing People with Mental Illness"

with more than 100 arrests, which has cost the county over $1 million "in repeated arrest- and detention-related costs." The sheriff states that a second inmate "recently had to be fitted with a hockey mask and thick gloves resembling oven mitts to keep him from gouging out his remaining eye. The 43-year-old man, who has bipolar disorder and schizophrenia, had ripped one eye from the socket before his arrival at the jail, complaining that he 'didn't want to see evil anymore.'"[34] Given the size and intensity of the needs of the jail population, Sheriff Dart appointed a clinical psychologist and correctional health expert to lead the Cook County Department of Corrections.[35]

Mark Ghaly M.D., who leads the Los Angeles County Department of Health Services and oversees correctional medicine at the Los Angeles County jail, points out that many inmates within the jail may not need long-term hospitalization, but many do need the intensive treatment that they can only receive in an inpatient hospital for at least a period of time. He also notes that many would not have become so sick if they had received proper treatment earlier. "It's the embarrassment of the way we've done mental health in this country in the last two decades," he stated.[36]

Tracey Love, a woman jailed for stabbing her abusive boyfriend in 2014, was one of the lucky ones whom jail helped. She credits the psychiatrist who listened to her in jail with properly diagnosing her condition as major depression and PTSD. Her attempted suicide 22 years before, in 1992, had not led to a diagnosis of mental illness. In the

[34] Kevin Johnson, "Mental illness cases swamp criminal justice system," in "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill," *USA Today*, July 21, 2014, accessed March 28, 2017, http://www.usatoday.com/story/news/nation/2014/07/21/mental-illness-law-enforcement-cost-of-not-caring/9951239/.

[35] "Half of the Inmates Shouldn't Be Here, Says Cook County Sheriff," Lesley Stahl, *CBS: 60 Minutes*, (August 20, 2017), accessed February 14, 2019, https://www.cbsnews.com/news/half-of-the-inmates-shouldnt-be-here-says-cook-county-sheriff-2/.

[36] Roth: 43.

meantime, she had lost her job, custody of her son, and now had a felony record that means she will likely not find permanent work.[37]

Amy Lynn Cowling was one who was not as lucky in Texas in 2010. Following her arrest and incarceration in the Gregg County Jail for "two outstanding misdemeanor warrants," the 33-year-old mother, who had bipolar disorder and opioid addiction, died five days later. Since 2003, Cowling had received methadone treatments for her addiction and other medications for her bipolar disorder and other health problems. However, the jail prohibited methadone treatments and her bipolar medications, so the jail's physician, who never saw her, prescribed alternative medications. A nurse described Cowling's conditions to him over the phone, since he only visited once a week. The jail did not include methadone despite Amy's mom telling the jailers, "if she didn't have the methadone, it would be bad." The staff at the jail would not allow her family to see her or to speak with her.[38] The other inmates later told Texas Rangers at the postmortem: "Within the first couple of days, Amy became unable to eat, 'could barely walk,' 'used the restroom on herself,' hallucinated, and had seizures." On her fifth day in custody, the jail's staff moved her to isolation, where, according to other inmates, she "was 'screaming' and 'moaning' the entire day." Medical staff, but not the doctor, saw her twice that day, and early that evening, the nurse told the doctor by phone that she was "hollering and uncooperative." The physician prescribed antipsychotic medication and told the jail staff to place her on suicide watch. She died that evening, and her autopsy

[37] Szabo, July 25, 2014.

[38] Ranjana Natarajan, Trisha Trigilio, Alexander Stamm, Amanda Gnaedinger, Alexandra Manautou, Mandy Nguyen, Kelly Cavnar-Thompson, Margaret Wittenmeyer and Brian Zubay, "Amy Lynn Cowling: Gregg County Jail, Dec. 2010," *Preventable Tragedies: How to Reduce Mental-Health Deaths in Texas Jails* (The University of Texas at Austin School of Law Civil Rights Clinic, Austin: November: 2016): 15.

concluded that she "likely died from seizures brought on by withdrawal from her medication."[39]

Perhaps one of the cruelest lack of concern for persons with an SMI is the fact that their untreated illness leads them to commit crimes that are punishable by death. Marc Bookman, in a 2013 article, "13 Men Condemned to Die despite Severe Mental Illness," questions why paranoid schizophrenics are eligible for execution when "juveniles and intellectually disabled people" are not. Bookman identified 13 such individuals condemned to die, seven in Texas, and six in other states. Texas executed six of its seven, but in the other states, all six had their sentences commuted.[40] All 13 had committed heinous crimes, but the state of Texas's punishment for six of them was just as heinous.

Emergency Rooms Provide Critical Evaluations for the Seriously Mentally Ill

When the police intervene in a mental health crisis, they attempt to calm the person and transport him/her to a hospital for evaluation; usually, this is to the emergency room (ER). Mental disorders account for over 4.7 million (3.6 percent of the total) hospital emergency room visits each year.[41] Many ERs do not have the staff to provide psychiatric evaluations quickly, meaning the mentally ill wait longer in an ER for help. On average, they wait twice as long as a patient with physical health problems does, and

[39] Ibid: 16.

[40] Marc Bookman, "13 Men Condemned to Die despite Severe Mental Illness," *Mother Jones*, March 12, 2013, accessed April 11, 2017, http://www.motherjones.com/politics/2013/01/death-penalty-cases-mental-illness-clemency.

[41] Rui P, Kang K, and Albert M, National Hospital Ambulatory Medical Care Survey: 2013 Emergency Department Summary Tables, Table 11 – Primary Diagnosis at Emergency Department Visits, U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics, accessed March 30, 2017, http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2013_ed_web_tables.pdf.

if they need services beyond what the ER can provide, they often have to wait for days in the ER for an open psychiatric bed.[42] Since an ER cannot release a patient who requires hospitalization, and if no psychiatric beds are available, Robert Pierattini, a professor of medicine at the Vermont College of Medicine and chair of psychiatry at Fletcher-Allen Healthcare, notes, "It's common for mentally ill patients … to languish for weeks in emergency rooms. … If this were cancer, we'd be talking about giving patients the very best treatments;" however, with mental illness, "a peculiarity in the funding formula is deciding how we treat patients."[43] Medicare and Medicaid, the two major public funding streams for services for the poor and elderly, both have significant restrictions on funding in psychiatric hospitals. While there are no limits on care in the psychiatric ward of a general hospital, Medicare has a lifetime limit of 190 days of inpatient care in a psychiatric hospital.[44] Medicaid does not allow payments to "Institutions of Mental Disease" (Stand-alone psychiatric hospitals) for adults between the ages of 21 and 65.[45] There are no such limits for Medicare or Medicaid with any other disease. While US laws require private insurance to provide parity between mental and physical health benefits, the two major public funding streams for serving the poor and elderly do not provide such parity. By limiting access to vitally needed services at a critical time, both Medicaid and Medicare are placing the lives of individuals in jeopardy.

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[42] "Emergency Room Visits for Mental Health Conditions: Expect Long Waits," American Psychiatric Association, November 10, 2016, accessed March 30, 2017, http://www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/11/emergency-room-visits-for-mental-health-conditions-expect-long-waits.

[43] Szabo, July 25, 2014.

[44] "Mental Health Care (Inpatient)," *Medicare.gov. The Official U.S. Government Site for Medicare*, accessed March 31, 2017, https://www.medicare.gov/coverage/inpatient-mental-health-care.html.

[45] "Section 1905a, paragraph B," *Compilation of Social Security Laws*, Social Security, accessed on March 31, 2017, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

One such tragic case occurred in 2013, when the 24-year-old son of Virginia State Senator Creigh Deeds stabbed his father 13 times and then killed himself. The onset of the son's illness had occurred three years earlier, but the only diagnosis the parents received was that he was "somewhat bipolar," which was treatable with medication. In 2013, the son stopped taking his medication in the spring, and by November of that same year, his condition had deteriorated to the point that he required admission to an emergency room for evaluation. Virginia law at the time provided for up to a six-hour window to find a psychiatric placement for a person with a mental condition under a temporary custody order. Unfortunately, the psychiatrist arrived late and, following his evaluation, was not able to find a placement in a psychiatric hospital in the allotted time. The doctor released the young man despite the pleas of his mother that her son "was in a very bad place," and he "would kill Creigh and himself if he was not hospitalized."[46]

The doctor's actions violated the nation's Emergency Medical Treatment and Labor Act (EMTALA) that requires the stabilization and treatment of anyone coming to an emergency room. Senator Deeds noted that letting him leave the hospital "makes absolutely no sense. An emergency room cannot turn away a person in cardiac arrest because the ER is full, a police officer does not wait to arrest a murder suspect or a bank robber if no jail space is identified." Virginia law has now changed, requiring the maintenance of a registry of available psychiatric beds and raising the time allowed to find a bed from six to 12 hours, and requiring state hospitals to admit the patient if no bed

[46] Jenna Portnoy, "Va. Sen. Creigh Deeds sues the state, others for $6 million in son's suicide, *"The Washington Post,* January 5, 2016, accessed March 31, 2017, https://www.washingtonpost.com/local/virginia-politics/va-sen-creigh-deeds-sues-the-state-others-for-6-million-in-sons-suicide/2016/01/05/1dfb4500-b3d9-11e5-a76a-0b5145e8679a_story.html?utm_term=.524c578ae0d5.

is available within eight hours.[47] Nevertheless, the new law continues to discriminate between physical and mental health. There is no time limit on finding a bed for a person having a heart attack or the victim of a tragic accident, so why must there be one for finding a psychiatric bed?

Dr. Ray Keller, medical director of an emergency room in Burlington, Vermont, notes that the mentally ill are in the ER because there are no other "services to keep them healthy. Even when all other resources have been cut, we're the ones who don't say no."[48] Mark Pearlmutter, chief of network emergency services for Steward Health Care near Boston, points out that some hospitals have "private rooms in the emergency department" for the mentally ill, while in other ERs severely mentally ill end up "in hallways, surrounded by noise, trauma and bright lights 24 hours a day." He also states that some of the mentally ill are "physically restrained" during their stay in the ER. Pearlmutter says that because many of the mentally ill have no insurance, the ERs diagnose and stabilize the mentally ill patients without compensation. He also notes that taxpayers pay part of the cost through federal "disproportionate share" payments to those hospitals that treat significant numbers of the indigent.[49] While the ERs and hospitals do

[47] Nikki Schwab, "Creigh Deeds Tells Son's Mental Health Horror Story," *U.S. News and World Report*, March 31, 2014, accessed March 31, 2017, https://www.usnews.com/news/blogs/washington-whispers/2014/03/31/creigh-deeds-tells-sons-mental-health-horror-story.

[48] Szabo, May 12, 2014.

[49] Ibid. Disproportionate share hospitals (DSH) receive Medicare DSH adjustment funding established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. Hospitals that treat a high proportion of Medicaid and SSI recipients or receive more than 30 percent or in some cases 15 percent of their "total net patient care revenues from State and local governments for indigent care (other than Medicare or Medicaid)" receive additional funding to compensate for the reduced funding they receive for these patients. In addition, under Section 3133 of the Affordable Care Act, an amendment to the law established section 1886(r), which provides additional payment to hospitals for uncompensated care. "Disproportionate Share Hospital (DSH): The Medicare DSH Adjustment (42 CFR 412.106)," Centers for Medicare & Medicaid Services, accessed June 13, 2017, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html.

provide treatment without compensation from the mentally ill patient, other patients in the hospitals pay more for services to make up for the hospital's loss not provided by disproportionate share payments.

For those not on Medicaid, the uncompensated medical care for the mentally ill comes in part from their lack of employment and access to private insurance. While the total percentage of unemployment among all those with mental illness is unknown, 80 percent of the mentally ill who receive treatment through public mental health services are unemployed.[50] Likely, this percentage is partly a reflection of the low-income ceiling for Medicaid eligibility for those states, including Texas, which did not expand Medicaid under the Affordable Care Act. According to a report of the National Alliance on Mental Illness (NAMI), "approximately 60 percent of the 7.1 million people receiving public mental health services nationwide want to work, but less than 2 percent receive supported employment opportunities provided by the states." NAMI's Executive Director, Mary Giliberti, states, "Work is a critical part of recovery." We, as a nation, do not recognize the link between supported work and the recovery of individuals with mental illness.[51]

Diane Volpe points to discrimination against the mentally ill as one reason they are not able to work. Her sister, who was a victim of a violent crime, lost her medical technician job when she began to exhibit signs of bipolar disorder. "They never gave her the option of medical leave or short-term disability." Disability payments and Medicaid

[50] "Mental Illness: NAMI Report Deplores 80 Percent Unemployment Rate: State Rates and Ranks Listed—Model Legislation Proposed," *National Alliance on Mental Illness*, January 1, 2014, accessed on April 1, 2017, https://www.nami.org/Press-Media/Press-Releases/2014/Mental-Illness-NAMI-Report-Deplores-80-Percent-Un. NAMI notes that most of these individuals could work with supportive work environments. However, these are expensive, and most states have not spent the money to develop them. "Road to Recovery: Employment and Mental Illness," National Alliance on Mental Illness, July 2014: 4, accessed June 13, 2017,

[51] NAMI Report Deplores 80 Percent Unemployment Rate.

are crucial for many of the mentally ill. The fear of losing those benefits keeps many out of the workforce, according to Giliberti.[52] In 2016, 34.7 percent of all disability payments from Social Security went to persons suffering from mental disorders.[53]

Too Many Seriously Mentally Ill Are Homeless

Many of the severely mentally ill are too sick to think about disability or Medicaid. These individuals are among the 138,250 of the 553,742 persons who are part of the official count of the homeless taken one night in January of 2017 by the Department of Housing and Urban Development. The count includes anyone not sleeping in a place designed for human habitation, including an automobile.[54] The actual number of people who are homeless and mentally ill changes daily as people move in and out of homelessness. An estimate of the total homeless population over a year reaches 3.5 million.[55] Rick Jervis, who examined the issue of the seriously mentally ill who are homeless for *USA Today*, says that such individuals

> are gripped by schizophrenia, bipolar disorder or severe depression—all manageable with the right medication and counseling but debilitating if left

[52] Liz Szabo, "'Bleak Picture' for mentally ill: 80% are jobless," in "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill," *USA Today*, July 10, 2014, accessed March 28, 2017, http://www.usatoday.com/story/news/nation/2014/07/10/high-unemployment-mentally-ill/12186049/.

[53] *Social Security Administration, Annual Statistical Report on the Social Security Disability Insurance Program, 2016 (Washington DC, 2016).*:39.

[54] "The 2018 Annual Homeless Assessment Report (AHAR) to Congress: Part 1: Point-in-Time Estimates of Homelessness," The U.S. Department of Housing and Urban Development, December 2018, accessed February 6, 2019, https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf. "Research Weekly: Homeless Increases among Individuals with Serious Mental Illness," Treatment Advocacy Center, January 11, 2018, accessed February 6, 2019, https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3965-research-weekly-homelessness-increases-among-individuals-with-serious-mental-illness-.

[55] "Homelessness in America: Overview of Data and Causes," National Law Center on Homelessness & Poverty, updated January 2015, accessed February 6, 2019, "Homelessness in America: Overview of Data and Causes," National Law Center on Homelessness & Poverty, last modified January, accessed February 6, 2019. https://www.nlchp.org/documents/Homeless_Stats_Fact_Sheet.ese.

> untreated. In the absence of such care, their plight costs the federal government millions of dollars a year in housing and services and prolongs their disorder.[56]

Deborah Zelinsky, 45, was homeless for two decades before being diagnosed with bipolar disorder, receiving treatment, and then finding an apartment for herself. She said, "On the streets, you don't have time to get treated. You are trying to survive."[57]

Ron Powers, in his 2017 book *No One Cares about Crazy People* presents his study of the treatment of mental illness in America as he tells the story of his two sons, both of whom were victims of schizophrenia, with one taking his own life and the other attempting to do so. His words paint a vivid picture of life for homeless persons suffering from severe mental illness.

> The sudden mass visibility and eccentric behavior of the homeless have made them subject to demonization on a scale and intensity not seen since the Dark Ages. Now the police round them up—from the adolescents just emerging, bewildered, into insanity, to the veterans of madness, who are helpless not just before mental illness but before the injustices that compound it: minority racial status, class disability, crabbed opportunity, inadequate medical care, and family instability. The police round them up for their of crimes of survival: for robberies of food; for possession of the illicit drugs used for self-destructive self-medication; for loitering, vagrancy, and street harassment; for bothering noninsane people with their monologues and declarations; for not having homes. Bereft of committed support from any quarter, they live marginal, miserable lives and die early deaths.[58]

A new emerging focus on treating the homeless mentally ill recognizes that the first step is getting the individuals off the street. Sam Tesemberis, a housing specialist with New York's Bellevue Hospital, witnessed the constant flow of persons from the

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[56] Rick Jervis, "Mental disorders keep thousands of homeless on streets," in "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill" *USA Today*, August 27, 2014, accessed March 28, 2017, http://www.usatoday.com/longform/news/nation/2014/08/27/mental-health-homeless-series/14255283/.

[57] Ibid.

[58] Ron Powers, *No One Cares About Crazy People: My Family and the Heartbreak of Mental Illness in America* (New York: Hachette Books, 2017): 3.

hospital's ER back to the streets. He began to realize that patients with schizophrenia who were given a place to live and received treatment for their illness "were able to hold jobs, manage their bills and cook their own meals, and he encouraged advocates to house first, treat later." Tesemberis concluded, "We have misunderstood profoundly what it means to be mentally ill."[59] A focus in Houston, Texas, on finding housing first for the mentally ill yielded a dramatic decrease of 57 percent, from 1,791 to 763, in the number of chronic homeless on the streets. Tory Gunsolley, CEO of the Houston Housing Authority, said that the key was housing the mentally ill "as quickly as possible. … Every time you have the homeless person in front of you, that's the time to get stuff done. Every time you let them go, they wind up back on the street."[60]

Suicide—Serious Mental Illnesses Are Killer Diseases

Whether on the streets, in their own homes, or in an institutional setting, for those battling severe mental illness, far too often, their illness becomes fatal. Thomas Insel M.D., the former director of the National Institute of Mental Health (NIMH), notes that mental illness is associated with 90 percent of suicides in America.[61] The Center for Disease Control (CDC) notes that normally, a single factor does not cause suicide, and many who commit suicide do not have a diagnosed mental illness at the time they take their own life. Other factors such as relationship issues, use of substances, declining physical health, loss of a job, or stress over a difficult work situation, and stress over

[59] Jervis.

[60] Ibid.

[61] Thomas Insel, "The Under-Recognized Public Health Crisis of Suicide," *Post by NIMH Director Insel,* National Institute of Mental Health, last Modified September 10, accessed February 7, 2019, *https*://www.nimh.nih.gov/about/directors/thomas-insel/blog/2010/the-under-recognized-public-health-crisis-of-suicide.shtml.

money, legal or housing issues are often factors in suicide. The rate of suicide in America increased by 28% from 1999 to 2016.[62] One can speculate that the difficult economic times of the last decade and the ongoing sense of crisis that seems to pervade our nation are factors in the increase. Suicide ranks number 10 in causes of death in the nation, and it is the second most frequent cause of death for those between the ages of 15 and 34.[63] The average cost of a single suicide is $1,329,553, with lost productivity accounting for 97 percent of the amount and the other 3 percent being medical cost.[64] With the loss of a life by suicide, "At least 6 [other] people are intimately traumatized by the death."[65] Insel shared with Liz Szabo that, "About one in 20 people with schizophrenia kill themselves within the first two years after their initial psychotic break [;] the brightest, most accomplished young people are the most at risk; perhaps they have the greatest sense of loss after becoming ill." He advocated "First Episode" programs that "change the trajectory of schizophrenia from one of tragic decline to one of a chronic but manageable condition." These "early intervention programs halt the deterioration so often seen in schizophrenia, allowing young people to get their lives back on track after their first full break with reality."[66]

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[62] "Suicide Rising Across the US: More than a Mental Health Concern," *Centers for Disease Control and Prevention—Vital Signs,,* accessed September 2, 2019, https://www.cdc.gov/vitalsigns/suicide/index.html.

[63] "Suicide," National Institute of Mental Health, last modified May 2018, accessed February 8, 2019. https://www.nimh.nih.gov/health/statistics/suicide.shtml.

[64] Donald Shepard, Deborah Gurewich, Aung k. Lwin, Gerald A. Reed, Morton M. Silverman, "Suicide and Suicidal Attempts in the United States: Costs and Policy Implications," *Suicide and Life Threatening Behavior* 46, no. 3 (June 2016), accessed February 8, 2019, https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.12225.

[65] Deborah Serani, "Understanding Survivors of Suicide Loss," Psychology Today, last modified November 25, 2013, accessed February 8, 2019. https://www.psychologytoday.com/us/blog/two-takes-depression/201311/understanding-survivors-suicide-loss.

[66] Liz Szabo, "Early Intervention could change nature of schizophrenia, in "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill," *USA Today*, December 31, 2014, accessed

Tiffany Martinez, who first heard voices when she was a freshman in college, benefited from such a program. Her father has schizophrenia, so she was aware that this was one of the first signs of a psychotic break. If untreated, 70 percent of persons who suffer the first break with reality will have their second break within a year. Her treatment at age 17 enabled her to continue her education, and today she is a psychiatric nurse practitioner helping others who are mentally ill. Martinez notes, however, that even after the delusions went away, she continued to have thoughts of suicide. "I struggled with that for a long time. When things got hard, suicide just seemed like an option for me."[67]

Karen Kelly, 55, had coped with depression for 15 years. She reached a point where she said, "I was in a very dark place and could not see the way out. I just felt like I was letting everybody down around me, and I was never going to get better. It's like being in a tunnel that's encased in with black and you can't see the way you came in or the way out, and you're all alone." Her psychiatrist tried to admit her to a hospital, but there was none available in the entire state since the only state psychiatric hospital in Vermont had flooded during a tropical storm, and the state had not opened another one. Kelly had attempted suicide several times, so her family members began staying with her all the time out of fear that she would make another attempt. Finally, in desperation, Kelly swallowed a whole bottle of pills and then told her husband, "Now they will have to admit me." The action resulted in evaluation and stabilization at the ER, and transportation to Massachusetts, over 200 miles away, to the nearest psychiatric hospital.[68]

March 28, 2017, http://www.usatoday.com/longform/news/nation/2014/12/31/early-intervention-mental-illness/18183737/.

[67] Ibid.

[68] Szabo, May 12, 2014.

Yolanda Solar of San Antonio, Texas, a 73-year-old grandmother who suffers from severe depression, tried to take her own life with an overdose of her medication. She received treatment at a hospital, but at discharge, she learned that she would have to wait seven months to see a psychiatrist because there were so few in the community, especially ones who specialized in seeing the elderly. The staff at the hospital's ER, however, were able to make an interim arrangement for her.[69] They referred her to the University of Texas Health Science Center at San Antonio's Transitional Care Clinic.[70] That clinic helps 1,500 persons with SMIs annually until a regular psychiatrist is available for them. They help the severely mentally ill "avoid winding up in the ER, where round-the-clock activity and confusion is ill-suited to the needs of patients who are already agitated, suicidal or psychotic." This arrangement in San Antonio has also saved money because the hospital ER is one of the most expensive places to treat patients. The ER cannot legally turn anyone away without treatment, but mentally ill patients often remain there for "hours, days or even weeks with minimal treatment, because doctors deem them too disabled to discharge[,] but [they] can't find them an inpatient bed, which would allow them to get more intensive care."[71]

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[69] Liz Szabo, Kaiser Health News, "Clinics help keep people with serious mental illness out of ER," *CNN U.S. Edition*, November 18, 2016, accessed April 11, 2017, http://www.cnn.com/2016/11/18/health/mental-health-care-emergency-room/.

[70] The Transitional Care Clinic is a unique program of the Department of Psychiatry at the University of Texas Health Science Center (UTHSC) at Antonio, which provides management of medications, psychotherapy and the coordination of services for persons transitioning from hospital psychiatric care to long term care in the community. It only serves those referred by hospitals with whom it has formal agreements. The program is staffed by psychiatric residents under clinical supervision of faculty at UTHSC, along with psychologists, social workers, and licensed professional counselors "Transitional Care Clinic," UT Health San Antonio Department of Psychiatry, accessed June 14, 2017, http://psychiatry.uthscsa.edu/CRRT/tcc/, and a phone conversation with Megan Frederik, Manager of the Program on June 14, 2017.

[71] Liz Szabo, Kaiser Health News.

Far too often, those who suffer from an SMI do not receive the treatment needed to prevent their suicide. Gregg Zoroya of *USA Today* tells the story of one young adult. Diagnosed with bipolar disorder and later, schizophrenia, when he was 24, Matthew Milam so wanted to die that he "dug his own grave in the backyard and stood outside in a lightning storm, begging God to strike him down." His symptoms grew worse after he discovered the body of his younger brother, who had died of a heroin overdose. Following each of four brief hospitalizations, one for a suicide attempt, his symptoms improved with medication. However, every time he left the hospital, he stopped taking the medications. Matthew's parents struggled to help their son, but they were not aware of his entire medical situation. Because he was an adult, the doctors could not communicate directly with them about Matthew's specific situation unless he authorized the communication. Matthew eventually took his own life. Over a lifetime, half of the individuals with schizophrenia attempt suicide, and one out of ten die by their hand. Matthew's parents believe that he "would be alive today if there had been a way to keep him medicated."[72] The Federal Health Insurance Portability and Accountability Act (HIPAA), which places restrictions on the release of private medical information concerning persons 18 and older without the individual's consent, prevents the sharing of information with family members unless the individual is incapacitated and not capable of making the decision. Along with laws that allow the mentally ill to refuse treatment, this law challenges the family's ability to prevent suicides. It suggests a need for

[72] Gregg Zoroya, "40,000 suicides annually, yet America simply shrugs," in "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill," *USA Today*, October 9, 2014, accessed March 28, 2017, http://www.usatoday.com/longform/news/nation/2014/10/09/suicide-mental-health-prevention-research/15276353/.

revisions in laws where the family is often so crucial for the ongoing health of a severely mentally ill member.

For many Americans, the prevailing attitude toward suicide is that if someone is trying to kill himself or herself, there is little that others can do to stop that person. Some question the willingness of the nation to focus resources on decreasing the growing rate of suicide. While other leading causes of death in America, such as HIV/AIDS and breast cancer, receive increasing resources, resulting in reductions in deaths, suicide was not a priority for research until recently. This lack of research changed, however, with the increase of suicides among returning veterans from the Middle East wars. This increase prompted the military and Congress to focus efforts to reduce the number of deaths among war veterans. There is hope that knowledge gained in working to prevent suicides in this subset will provide answers for its prevention in the much larger civilian cohort for whom mental illness is fatal.[73]

Severe Mental Illness Radically Compromises the Physical Health of its Victims and adds to the Expense Born by Families and the Government.

Direct spending for the treatment of mental disorders from all sources is more than for the treatment of any other medical condition in the United States, totaling more than $201 billion in 2013. Over 40 percent of that total spending is for institutionalized patients.[74] While that amount is exceptional, as Insel states, the real cost to the nation was "at least $467 billion" in 2012. $201 billion was the actual medical expenditures, but Insel's number adds the costs of disability payments and lost income from the unearned

[73] Ibid.

[74] Charles Roehrig, "Mental Disorders Top the List of The Most Costly Conditions in the United States: $201 Billion," *Health Affairs* 35, no. 6 (2016): 1130-1135, accessed June 14, 2017, http://content.healthaffairs.org.ezproxy.lib.uh.edu/content/35/6/1130.full.pdf+html.

wages of the mentally ill.[75] Though these are the economic costs to the nation, Insel shared with Liz Szabo the personal costs to the lives of the mentally ill.

> Mental illness costs Americans under 70 more years of healthy life than any other illness. That is because mental illness, unlike cancer or heart disease, is not a disease of aging. It often develops when people are in the prime of life, arising during adolescence or young adulthood. Left untreated, mental illness can rob people of decades of life. … People with serious mental illness die up to 23 years sooner than other Americans, giving them a life expectancy on par with people in Bangladesh.[76]

A 2008 study of persons suffering from a psychotic disorder found that their odds of having access to a primary care physician were 45 percent less likely than for those without mental disorders.[77] The same study also found that the odds of those with severe mental illness reporting difficulty in accessing care ranged from 2.5 to 7 times greater than the average population. These individuals "have greater difficulties navigating the health care system to get their needs met." They face "financial issues delaying care, and being unable to get a prescription medicine."[78] Likely, a critical factor in the result of this study was the lack of employment from their disability and the resulting lack of private, employment-based health insurance on which America's health system relies. When they do have access to healthcare, because of their illness, those with schizophrenia fail to take their medication 50 to 60 percent of the time.[79] The consequences of that failure can be

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[75] Insel, May 25, 2015.

[76] Szabo, May 12, 2014.

[77] Daniel W. Bradford, Mimi M. Kim, Loretta E. Braxton, Christine E. Marx, Marian Butterfield, and Eric B. Elbogen, "Access to Medical Care Among Persons with Psychotic and Major Affective Disorders," *Psychiatric Services* 59, no. 8, (August 2008): 850.

[78] Ibid: 849-850.

[79] "Program Brief: Mental Health Research Findings," Agency for Healthcare Research and Quality, AHRQ Pub. No. 09-P011, (September 2009): 1, accessed August 10, 2016, http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/factsheets/mental/mentalhth/mentalhth.pdf.

hospitalization, if it is available, or jail if a hospital bed is not available, and their behaviors lead to a chargeable offense.

A far more significant portion of those with mental illness report not being able to afford care than those with only physical illness. In 2014, a survey by the Substance Abuse and Mental Health Services Administration (SAMSHA) found that 43.6 million adults age 18 and older suffered from a mental illness in 2013, but only 45 percent of them received mental health services that year. The seriously mentally ill made up almost 10 million of that total, but despite the severity of their illnesses, over one-third of them received no treatment for their SMI in 2013. When asked why they had not received care if they had had a "perceived need" for services that went unmet, 51.3 percent of the larger group and 56.1 percent of the seriously mentally ill reported that they did not receive care for their need because "they could not afford the cost of care."[80] In contrast, the U.S. Department of Health and Human Services noted that in 2014 in all of health care, 8.2 percent of persons in the United States stated that they had delayed or not received medical care because of cost, and 5.6 percent reported not obtaining prescription drugs due to cost.[81] The World Health Organization (WHO) states that there is a significant gap between the actual need for treatment of mental illness and the funds available to treat it. In developed nations with adequate health care systems, between 44 percent and 70 percent of patients with mental disorders fail to receive treatment. It is worse in

[80] Beth Han, Sarra L. Hedden, Rachel Lipari, Elizabeth A. P. Copello, and Larry A. Kroutil, "Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health," *Substance Abuse and Mental Health Services Administration, NSDUH DATA REVIEW*, September 2015, accessed August 15, 2016, http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf: 19-25.

[81] "Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities," U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Center for Health Statistics, Hyattsville, MD. 2016, accessed August 10, 2016, http://www.cdc.gov/nchs/data/hus/hus15.pdf.

developing countries where the gap between treatment need and available resources is near 90 percent.[82] Insel notes that in America, the "losses are especially tragic because of growing evidence that early intervention can prevent the mentally ill from deteriorating, halting what once seemed like an inevitable decline." He further points out: "The way we pay for mental health today is the most expensive way possible. We don't provide support early, so we end up paying for lifetime support."[83] A National Institute on Aging study by the Rand Corporation and Washington University School of Medicine in Saint Louis in 2010 found that the "the long-term economic damages of childhood psychological problems are large—a lifetime cost in lost family income of approximately $300,000, and total lifetime economic cost for all those affected of 2.1 trillion dollars." The researchers noted their numbers are a "significant understatement" because it does not consider the "non-economic costs" experienced by those suffering from the disorders.[84]

The Tragic Impact on Families

While the primary victim of serious mental illness is the individual afflicted, the second victim is his or her family. Families provide care for approximately 40 percent of the most disabled, seriously mentally ill. Doris Fuller of the Treatment Advocacy Center told Rick Hampson of *USA Today*, however, that the care is usually "not forever. … In the end, most of them bail out. They can't take it any longer."[85] Hampson, who examined

[82] "Investing in Mental Health," World Health Organization, Geneva Switzerland, (2003): 5, accessed August 21, 2017, https://www.who.int/mental_health/media/investing_mnh.pdf.

[83] Szabo, May 12, 2014.

[84] James Patrick Smith and Gillian C. Smith, "Long-Term Economic Costs of Psychological Problems during Childhood," *Social Science and Medicine* 71 no. 1, (July 2010): 115.

[85] Rick Hampson, "The Fortunate Mother: Caring for a son with schizophrenia," in "The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill," *USA Today*, November 16, 2014,

the impact of the seriously mentally ill on their families, notes that families could obtain care in a hospital setting for their mentally ill member "only by proving they're dangerous to themselves or others. Even then, a shortage of facilities ensures that patients often are discharged prematurely. And families face exorbitant out-of-pocket costs for all but the most basic care."[86]

Laura Pogliano considers herself "lucky" because her son, who has schizophrenia, is still alive. However, she has a tough life. Laura spent $220,000 in savings on Zac's (her son)'s care and estimated that she spent another $80,000 from her income as well. When she could no longer make the payments on her home in Illinois, she lost it to foreclosure. Pogliano drives a 12-year-old car with 100,000 miles on it, and she owes $150,000. However, she is lucky because, for the last two years, Medicare disability has paid for Zac's medical bills, and she is close to one of the best psychiatric hospitals in the nation at Johns Hopkins University. She is also lucky because Zac "is not homicidal or suicidal," and when hospitalized, which has occurred 13 times in six years, he usually does not exercise his right to keep his mother from obtaining his medical information. Laura noted that her life is on hold because Zac "never stops dying. … Twice a year, right in front of me, he disappears into psychosis, and there is very little left of who he is. Then medicine resurrects him for a few months, I have much of my child back, then he dies again."[87]

Before his illness began, "Zac was popular, athletic, musical, (and) charismatic – a bit of a ladies man.'" At 17, his illness began with a diagnosis of obsessive-compulsive

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accessed March 28, 2017, http://www.usatoday.com/longform/news/nation/2014/11/16/schizophrenia-mental-illness-treatment/18647395/.

[86] Ibid.

[87] Ibid.

disorder, but his condition worsened. He became paranoid and slept with a knife, and a further diagnosis confirmed that he was psychotic. The company where Laura worked could not "accept her constant interruptions and sudden departures," and her boss, in front of her co-workers, called the situation "Laura's little problem," and said to her in private, "No one gives a s---." She quit her job, then more jobs after that, to be with her son, who missed more school than he attended. Laura's mental health declined, with panic attacks and sleepless nights. She was isolated and realized "as his (Zac's) world shrank, so did mine." Laura missed planning for her daughter's (Leah) wedding as well as being with Leah at the birth of her grandchild because of Zac's illness. Today, Laura works in jobs that have a short duration and are close by, so she can be available when Zac needs her. She takes medication prescribed by her psychiatrist for depression.[88]

Laura hopes someday "that Zac, like many with schizophrenia, will stabilize as he ages, that maybe after a decade the illness will loosen its grip." Realistically, however, she knows that responsibility for Zac will become the task of his sister, Leah, and her husband, Dan. When Dan asked Laura for her approval of his marriage to Leah, she remembers, "I said yes, on one condition: 'You have to accept Zac and all the things that come with him. You have to treat him with compassion, always, or I will haunt you!'"[89]

Laura struggles with understanding the lack of concern and even anger that people express about mental illness. She says she can

> understand people's reaction to the mentally ill—mysterious disease, atrocious symptoms—but what about their relatives? Why have autism advocates been able to mobilize public support, and not families of the mentally ill? … Schizophrenia is not a casserole illness … no one is bringing food to the door. Nor are they staging fundraisers, as they do for

[88] Ibid.
[89] Ibid.

> cancer patients. … Who's going to come to a fundraiser for *my* son? … To them, he's a *problem.*[90]

In concluding his article about Laura and Zac, Rick Hampson states, "Of all the costs borne by Laura Pogliano and millions like her, the one of not caring may be the cruelest of all."[91]

Mental Illness—the Misunderstood Disease

Why is the treatment of mental illness so different from the treatment of physical illnesses? Governments spend billions on research on cancer, heart disease, and other illnesses that are not as common as mental illness. Private insurance pays for expensive heart transplants, involved chemical and radiation treatments for cancer patients, and lifelong dialysis or transplants for patients with kidney disease. As noted above, both Medicare and Medicaid have a significant limitation on the treatment of the mentally ill. Why do we, as a nation, tolerate these differences? Our jails and prisons have replaced mental institutions as the place we send the severely mentally ill after they commit a crime because we do not treat their illness. The seriously mentally ill live hopeless chaotic lives on the street or moving between family, shelters, hospital, and jail. Why are we willing to allow such treatment, or lack of treatment, for the sickest members of our society?

Gerald Grob has written, "For too long mental health policies have embodied an elusive dream of magical cures that would eliminate age-old maladies." He also points out that we have accepted "without question the illusory belief that good health is always

[90] Ibid.
[91] Ibid.

attainable and purchasable. The result has been periods of prolonged disillusionment that have led to the abandonment of severely incapacitated persons."[92]

Nancy Andreasen M.D. writes about our reactions to the mentally ill as the reason we misunderstand it and allow such discrimination.

> Mental illnesses are often ignored, misunderstood, or stigmatized. Confronting any serious illness makes us feel charged with emotion and fear. It makes those of us who have a capacity for empathy or introspection recognize that we too are vulnerable, and that we too could suffer the same fate, as could any of our loved ones. We speak the names of illnesses—"cancer" … "heart attack"—in a hushed and respectful voice. Mental illnesses probably produce the most intense reaction of all, since they are the least well understood among the many human illnesses. Our intuitive reaction, when confronted on the sidewalk with a mumbling and disheveled person suffering from a mental illness, is to look away. Even when a close friend has a problem that requires hospitalization, we are reluctant to visit her.[93]

Andreasen also recognizes the fallacy of ignoring mental illnesses. They are "among the most common diseases that afflict human beings." They are also "incredibly costly" to treat and care, and they place such a heavy burden on the individuals suffering from them and their families. These are "frightening" illnesses because "they affect the brain and its product the mind."[94]

E. F. Torrey M.D., a strong advocate for those suffering from severe mental illness, states that several "forces impede" the nation's understanding of the "nature of serious mental illness." He argues, "Schizophrenia, bipolar disorder, and severe depression are brain diseases just like multiple sclerosis and Alzheimer's disease." He maintains that because of the influence of Freudian concepts, many still see these

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[92] Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994): 311.

[93] Nancy C. Andreasen, *(*2001): 4.

[94] Ibid: 4-6.

illnesses as psychological and not biological illnesses.[95] Torrey's argument that these serious mental illnesses are diseases of the brain has validity; however, one must note that other factors are often involved in severe mental illnesses. Torrey also contends that the public fails to realize the "magnitude of the mental illness problem." America dramatically reduced the use of mental institutions, moving the mentally ill to nursing homes, jails, and prisons, or the streets. As a nation, we stopped questioning their fate.[96] He also maintains that Americans misunderstand "the civil rights of people with severe mental illness." The public believes the mentally ill should be free to choose where they want to live but fails to recognize that they are not free, for their "actions are dictated by their delusions," and those actions often "interfere with the rights of others in the community."[97] In addition, he cites the "public mistrust of psychiatry," and the "economic interests" and "political interests" that work to "maintain the status quo." He identifies the federal government as the facilitator of the current state of the treatment of mental illness within the nation with its intervention in the 1960s with community mental health centers, and its continued "potpourri of completely uncoordinated programs" for persons suffering from an SMI. Chapters III and IV will show, however, that multiple causes were leading to the system we have today, and not just the federal government's intervention or Freudian theories. Lastly, Torrey sees the there is a lack of effective leadership for improving mental health from advocacy groups and political leaders.[98]

[95]E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (New York City: Oxford University Press, 2014): 140-141.

[96] Ibid: 141.

[97] Ibid.

[98] Ibid: 142-143.

Grob, Andreasen, and Torrey, each present important aspects of why we misunderstand mental illnesses and treat them so differently from physical illnesses.

This examination of the plight of the seriously mentally ill in America presents the results of the existing broken system for people suffering from terrible diseases. The ways various funding streams, both public and private, operate and the ways multiple levels of governmental and private responsibility address the needs of those suffering from an SMI all point to the difficulty of addressing such a complex problem. Beyond funding and the responsibility for providing services, the role of the courts in addressing the rights of the mentally ill is another factor that plays a crucial role in creating the inadequate system of care we have today. Chapter IV provides further information and analysis of the role federal court decisions played in creating the system we have today.

The Status of a State System Serving the Seriously Mentally Ill

This study will seek to understand how the current inadequate system for treating those with an SMI developed in our nation by examining how changes at the federal level changed the work of treating those with mental illness at the state and local levels of government. As we look at one state, Texas, we find that there are limited solutions to improving the system, and especially in such a rapidly growing state. State Senator Jane Nelson, R-Flower Mound, Texas, points to the "significant resources" that Texas has put into mental health care, which grew by $192 million from the 2013 to the 2015 legislative sessions. She also notes that if one includes the joint state and federal Medicaid funding for mental health, the total increase was $483 million. That seems like many resources, but in Texas—the second largest state in the Union and one of the fastest-growing—that increase in funding saw the per-capita number of psychiatric beds decrease from "11.3 to

10.5 beds per 100,000" between those two legislative sessions. The number of psychiatric hospital beds funded by the state has remained the same for over fifteen years.[99] Christine Mann, Press Officer with the Texas Department of State Health Services (DSHS), states, "Almost all of our state hospitals are currently at capacity, and we are admitting patients as soon as other patients are discharged."[100] One issue with that capacity is that less than half of the state-owned hospital beds (1,100) are available of civil commitments for individuals suffering from an SMI and in need of hospitalization—and this for a state with over 28 million in population. More than half of the state-owned beds (1,200) treat individuals with a "forensic commitment" from the criminal courts for the restoration of mental competency so they can legally stand trial.[101]

Stephen Glazier MBA, a fellow of the American College of Healthcare Executives (FACHE), and the chief operating officer of the Harris County Psychiatric Center (HCPC), points to the way the state has met the needs for civil commitments in Harris County, the state's largest county. In 1988, 1,525 persons with an SMI were admitted to state hospitals from Harris County, but in 2013, "that number had fallen to two." Now HCPC, a 276-bed public psychiatric hospital, serves as "Houston's primary safety net hospital for psychiatry." It remains "functionally full. … If there is an empty bed, it's only because there's an assigned patient who hasn't arrived yet." He states that, unfortunately, "about 14 percent of their patients are 'super-utilizers' who are likely to be readmitted because they have few options for supportive care after they've been

[99] Edgar Walters, "State Spending More on Mental Health Care, but Waitlist Grows," *The Texas Tribune*, May 1, 2016, accessed April 11, 2017, https://www.texastribune.org/2016/05/01/despite-state-spending-dearth-pysch-hospital-beds/.

[100] Ibid.

[101] Ibid.

discharged." The system is insufficient to meet the need. It is also inefficient with the constant movement of patients in and out of the system. Glazier also noted, "We discharge many people to a [homeless] shelter," and "we see a lot of chronic recidivists," with many patients returning within 30 days.[102] The word, recidivists, comes from the language of criminality, which suggests that at least subconsciously, it is not just the severely mentally ill who are jailed and in prisons who are seen as criminals, but those who need more treatment than our hospitals are providing. Chapter IX identifies new plans and funding from the Legislature for the much-needed expansion of HCPC to double its size that will be available early in the next decade. It will help with the constant turnover in patients by allowing them to remain in treatment. The expansion will also make HCPC the most extensive academic hospital in the nation for the treatment of mental illness.

Dr. David Lakey, associate vice chancellor for population at the University of Texas Health System and a former commissioner of DSHS, stated that the Texas state psychiatric hospitals (SPHs), which "were built in the 19th and early 20th centuries . . . are decaying."[103] A recent study of DSHS hospitals found that five of the SPHs—Rusk, Austin, San Antonio, Terrell, and North Texas at Wichita Falls—are obsolete and need to be replaced. It also noted that there is "ongoing maintenance and renovation" needed at the other five state psychiatric hospitals as well as the Waco Center for Youth.[104] Given

[102] Ibid.

[103] Ibid.

[104] "Analysis for the Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals (SPHs): Consulting Services for DSHS Rider 83 RFP No. 529-14-0066 Final Report," Prepared for the Department of State Health Services (DSHS) by CannonDesign, CBRE, The Innova Group, Pacheco Koch, Pape-Dawson Engineers, rh2, Twogether Consulting, VAI Architects, and WestEast Design, November 2014, 25.

the projected growth of Texas from 26.6 million in 2014 to 33 million in 2024 and the existing shortfall in the number of beds in the state system, Texas will need to increase its total state-owned beds, contracted beds, and privately funded beds from 4,855 to 6,033 by 2024.[105] This increase will only keep the number of beds proportional to the population as it exists now, which is not adequate for today's needs. The study also recognized the lack of state hospitals in three key areas, including two that are in rapidly growing urban centers.[106] The costs and political capital necessary to change the system to meet the sickest of the seriously mentally ill's needs will be a tremendous ongoing challenge.

America's Health Care System Needs Major Reform and Prioritization

America spent $3.5 trillion or $10,739 per person, which is 17.9 percent of the Gross Domestic Product (GDP) in 2017 on healthcare, an amount that far exceeds the amount spent by all other countries in the world.[107] The Organisation for Economic Co-operation and Development (OECD) is an organization of 35 nations that work together to "improve the economic and social well-being of people around the world."[108] It reported that the closest countries to the United States in per capita spending are Switzerland at 11.5 percent of GDP and Japan at 11.2 percent for 2015. Switzerland

[105] Ibid: 9, 14, and 17.

[106] Ibid: 19.

[107] "National Health Expenditure Data," Centers for Medicare and Medicaid Services, last modified on December 6, 2016, accessed July 16, 2019, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

[108] "Our mission," About the OECD, Organisation for Economic Co-operation and Development accessed on June 14, 2017, http://www.oecd.org/about/.

spent $6,934 and Japan $4,149 per capita for healthcare.[109] Given the amount of money and the comparative rates of expenditure by other countries, it is hard to understand the callous lack of treatment for the victims of serious mental illness that exists in America today. In Texas, with its wealth of natural resources and growing economic base, it is difficult to comprehend the critical status of its current system. Nevertheless, today, the banishment of the seriously mentally ill to the jails and prisons is, in reality, a return to the treatment they received before the building of asylums. The pain of their untreated illness and the burden placed upon their families is something that we, as a nation and state, choose to ignore. The stigma and shame associated with the individuals and their families are frankly beyond that afforded any other illness in our nation.

[109] "OECD Health Statistics 2016-Health Expenditures and Financing," Organisation for Economic Co-operation and Development, accessed June 14, 2017, http://www.oecd.org/els/health-systems/health-data.htm.

II. HISTORIANS' UNDERSTANDING OF THE TREATMENT OF SERIOUS MENTAL ILLNESS IN AMERICA

An imperative for any study of history is an understanding of how other historians have viewed aspects of that study. Before the 1960s, historians wrote little about the treatment of serious mental illness in the United States. Albert Deutsch's (1905-1961) *The Mentally Ill in America* (1938) was the only significant history on this subject before that time, and it unrealistically painted a picture of a continually improving system while highlighting the accomplishments of key leaders.[1] Within a decade, his work *The Shame of the States* (1948) would portray the treatment in a much more negative light.[2] Circumstances revealed during World War II created a far different understanding of the treatment of severe mental illness in America. The works Nina Ridenour in 1961, of Jeanne Brand in 1965, and Steven Taylor in 2009 show how the events of World War II became part of the that changed the treatment of mental illness in America. Chapter III details these World War II events.

Beginning in the 1960s, those changes, and others, brought a new level of interest in the history of mental illness. Historians have focused on the history of moral treatment within the asylums, the treatment and care in the public mental hospitals, and the community mental health center movement. They have also examined the changes in federal funding that began the rapid deinstitutionalization of the nation's mental hospitals in the 1960s and 70s. They have highlighted the lack of planning for the aftermath of deinstitutionalization and the failure of the nation to serve the severely mentally ill

[1] Albert Deutsch, *The Mentally Ill in America: A History of their Care and Treatment from Colonial Times* (Garden City, N.Y.: Doubleday, Doran, 1937).

[2] Albert Deutsch, *The Shame of the States* (New York: Harcourt, Brace and Company, 1948).

appropriately. This history has noted the difficulty in understanding and treating a disease for which we often lack knowledge of its causality. Not knowing its cause, our attempts at treating the illness have often focused on trying to alter the environment of the mentally ill person. In the 19th century, we moved the mentally ill from their family to an asylum to give them a new environment. In the 20th century, with the emphasis of community mental health, we attempted to alter the environment of communities and individuals to prevent mental illness. Both attempts failed to achieve the needed results.

Most of the history written about the treatment of mental illness in the United States presents it as a monolithic system of care when, in reality, it has never been that. Each state has had its care system, and for most of the nation's history, those systems were the only providers of care for the severely mentally ill. In 1963 and 1965, the federal government partially funded the creation of a community mental health center program and provided new funding streams, including Medicaid and, later, disability insurance that pays for much of today's public care system for those with an SMI in partnership with the states. Recent observations of that care reveal that this population is ill served by the system of treatment in place today. This chapter presents an overview of this history, noting particularly the variations of views and understandings of the writers.

The Era of Asylums and Large Public Hospitals for the Insane

Four early works: Philippe Pinel's M.D. (1745-1826) *A Treatise on Insanity* in 1806,[3] Benjamin Rush's M.D. (1746-1813) *Medical Inquiries and Observations upon the*

[3] Philippe Pinel, *A Treatise on Insanity, in which are contained the Principles of a new and more Practical Nosology of Maniacal Disorders than has yet been offered to the Public,* trans. D. D. Davis. (1806; repr., Washington, DC: University Publications of America, 1977).

Diseases of the Mind in 1812, [4]Samuel Tuke's (1784-1857) *Description of the Retreat* in 1813,[5] and Jean-Étienne Dominique Esquirol's M.D. (1772-1840) *Mental Maladies: A Treatise on Insanity* in 1838,[6] were descriptions of a new method of care. All four presented the need to treat the insane kindly and with respect. Pinel's work, in its translation to English from the original French, coined the term "moral treatment" to describe programs where the physician, assisted by staff and using kindness and clear direction, guided patients back to sanity. Pinel's book gained acceptance across Europe as an innovation away from cruel, inhumane means used previously. Samuel Tuke described the Retreat at York that his grandfather William Tuke (1732-1822) began in the 1790s using kindness and direction in a family-like setting to serve mentally ill British Quakers. His book was a practical description of the establishment and operation of the small facility, from fundraising and building design to treatment concepts. Esquirol was a student of Pinel, and his work served as the primary text for psychiatry in France for more than fifty years. Benjamin Rush also wrote of treating the insane with kindness, but his work focused on the more traditional concepts of medicine that were prevalent at that time. All of these writers influenced the treatment of mental illness, and Pinel and Tuke's works, with their focus on moral treatment, launched the start of the asylum movement both in Europe and in the United States.

[4] Benjamin Rush, *Medical Inquiries and Observations upon the Diseases of the Mind,* (1812; repr., Philadelphia: Grigg and Elliot, 1835).

[5] Samuel Tuke, *Description of the Retreat, an Institution near York for Insane Persons of the Society of Friends. Containing an Account of its Origin and Progress, The Modes of Treatment, and a Statement of Cases* (1813; repr., London: Dawsons of Pall Mall, 1964).

[6] Etienne Esquirol, *Mental Maladies: A Treatise on Insanity,* trans. E.K Hunt (Philadelphia: Lea and Blanchard, 1845).

Two events in the 1840s profoundly influenced the treatment of the seriously mentally ill in America for the next 120 years. Dorothea Dix (1802-1887), a teacher, became a champion for the insane. She visited the jails and poorhouses that housed the insane, and she wrote "Memorials" to state legislatures in each of the eight states she visited, plus one to the United States Congress. She asked the state legislatures and Congress to move away from the barbaric treatment of the insane and to build new public asylums to house and treat them.[7] Her "Memorials" were quite successful in persuading states to build the new structures. Her work reinforced the movement to commit the nation to the treatment of those with serious mental illness within institutions explicitly built for that purpose.

A second movement in the 1840s that reinforced this commitment was the founding of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), which eventually became the American Psychiatric Association (APA). AMSAII formed a powerful group committed to treating the insane within asylums. It set standards for the new facilities and the administration of the work within them. Amariah Brigham M.D. (1798-1849), superintendent of the Utica State Lunatic Asylum in New York, published the independent *American Journal of Insanity* until his death in 1849. Subsequent superintendents at Utica continued the publication, and it became the official voice of the association, regularly reporting its minutes, its actions, and frequently, articles from its members. During its first half-century, the association

[7] D. L. Dix, "Memorial. To the Legislature of Massachusetts," (1843; repr., Dorothea L. Dix, *On Behalf of the Insane Poor: Selected Reports* (New York: Arno Press & The New York Times, 1971). D. L. Dix, "Memorial: To the Senate and House of Representatives of the United States in Congress Assembled" (1843; repr., Dorothea L. Dix, *On Behalf of the Insane Poor: Selected Reports* (New York: Arno Press & The New York Times, 1971). David L. Lightner, *Asylum, Prison, and Poorhouse: the Writings and Reform Work of Dorothea Dix in Illinois* (Carbondale and Edwardsville: The Southern Illinois University Press, 1999).

guided the states as they looked to it for everything, from building designs for new asylums to staffing needs and basic organizational plans.

Historians' interest in the early treatment of mental illness emerged primarily in the 1960s as mental institutions came under direct attack by an anti-psychiatry movement and by many psychiatrists who had abandoned the institutions and who now saw them as evil themselves. The term "institutionalization," which developed at that time, suggested that just being in an institution, harmed the patients they existed to serve. One historian, David J. Rothman, accepted the arguments of the anti-psychiatry movement, and in *The Discovery of the Asylum* in 1971, he challenged the concept of asylums as benevolent institutions focused on curing or even helping the mentally ill.[8] Linking mental asylums with other institutions of that period such as prisons and almshouses, he concluded that society in the first half of the nineteenth century became obsessed with losing control of the established order of colonial America, as changes in the economy and the arrival of new immigrants transformed the demographic makeup of the nation and altered its culture. Rothman argued that urban, middle-class reformers feared that lawbreaking, poverty, idleness, and illness would bring irreparable damage to the nation. For Rothman, the asylums for the mentally ill and the other institutions were the reformers' way of bringing social control to their changing world. These institutions also provided a way to hide the deviant from the rest of society. Rothman sees the asylums as places of authoritarian control, which inevitably led to the abuse of the helpless inmates housed within them. Rothman's work provided fodder to the deinstitutionalization movement sweeping the country in the early 1970s. However, his theoretical focus failed to

[8] David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little Brown, 1971).

recognize the legitimate role the asylums played in helping even some extremely ill individuals recover their sanity.

Historian Gerald N. Grob's (1931-2015) *Mental Institutions in America* (1973) challenged Rothman's views.[9] He argued that Rothman approached the treatment of mental illness from an ideological framework, not examining the real world of care for the patients. Grob's study found people leaving asylums without having to return, helped in such a way that they could function in society. Instead of finding evidence of harsh treatment in the institutions, Grob found places of kindness and positive management. He also found that in the "moral treatment" era, before the number of patients grew so large around 1890, the majority of patients spent three to nine months in care before returning to society. In looking past the flourishing cry to close the institutions prevalent as he wrote, Grob found historical evidence that the asylums were not places of coercion and control, but practical facilities where mentally ill persons did recover when treated with kindness.

Nancy Tomes' *A Generous Confidence* (1984) drew from the writings of Thomas Kirkbride M.D. (1809-1883) and the early records of the Pennsylvania Hospital for the Insane, where he served as superintendent. Tomes also challenged Rothman's view by noting that asylums were the standard treatment for the mentally ill in Europe as well as America, and therefore not solely determined by fears of the changing society in America. Kirkbride was one of the earliest leaders of AMSAII, and his ideas and architectural plans became the standard as states planned and built new facilities. Kirkbride saw the institution itself as key to improving the lives of the insane. Tomes

[9] Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875*, (New York: Free Press, 1973.)

concluded, "Notwithstanding the limitations apparent to a modern observer, Kirkbride's approach to patient care was certainly far superior to our own in one crucial respect: The care of chronic insane."[10] Tomes was not suggesting a return to the asylums, but her focus on the humane care and treatment of those suffering from serious mental illness is a reminder of how far our nation had moved away from its previous concern for these individuals.

Constance M. McGovern, in *Masters of Madness* (1985), examined sources from the founding of AMSAII and gleaned information about several of its founders.[11] Her work presents these leaders as focused on creating the ideal place for the treatment of mental illness and helping others to use their understandings to provide better care. Grob, Tomes, and McGovern all present the early asylums as positive places for the mentally ill for the time and place in which they existed. Their arguments and evidence suggest that asylums provided a vital role for society and individuals at a time when there was no other place for those with serious mental illness. Today, we again have no place for them.

The moral treatment of the mentally ill in small asylums gave way to the rapid growth of large institutions as the numbers of mentally ill began to proliferate in the last quarter of the nineteenth century. Edward Shorter in *A History of Psychiatry* (1997) suggests that in part, this rapid growth of mental institutions came from changes in families who became less willing to tolerate the insane within their homes. He also points out that the number of persons in the asylums rose dramatically during this time, with increasing patients suffering from neuro-syphilis and alcoholism. While there is ample

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[10] Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and* The *Art of Asylum-Keeping, 1840-1883* (Cambridge: Cambridge University Press, 1984): 321.

[11] Constance M. McGovern, *Masters of Madness: Social Origins of the American Psychiatric Profession*, (Hanover: University Press of New England, 1985).

documentation of the increase in these illnesses, he also argues that schizophrenia, rather than being an ancient disease that psychiatry identified more clearly might be a disease of recent origin since there is little documentation of its existence before 1800. Adherents to this recency (new disease) theory see it as accounting for the significant growth of mental illness beginning in the late nineteenth century.[12] Shorter's work focuses on the history of psychiatry and how that specialty has attempted to help the mentally ill while at the same time dealing with the changing cultural environment in which it practices. The recognition of how culture and society have changed the practice of psychiatry and the public's understanding of mental illness are essential concepts in presenting the history of the treatment of serious mental illness. His presentation of the significant growth in new mental institutions and their burgeoning growth in size provides evidence of the change in treatment venues from small intimate facilities to large custodial institutions with too many patients and not enough resources to provide the treatment needed.

One who experienced first-hand this change in mental institutions was Clifford Beers (1876-1943). Beers' *A Mind that Found Itself*, written in 1908, tells of his own experience with mental illness and the harsh and abusive care he experienced in a variety of mental institutions.[13] It caught the attention of progressive thinkers of that era who were open to new ideas. Beers' work presented a realistic picture of what mental illness was like for the person suffering from it, and what that individual endured as he received treatment for his illness. Beers initially wanted to correct the abuses he had suffered within mental hospitals; however, Adolf Meyer M.D. (1866-1950), the most prominent

[12] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, Inc. 1997): 48-68.

[13] Clifford Whittingham Beers, *A Mind That Found Itself: An Autobiography*, (New York: Longmans, Green, and Co., 1908).

neuropsychiatrist of his day, persuaded him to broaden his focus to one of preventing mental illness. While there was no real understanding of how to prevent mental illness, Beers' book led to the formation of the mental hygiene movement that advocated for early intervention (particularly with children), the promotion of mental health, and the prevention of mental illness using public health concepts.[14] On the downside, Wendy Kline, in *Building a Better Race* (2001), notes that a parallel movement focused on eugenics. That movement led to the incarceration and sterilization of many women and men because they had the label of "feeble-minded"[15] Instead of Beers' work leading to a needed examination of the abusive treatment in overcrowded state hospitals, it launched a movement focused on unproven ideas on ways of preventing mental illness. Eugenics focused on measuring intelligence and creating standards of what was normal and abnormal. Though the two movements were separate, the concept of norms and the belief that both mental illness and mental intelligence were inherited traits, which passed from one generation to the next, were characteristics they had in common.

The Progressive Era Brought Change to Psychiatry, but Few Changes to the Institutions

The Progressive Era, from the turn of the century and the first two decades of the twentieth century, brought new concepts and changes thanks to Beers' book and his subsequent work of developing the mental hygiene movement. David J. Rothman, in *Conscience and Convenience* (1980), asks why the rise of the mental hygiene movement and the limited development of outpatient clinics and psychopathic hospitals did not lead

[14] Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994), 152-156.

[15] Wendy Kline, *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley: University of California Press, 2001):19-31.

to the replacement of the mental asylums. He notes that other than changing the name of asylums to hospitals and adding many new patients to them as the local poorhouses and county homes closed as part of the reforms of the Progressive Era, none of the progressive concepts succeeded "in reforming the asylum, in elevating conscience over convenience."[16] Rothman's commitment to the deinstitutionalization movement led him to overlook the reality that there was nothing to replace the mental hospitals at the turn of the century. Closing the institutions without well-planned programs to take their place was not a practical solution, yet this is precisely what happened in the deinstitutionalization movement of the 1960s and 70s.

Grob's *Mental Illness and American Society 1875-1940,* published in 1983 and using sources from a much broader era than Rothman, continue to note that despite the overcrowding and increasing problems within the mental hospitals in America, they "did provide *minimum* levels of care for individuals unable to survive by themselves."[17] He also traces psychiatry's movement away from the administrative role within the institutions and toward the mainstream of medicine with a new focus on the mental hygiene movement. This, he states, took place at the same time that "the nature of the patient population of the institutions changed drastically" from the bulk of the patients being acute mental cases requiring shorter-term care, to the higher number becoming chronic cases of older persons with "somatic disorders" and "accompanying behavioral symptoms." Many of the new patients spent much of their lives in the institutions. Grob states that in this era, "the central issue was not access to therapy or therapeutic

[16] David J. Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston: Little Brown, 1980): quote on page 421.

[17] Gerald N. Grob, *Mental Illness and American Society 1875-1940* (Princeton: Princeton University Press, 1983): quote on page xi.

effectiveness, but rather decent and humane *care* of patients whose physical and mental conditions precluded the possibility that they could care for themselves."[18] Grob shows how the changes in psychiatry during this time put in place the first elements of the coming change in psychiatry and its institutions before World War II. Grob's statement about "minimum levels of care" for those with serious mental illness may be generous. My work suggests that in Texas and other states, there was no real treatment for mental illness, and the care was not always decent and humane.

Grob states that the Progressive Era saw the movement of psychiatry out of the institutions to service in the community. Historian Elizabeth Lunbeck in *The Psychiatric Persuasion* (1994) asserts that in the Progressive Era at the beginning of the twentieth-century psychiatry moved from a focus on the insane to a focus on the ordinary lives of people.[19] She found that psychiatrists of the early twentieth century, who worked in the community outside of the asylums and hospitals, were bringing "their specialty's insight to bear on every human endeavor," describing normal "as that which is most common" and evaluating person's actions on "what ought to be."[20] She states that psychiatry, which in the nineteenth century was "visible only in the margins—in the asylum—had by the second decade of the twentieth century established itself as the center of social and cultural life."[21] With these changes, she suggests, the place of practice for psychiatrists began to move from the large state institutions to smaller hospitals, outpatient clinics, and private practice. She is right that psychiatry began to change in the Progressive era.

[18] Ibid: xi-xii.

[19] Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton: Princeton University Press, 1994): 3.

[20] Ibid: 4.

[21] Ibid: 10.

However, Lunbeck's close identification with the work of Michel Foucault, a critic of psychiatry, is reflective of his (Foucault's) criticism. Through her case studies, she argues that psychiatrists became the definers of normality, and that definition showed the bias distinctions of male psychiatrists over female social workers. To her, psychiatry was a pseudoscience that assisted people with normal living, and she no longer saw mental illness as a valid diagnosis. She began her work with the belief that the profession of psychiatry and the diagnosis of mental illness were invalid ideas that had outlived their time. She then found evidence to prove her thesis in a unique setting at the Boston Psychopathic Hospital from 1912 to 1921.

The Community Mental Health Movement

Jack Ewalt, a psychoanalyst by training, professor of psychiatry at Harvard, and administrator of the Massachusetts state mental health system, and his wife, Patricia, a psychiatric social worker, saw the role of psychiatry much broader than that pictured by Lunbeck. In their 1969 article, "History of the Community Psychiatry Movement," they traced the development of community psychiatry and the movement toward community mental health beginning from the latter part of the nineteenth century. To them, mental illness was real, but its treatment should be in the community away from the hospitals. They saw its role expanded to focus on prevention with the underlying assumption that there was a relationship between the environment and mental illness.[22] Essentially, they tied each of the critical developments in psychiatry and the treatment of mental illness to the need to change the environment. To them, psychiatry had moved away from the

[22] Jack R. Ewalt M.D. and Patricia L. Ewalt M.S., "History of the Community Psychiatry Movement," *American Journal of Psychiatry* 126, no. 1 (July 1969): 44.

institution –the asylum--that gave it birth to the broader focus on the causes of mental illness that existed in the community. The Ewalts concluded with a call for action:

> If we are to make any substantial progress in promoting mental health and preventing mental illness and social disorder, we must involve ourselves in informed consent activism to change our national goals and priorities. We cannot afford to have health, welfare, and education programs cut to give higher priority to highways, wars, farm support, and missiles.[23]

The Ewalts wrote at the height of the excitement about the community mental health center movement when all things seemed possible. Just six years later, Jack Ewalt would acknowledge that community psychiatry had its limitations. He saw that the Community Mental Health Centers (CMHCs) that focused their efforts on the medical treatment of clients with mental illness were "very successful." Whereas those CMHCs that focused on trying to change the broader community by attacking "racism, poverty, and education" were less successful.[24]

Gerald Grob, in *From Asylum to Community* in 1991, points out in the 1960s, this focus on treatment within the community came to define psychiatry. Community psychiatrists and psychoanalysts believed that their work, together with movements for social justice, would significantly improve individuals and society. Psychiatrists, much more than physicians in other specialties, came "to support legislation designed to assist less fortunate individuals and groups."[25] Grob states, "The pervasive confidence of these years grew out of a conviction that medical and scientific advances, combined with new institutional forms and enlightened federal leadership, provided the mechanisms that

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[23] Ibid: 51.

[24] Jack Ewalt, "The Birth of the Community Mental Health Movement," in *An Assessment of the Community Mental Health Movement*, ed. Walter E. Barton and Charlotte J. Sanborn (Lexington: Lexington Books, 1975): 19.

[25] Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991): 241.

would overcome the existing defects of public hospitals."[26] President Harry Truman (1945-1952) wrote to a joint meeting of the APA and the American Psychoanalytic Association (APsaA)

> Never have we had a more pressing need for experts in human engineering. The greatest prerequisite for peace, which is uppermost in the minds and hearts of all of us, must be sanity –sanity in its broadest sense, which permits clear thinking on the part of all citizens. We must continue to look to the experts in the field of psychiatry and other mental sciences for guidance in the evaluation of our mental health resources.[27]

Grob states in the 1950s, "pervasive faith in the national government and a corresponding belief that states were backward, parsimonious, and reactionary" began to reshape the nation's views about the treatment of mental illness. He notes that mental health activists within the APA and the AMA joined forces to work to change the treatment of mental illness in the nation. Working with other groups and with the personal interests of President John Kennedy because of his sister's intellectual disability, Congress passed the Community Mental Health Centers Act of 1963. Grob argues that this act "undermine[d] the traditional emphasis on institutional care and treatment of the severely mentally ill."[28] The passage of this act and subsequent legislation in 1965 brought significant change to the treatment of severe mental illness in the United States. Grob's understanding of the events and circumstances leading to this dramatic change are noted in chapters III and IV, which focuses on the movement to community mental health and the subsequent deinstitutionalization and abandonment of those with severe mental illness.

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[26] Ibid: 238.

[27] Letter from Harry S. Truman to William C. Menninger, May 25, 1848, cited in Rebecca Jo Plant, "William Menninger and American psychoanalysis, 1946-48," *History of Psychiatry* 16, no.2, 2005:184.

[28] Grob, (1991): 182-183.

Interpretations of the National Politics of Community Mental Health

As historians and others have examined the politics of changing the nation's treatment of mental illness, they have found differing understandings of how and why it occurred. Frances Fox Piven (b. 1932) and Richard A. Cloward (1926-2001) saw the CMHC legislation in a broader context as part of a wave of legislation aimed at providing resources directly to the cities in order to quell growing concern in the 1960s over the so-called "urban crisis" in America.[29] Unfortunately, there never was enough funding in community mental health to provide all the services needed for direct treatment, and there was unquestionably little money to tackle the issues seen as causing mental illness.

Henry A. Foley M.D., a physician and federal bureaucrat at the time of the passage of the CMHC Acts, argued that the leadership of Robert H. Felix, M.D. (1904-1990), the first director of the NIMH, was critical in creating the community mental health movement. Felix had an excellent rapport with crucial legislative figures and financial sponsors who supported improving the treatment of mental illness in the nation. Foley stated that the mental health portion of the CMHC Act of 1963 and the subsequent staffing amendment in 1965 resulted from the work of a group that included the NIMH staff and advocates working under the leadership of Felix. Foley, who worked with the NIMH, noted that this "oligarchy" of advocates, government bureaucrats, and politicians worked together over several years to raise the nation's awareness of the need for change in mental health care.[30] Their central premise was that psychiatric care needed to shift

[29] Frances Fox Piven and Richard A. Cloward, *Regulating the Poor: The Functions of Public Welfare* (New York: Pantheon Books), 1971: *257*-258.

[30] Henry A. Foley, *Community Mental Health Legislation: The Formative Process* (Lexington: Lexington Books, 1975): 137-138.

from institutional care to community care because the mentally ill "could be better served through community mental health centers and not through large state mental institutions isolated from community life."[31] Foley pictured the NIMH and its community mental health advocates as creating the issue and need for change and supplying the solution it wanted, which was the law to fund the creation of community mental health centers.[32]

Foley and Steven S. Sharfstein, M.D. (b. 1942), former associate director of behavioral health at the NIMH, noted that President Kennedy appointed an Inter-Agency Committee on Mental Health to advise him on how to proceed with recommendations for mental health. This committee chaired officially by Secretary of Health Education and Welfare (HEW) Abraham Ribicoff included the Secretary of Labor, the administrator of Veterans Affairs, and representatives of the Council of Economic Advisors and the Bureau of the Budget. The NIMH worked with the committee "to develop specific proposals for consideration." President Kennedy accepted the committee's plan, and it formed the basis for the creation of comprehensive community mental health centers (CMHCs).[33] Foley and Sharfstein point out that the committee and President Kennedy wanted the Community Mental Health Center Act in 1963 to pay for both the construction of the centers and the initial cost of staffing them. The President believed that the state and local governments would not build the centers without initial federal operating support because they could not afford to do so.[34] Congress in 1963, however, was "wary of legislation that called for further federal involvement in the nation's health

[31] Ibid: 38.

[32] Ibid: 137-138.

[33] Henry A. Foley and Steven *S* .Sharfstein, *Madness and Government: Who Cares for the Mentally Ill?* (Washington, D.C.: American Psychiatric Press, 1983):45.

[34] Ibid: 45-51.

sector."[35] When the AMA opposed the staffing expenditures in the 1963 bill, claiming it would lead to socialized medicine, the President and the supporters accepted the construction bill. They hoped that if Republican Barry Goldwater ran for President in 1964, his ultra-conservativism might lead to the election of a more liberal Congress that would pass funding for the staffing of the centers.[36]

Historian Randal Woods notes that when Lyndon Johnson assumed the presidency upon the President's assassination, he began immediately to work toward putting Kennedy's legislative agenda in place, expanded by his views. In 1964, President Lyndon Johnson (1963-1969) used his political skills and relationships with Congress to pass the Civil Rights Bill and a tax reduction bill. Those same skills and relationships then played a significant part in the passage of the CMHC staffing bill in 1965, along with Medicare and Medicaid and several other bills called the "Great Society" legislation. Woods points out that in working with Congress, Johnson knew the details of over 1,000 significant bills that Congress had considered from 1963 to 1966 and worked with members of Congress to pass most of his agenda.[37] Historian Julius Zelizer states that the key to passage of the legislation went beyond Johnson's political skill and owed much to the election of large Democratic majorities in both houses of Congress in 1964 with the defeat of Goldwater. That election enabled a liberal majority of Democrats and some liberal-to-moderate Republicans to overwhelm the coalition of Southern Democratic committee chairs and conservative Republicans to create a brief "aberration" in an

[35] Ibid: 56.
[36] Ibid: 56.
[37] Randall B. Woods, *Prisoner of Hope: Lyndon B. Johnson, The Great Society, and The Limits of Liberalism* (New York: Basic Books, 2016): 39.

otherwise conservative Congresses from the end of the New Deal in the 1930s onward.[38] Kennedy's death, Johnson's overwhelming victory in the 1964 election, and his legislative skills played significant roles in the creation of community mental health centers in the nation.

E. Fuller Torrey M.D. (b. 1937), a psychiatrist and critic of deinstitutionalization in *American Psychosis* in 2014, blames the failure to treat the nation's seriously mentally ill on the creation of community mental health as government policy. He identifies President Kennedy and Robert Felix as the key individuals responsible for that action.[39] He declares that by moving care from the sole responsibility of state governments, the federal government made a fundamental error, and he calls for a reversal of policy and a return to a time when the states had responsibility for decision-making for the treatment of the mentally ill. To him, the problem in the nation's mental health system is determining who is accountable and responsible for the services provided. The federal government provides funding through several different programs, but Torrey sees no entity as really being in charge of services to the seriously mentally ill.[40] Torrey's focus is on those with severe mental illness. To Torrey, the major flaw of our nation is its focus on the broader concept of mental health, which emphasizes prevention and treating less debilitating mental disorders, rather than the more specific treatment of serious mental *illness.* He points out that the organizational and funding system devoted to mental *health*

[38] Julian E. Zelizer, *The Fierce Urgency of Now: Lyndon Johnson, Congress, and the Battle for the Great Society* (New York: Penguin Press, 2015): 5-6.

[39] E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (Oxford: Oxford University Press, 2014): 36-42.

[40] Ibid: 161-162.

has not worked to prevent mental illness nor provide appropriate treatment for the mentally ill over the past half-century.[41]

Political scientist David A. Rochefort, writing in 1984, saw the CMHC Act of 1963 as the third psychiatric revolution, with psychoanalysis in the 1910s and '20s being the first and the introduction of psychotropic medications in the 1950s the second.[42] In pointing to the CMHCs as a revolution, he identifies the "new image of the mentally ill that became prevalent in American society during the decades following World War II" as the source of the act and its passage.[43] Citing surveys and the popular media portrayals of mental illness, he concluded that rather than seeing the passage of the CMHC Act as the product of elite policymakers in Washington, it actually "reflected a broad cultural shift in views of mental illness and the mentally ill that had occurred from the late 1940s to the early 1960s in America."[44] He suggested that the "passage of the CMHC Act thus can be seen as a case study of a policymaking process based less on proven solutions to well-defined problems than on widely-held social perceptions as to the nature of a particular social issue and some appropriate responses."[45]

Conclusion

Historians of the treatment of severe mental illness emerged in the last half of the twentieth century at the time the nation was experiencing both tremendous societal changes and changes in its understanding of the treatment of severe mental illness. As the

[41] Ibid: 162.

[42] David A. Rochefort, "Origins of the 'Third Psychiatric Revolution': The Community Mental Health Centers Act of 1963," *Journal of Health Politics, Policy and Law* 9, No. 1, (Spring 1984): 2.

[43] Ibid: 2.

[44] Ibid: 18.

[45] Ibid: 25.

federal government led the nation from treatment in institutions to treatment in the communities, some historians looked back on the early institutional history through the anti-psychiatric and anti-institutional concepts of their own time and found only harm in the institutions. Other historians found that the institutions had achieved positive outcomes for those suffering from severe mental illness at an earlier time. They also saw that with the wholesale movement to the community in their own time, many sufferers of chronic severe mental illness did not receive appropriate care and treatment. Still, other historians found that instead of being a movement based upon careful planning and realistic ideas of the needs of these individuals, the movement to the community rested upon changing societal understandings based upon the perceived evils of institutions. Led by individuals with a commitment to community treatment and occurring at a time of political and societal change, the nation committed itself to a course of action that prevails to this day.

The historians noted above, and others identified in chapter IV, all see the nation as one large structure and fail to recognize the critical roles played by states and local governments in providing and funding that care. In seeing the treatment of severe mental illness only from a national viewpoint, historians have failed to see the unique events and circumstances within a state that have influenced the treatment of severe mental illness. Since the states bring distinctive perspectives, it is important to add such a study to this history. This work will focus primarily on the history of the treatment of severe mental illness in the state of Texas and its most populous city Houston, located in Harris County. It will look for information gained there that may have implications for understanding what happened across the nation that led to the unfortunate treatment of the severely

mentally ill that exists today. I hope that it will also inform Texas and Harris County about needed reforms in their systems of care.

III. PSYCHIATRY BECOMES A SIGNIFICANT POLITICAL FORCE AND PUSHES THE NATIONAL GOVERNMENT TO TAKE A MAJOR ROLE IN THE TREATMENT OF MENTAL ILLNESS AND TO MOVE AWAY FROM THE INSTITUTIONS

At the end of the nineteenth century, psychiatry began to move away from its historic role in the state mental asylums and hospitals. Its new growing focus became the office-based treatment of individuals in the community. In 1894, Neurologist S. Weir Mitchell, M.D. (1829-1914), challenged the psychiatrists' historic role in an address to the 50th-anniversary conference of the American-Psychological Association formerly the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) and would later become the American Psychiatric Association. He was highly critical of the psychiatrist's position in asylums that now primarily served only custodial patients. He questioned their lack of "reports of scientific study, of the psychology and pathology of [their] patients." He questioned how they could make any scientific progress as was happening in surgery and other medical practices of the day.[1] The Mental Hygiene movement launched by Clifford Beers in the next decade encouraged the movement of psychiatrists away from the institutions.[2] The bulk of the patients within the hospitals had changed with far fewer patients suffering from short-term acute mental illness to many more persons needing long-term custodial care for their chronic illnesses.[3] The number of

[1] S. Weir Mitchell, M.D. "Address before the Fiftieth Annual Meeting of the American-Psychological Association, Held in Philadelphia, May 16th, 1894," *Journal of Nervous and Mental Illness* 19 no. 7, (July 1894): 422, 424.

[2] Clifford Whittingham Beers, *A Mind That Found Itself: An Autobiography*, (New York: Longmans, Green, and Co., 1908).

[3] Gerald N. Grob, *Mental Illness and American Society 1875-1940* (Princeton: Princeton University Press, 1983): quote on page xi-xii.

patients also grew exponentially in the hospitals as county, and local facilities closed, and those patients moved to the state hospitals. This movement away from serving the severely mentally ill patients in the institutions would climax a half-century later in a new movement led by psychiatry and the medical community to create new federally funded community mental health centers to replace the hospitals. Psychiatry would gain a significant political advantage following World War II that would allow it to lead the nation to make this change. This chapter is a study of the critical steps that created this advantage for psychiatry and the medical community to bring about this change.

Introduction

The circumstances leading to what ultimately became a catastrophic loss of care and treatment for those suffering from an SMI included the growing criticism of public mental hospitals that began at the close of World War II and ultimately morphed into a significant anti-psychiatry movement. Another critical factor was the perception that mental illness was a much more significant problem than previously thought and needed to be addressed differently. Also, the growing number of mentally ill in state hospitals and the increasingly high costs incurred by the states to provide for them led states to explore new alternatives. Moreover, new antipsychotic drugs became the first breakthrough in the treatment of those with an SMI since the development of "moral treatment" almost 130 years before.[4] The marketing and excitement created by the new medications was the catalyst that accelerated the changes that followed. All of these circumstances led to significant modifications from the 1960s to 1980 at the federal

[4] Anthony Hordern and Max Hamilton, "Drugs and "Moral Treatment,'" *British Journal of Psychiatry* 109, no. 461, (July 1963): 500.

government level, altering the traditional leadership role by the states in the treatment of mental illness, and ultimately leaving no specific level of government with the responsibility for the treatment of those with an SMI.

The lack of actual research and data supporting the conceptualization of community mental health programs and its reliance on faith in the medical community is reminiscent of the claim by the early superintendents of the asylums that moral treatment alone could cure mental illness. In the end, both failed to meet the needs of the patients and the expectations of the psychiatrists and the community.

Chapter IV addresses the changes that took place from 1963 through the early 1980s, in which the new federally supported community mental health center programs, new federal funding streams, and federal court decisions launched a movement to deinstitutionalize people with a mental condition in the United States. This movement drastically and rapidly reduced the available institutional facilities for those with an SMI without providing appropriate alternative care. To understand the changes in the treatment of the seriously mentally ill in Texas, one must understand changes at the national level detailed in this chapter and the next.

Significant events during World War II Led to Changes in the Treatment of Mental Illness

World War II (WWII) proved to be the beginning of the turning point for the treatment of mental illness in America. Medical historian Jeanne L. Brand (1918-2013), writing in 1965, described the growing role of the federal government in mental health "as part of a larger, over-all commitment to community responsibility for the health and

welfare of its members."[5] To this point in time, the federal government had accepted no role in the treatment of mental illness, deeming it a state responsibility. A century before, in 1854, following a major campaign led by Dorothea Dix, Congress had passed a bill setting aside 12,225,000 acres in federal land to fund the treatment of mental illness. The bill failed to become law when President Franklin Pierce vetoed it, stating, "If Congress have power … to make provision for the indigent insane … it has the power to provide for the indigent who are not insane, and thus to transfer to the federal government the charge *of all the poor in all the States*."[6] Now, ninety years later, wartime experiences raised the nation's concern about mental illness. Nina Ridenour (b. 1904) found that psychiatrists at the beginning of World War II asked the federal government to include their profession in the selection process for military draftees to prevent what had happened in World War I, when so many soldiers succumbed to "shell shock" and required intensive treatment at government expense. The psychiatrists pointed out, "Every psychiatric casualty in World War I had cost American taxpayers $30,000. … [And] three out of five beds in the 79 veterans' hospitals were occupied by patients with nervous and mental diseases."[7] With the psychiatrists' help, the WWII selection process rejected over 1.75 million inductees for military service because of mental and emotional disability and discharged another 750,000 for psychiatric reasons during the war.[8] The

[5] Jeanne L. Brand, "The National Mental Health Act of 1946: A Retrospect," *Bulletin of the History of Medicine* 39, (January 1, 1965): 244.

[6]Albert Deutsch, *The Mentally Ill in America: A history of their Care and Treatment From Colonial Times* (Garden City: Doubleday, Doran & Company, Inc., 1938):178.

[7] Nina Ridenour, *Mental Health in the United States, a Fifty-Year History* (Cambridge: Commonwealth Fund by Harvard Press, 1961): 55.

[8] Ibid: 60.

military rejected more persons for mental conditions than for any other reason, and this suggested that mental illness was a significant problem for the nation.[9]

Though those numbers got the nation and its politicians' notice, one recognizes that due to the significant influence of eugenic ideas and the theoretical bases of psychiatry at the time, the rejections and discharges were over-inflated. Recent studies have shown that psychiatry's attempt to identify and reject mentally ill or intellectually disabled[10] persons from the military during WWII neither reduced the numbers of "psychological casualties" from the war nor successfully identified those "who would have made good soldiers."[11] Whether or not the work of the psychiatrists was accurate, the finding that millions of young men, screened for the draft or enlistment, were mentally unfit for duty raised the issue that mental illness was a growing concern that needed national attention.

Brand also stated that during the war, "early intensified treatment" of the soldiers had enabled the "discharge of seven out of every ten psychotic patients admitted to hospital(s)."[12] Brand, in using the term "psychotic" misused the term, for the patients were not psychotic since "battle fatigue" is not a psychosis, but a milder form of mental illness. However, the success highlighted by Brand did lead to a dramatic increase in

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[9] Brand: 236.

[10] I use the term intellectually disabled intellectual disability throughout this work in place of the older term "mentally retarded" prevalent during much of the time covered in this history. Rosa's Law (PL. 111-256) passed unanimously by Congress and signed into law by President Obama required the federal government to replace the term "mental retardation" with "intellectual disabled" in 2010.

[11] E. Jones, K.C. Hyams, and S. Wessely, "Screening for vulnerability to psychological disorders in the military: an historical survey," *Journal of Medical Screening* 10, no. 1 (2003): 40 (quotes). See also G.L. Klerman, "Paradigm Shifts in USA Psychiatric Epidemiology Since World War II," *Social Psychiatry and Psychiatric Epidemiology* 25*,* no. 1 (January 1990): 28. Robert A. Cardona and Elspeth Cameron Ritchie, "U. S. Military Enlisted Accession Mental Health Screening: History and Current Practice," *Military Medicine* 172, no. 1 (January 2007): 33.

[12] Brand: 237.

interest by physicians in psychiatry and particularly in psychoanalysis, which was successful in treating early PTSD at the front line right at the onset of the disease. Psychoanalysis was not as successful in the treatment of psychoses from which most individuals with an SMI suffer. The success of treating these patients during the war, however, suggested to the public that there could be new hope for patients in overcrowded public mental hospitals across the nation.

A second wartime experience that raised the concern of the nation for the mentally ill came from the work of conscientious objectors (COs). In place of military service, over 3,000 COs worked as low-paid attendants in the nation's mental hospitals during the war. While Clifford Beers, had told of his own experience in a variety of mental institutions in 1908,[13] Brand noted, "For the first time in American history, intelligent, high-caliber attendants witnessed the neglect, over-crowding, often barbarism, in public mental hospitals throughout the country."[14] Ridenour found that the COs shared what they saw in the mental hospitals through a "mimeographed bulletin called *The Attendant."* From this exchange of concerns in the newsletters, the COs created plans to reform the hospitals.[15] They did not blame the deplorable conditions within the hospitals on the "negligence and indifference of incompetent superintendents, but rather to the lack of funds which was traceable to public apathy." During the war, the COs began to expose the conditions they saw "in a context of interpreting the reasons for bad conditions and collaborating with public officials in bringing about improvements."[16] Portions of the

[13] Clifford Whittingham Beers, *A Mind That Found Itself: An Autobiography*, (New York: Longmans, Green, and Co., 1908).

[14] Brand: 238.

[15] Ridenour: 104.

[16] Ibid: 105.

reports were published in Frank L. Wright, Jr.'s *Out of Sight, Out of Mind* (1947), with an introduction by Eleanor Roosevelt, the widow of President Franklin Roosevelt.[17] Wright's selections described some of more than 2,000 conditions the COs had witnessed in 46 mental hospitals in 16 primarily Northeastern and Midwestern states. Steven Taylor (1949-2014) stated that from the COs reports, "the implication was clear … the conditions and treatment reported … had been found in institutions among the most progressive and wealthy states—not poor states in the South."[18]

The findings of the COs within America's psychiatric hospitals inspired a significant change in thinking about the public mental hospitals and their treatment of the mentally ill. Albert Q. Maisel published a long pictorial article in *Life* magazine entitled "Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a Disgrace" based upon the COs' work. He described inhuman conditions of physical abuse, overcrowding, mediocre food, inadequate staffing, and a minimal number of poorly trained physicians to care for thousands of patients. Maisel stated, "Through public neglect and legislative penny-pinching, state after state has allowed its institutions for the care and cure of the mentally sick to degenerate into little more than concentration camps on the Belsen pattern."[19] Bergen-Belsen was a Nazi concentration camp where thousands, including Anne Frank, died during the Holocaust. This reference, written a year after the close of the war and following vivid public descriptions of the concentration camps by the media, sent a

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[17] *Frank L Wright Jr., Out of Sight out of Mind: A Graphic Picture of Present Day Institutional Care of the Mentally Ill in America, Based on More Than Two Thousand Eye-Witness Reports (Philadelphia: Natinal Mental Health Foundation Inc., 1947).*

[18] Steven J. Taylor, *Acts of Conscience: World War II, Mental Institutions, and Religious Objectors* (Syracuse: Syracuse, University Press, 2009): 139. The 46 hospitals were from sixteen states: Connecticut, Delaware, Illinois, Indiana, Iowa, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin.

[19] Albert Q. Maisel, "Bedlam 1946," *Life Magazine* 20, (May 6, 1946): 102.

powerful message to American readers. *Reader's Digest* published the article without the pictures under the title "The Shame of Our Mental Hospitals."[20] Ridenour stated, "These two articles, appearing in two of the magazines with the widest circulation in the United States, triggered a volcano of exposés and feature articles in other magazines and the daily press which continued for several years."[21] The hospitals' staffs, the communities' medical leadership, and public officials co-operated in the disclosures, which brought even more attention to the conditions in the state psychiatric hospitals.[22]

Other writers, also drawing on the work of the COs and their research, provided additional information about the treatment provided in the institutions for the mentally ill. Albert Deutsch's *The Shame of the States* (1948) described the large public hospitals across the country:

> The most serious defects arise from the deadly monotony of asylum life, the regimentation, the depersonalization and dehumanization of the patient, the herding of people with all kinds and degrees of mental sickness on the same wards, the lack of simple decencies, the complete lack of privacy in overcrowded institutions, the contempt for human dignity.[23]

Mary Jane Ward (1905-1981) published her novel, *The Snake Pit*, in 1946, and it became an Academy Award-winning movie by the same name in 1948. The book and movie accurately portrayed the warehousing of the mentally ill in large, crowded state psychiatric hospitals where conditions allowed very few to receive treatment. In the movie, a young psychiatrist, using elements of Freud's psychoanalytic therapy, eventually cures the heroine, whose placement in the hospital came after she had a mental

[20] "The Shame of Our Mental Hospitals," *Reader's Digest*, (July 1946): 1-7.
[21] Ridenour: 107.
[22] Ibid: 108.
[23] Albert Deutsch, *The Shame of the States* (New York: Harcourt, Brace and Company, 1948): 28.

break following a major crisis in her marriage.[24] These dramatic public presentations marked the end of any positive regard for the asylum/hospital movement after 130 years, with half a million people still housed in large public hospitals across the country.

The Creation of the National Institute of Mental Health (NIMH)

Other concerns leading to action by Congress were the fact that psychiatric patients occupied more than half of the nation's hospital beds, that there was a significant shortage of psychiatrists, and that research and training resources for new staff to serve the mentally ill "were hopelessly inadequate." [25] Robert Felix M.D., a psychiatrist who headed the Division of Mental Hygiene within the United States Public Health Service, led an effort to make mental illness a federal—not just a state—concern. Gerald Grob, perhaps the most respected historian of the treatment of mental illness in America, states that Felix's "goal was to alter the entrenched tradition of state responsibility for mental illnesses and use the prestige and resources of the national government to redirect mental health policies."[26]

Concerns that mental illness was a growing factor in the United States and increasing concerns about the lives of patients in public psychiatric hospitals led Congress to take action. With President Truman's support, on July 3, 1946, the National Mental Health Act passed, creating the National Institute of Mental Health (NIMH) within the Public Health Service of the United States as part of the National Institute of Health. The purpose of this new entity and its National Advisory Mental Health Council was

[24] Mary Jane Ward, *The Snake Pit* (New York: Random House, Inc., 1946).

[25] Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991): 51.

[26] Ibid: 49.

> the improvement of the mental health of the people of the United States through the conducting of researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders: … [T]raining personnel in matters relating to mental health; and developing, and assisting States in the use of, the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders.[27]

One provision of the law required the states, in order to receive funding from the NIMH, to select a mental health authority, which could be either the health department or another separate mental health authority.[28] However, the states could not designate their mental hospitals for this role since no funding from the NIMH could go "for the care of mental hospital patients."[29] The states, therefore, had to create new mental health linkages to the NIMH that were separate from their treatment systems for the mentally ill.

The NIMH became one of the fastest-growing departments of the federal government, increasing from $4.5 million in expenditures in 1948 to over $186 million in 1965.[30] Its resources, however, did not benefit those with an SMI within the state hospitals. Instead, the NIMH grants for training enabled the significant growth in "the number of university-trained psychiatrists." Also, the NIMH grants to the states to establish community-based practices dramatically increased the number of available employment positions for these new psychiatrists. Unfortunately, the state hospitals serving those with an SMI could not compete with the universities for the best residents, nor could they be competitive with the more generous jobs offered by private practice

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[27] National Mental Health Act of 1946, Public Law 487, 79th Congress, 2d sess. (July 3, 1946), Chapter 538, 421, accessed January 15, 2018, http://legisworks.org/sal/60/stats/STATUTE-60-Pg421.pdf.

[28] Ibid: 421, 425.

[29] Ernest M. Gruenberg and Janet Archer, "Abandonment of Responsibility for the Seriously Mentally Ill," *The Milbank Memorial Fund Quarterly. Health and Society* 57, no. 4 (Autumn 1979): 490.

[30] Robert H. Connery, *The Politics of Mental Health: Organizing Community Mental Health in Metropolitan Areas* (New York: Columbia University Press, 1968): 22. In 2018 dollars, those expenditures were equivalent to over $46.2 million and $1.4 billion respectfully. "Inflation Calculator," accessed March 14, 2018, Https://www.in2013dollars.com.

and community-based clinics. Ernest Gruenberg and Janet Archer from Johns Hopkins University's School of Hygiene and Public Health stated, "The state mental hospitals never recovered the loss of leadership they sustained during the war" because they could not compete with the resources provided by the NIMH to each of the states. The NIMH funding did not benefit the hospitals and the NIMH's argument that community psychiatry would "'save the states money' … created an atmosphere of antagonism between state mental hospital psychiatrists and the NIMH." [31] At a time when the states saw rising inpatient populations and expense, the NIMH provided nothing to help the state hospitals. It hurt them, by denying the state hospitals quality staff by creating new work with better pay and less complicated patients through the programs created by its grants.

The NIMH used the concerns from WWII of the increasing number of mentally ill in the nation to provide "financial and policy support for community surveys" through the 1950s and early 1960s that provided evidence to the American people that mental illness was a significant problem in the nation. Gerald L. Klerman, M.D. (1928-1992), a psychiatrist who headed the Alcohol, Drug Abuse, and Mental Health Administration under President Jimmy Carter from 1977 through 1980, identified the 1950s and early 1960s as the "'golden era' of social epidemiology."[32] Several extensive studies, including one in midtown Manhattan, a nationwide survey by the University of Michigan in 1960, several Canadian surveys, and the Hollingshead and Redlich study in the late 1950s, emphasized that the prevalence of mental illness was significant and growing. These

[31] Gruenberg and Archer: 490.

[32] G.L. Klerman, "Paradigm Shifts in USA Psychiatric Epidemiology since World War II," *Social Psychiatry and Psychiatric Epidemiology* 25, no. 1 (January 1990): 28.

studies, however, used "general impairment scales" of mental illness instead of clinical diagnoses to determine mental illness. General impairment scales were more economical to use, and they did not rely on the traditional medical model of differential diagnosis. They instead placed an "emphasis on social causes of mental illness." As such, there was no way to determine the "rates of treated or untreated specific psychiatric disorders."[33] One study found, "Only 17 percent of the population was 'probably well.'" Other research discovered "a firm link between environment and mental health, and at least the outlines of the kinds of interaction necessary for normal human development." [34] Researchers and public policymakers began to see mental illness as widespread and advocated treatment or "crisis intervention" at the earliest signs of mental illness.[35] Leonard Duhl M.D. of the NIMH called for psychiatry's "total resources and responsibility' … to be reanalyzed and reallocated so that psychiatry could realize its potential as the 'humanistic aspect of a technological society.'"[36] For Americans reading the public accounts of these studies and the NIMH's call for action by psychiatry, there was a growing impression of the need for societal change to prevent the growth of mental illness.

"Miracle" Antipsychotic Drugs Bring New Hope to the Treatment of SMI

The advent of new antipsychotic medications, more than any other event, offered new hope for the treatment of SMIs, and these new drugs would become a significant

[33] Ibid: 29.

[34] David F. Musto, "Whatever Happened to 'Community Mental Health?," *The Public Interest* 0, no. 39 (Fall 1975): 54.

[35] David F. Musto, "The Community Mental Health Center Movement in Historical Perspective," in *An Assessment of the Community Mental Health Movement*, ed. Walter E. Barton and Charlotte J. Sanborn (Lexington: Lexington Books, 1975), 8.

[36] Musto, (Fall 1975): 54.

driver for creating a new federally supported community mental health system. In 1954, John Vernon Kinross-Wright M.D. (d. 1999), a young academic psychiatrist from England on the faculty of the Department of Psychiatry and Neurology at Baylor University College of Medicine in Houston, Texas, published the first research article in America validating the use of Chlorpromazine (CPZ) with psychotic patients.[37] He noted,

> For decades psychiatrists have searched for a simple chemical agent with which to treat mental illness, one which would be effective without producing narcosis or coma and at the same time increase the patients' capacity to respond to psychotherapy. Recently a derivative of phenothiazine which appears to fulfill these requirements was discovered in France and named chlorpromazine.[38]

In a subsequent publication, Kinross-Wright described the change the new drug brought to one chronically ill woman.

> [A] 48 year old paranoid schizophrenic had spent most of the past ten years in private and state mental institutions. She received electro-shock, insulin treatment, and two prefrontal lobotomies without significant benefit. On admission, she was bellicose, sloppy in appearance, and actively hallucinating and entertained loosely systematized delusion of persecution. She responded slowly to CPZ, being maintained on 2400 mg. daily for almost three weeks. Improvement continued for three months on a maintenance dose of 75 mg. daily. For the past four months she has been symptom free, manages her home, goes to bridge parties, dresses well, and amazes her husband and friends with her affectionate friendliness.[39]

Smith, Kline and French (SK&F), the company licensed to market CPZ in the United States, trademarked it under the name Thorazine. In the first year of its introduction, it increased SK&F's total revenue by one-third.[40] The company would grow

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[37] Judith P. Swazey, *Chlorpromazine in Psychiatry: A Study of Therapeutic Innovation* (Cambridge: The MIT Press, 1974: 198-199. Another study published that same year, but before Kinross-Wright's work, focused on trials using CPZ with psychoneurotic patients. It was by N. William Winkelman, Jr., "Chlorpromazine in the Treatment of Neuropsychiatric Disorders," *JAMA* 155 (1954): 18-21.

[38] Vernon Kinross-Wright, "Chlorpromazine—A Major Advance in Psychiatric Treatment," *Postgraduate Medicine* 16, no. 4 (October 1954): 297.

[39] Vernon Kinross-Wright, "The Intensive Treatment of Schizophrenia," in *Pharmacologic Products Recently Introduced in the Treatment of Psychiatric Disorders*, ed. William T. Lhamon (Washington, DC, American Psychiatric Association, 1955): 55.

[40] Swazey: 164.

from $53 million in net sales in 1953, the year before the drug's introduction, to $347 million in 1970, thanks "in no small measure to Thorazine and to the research and development of new products that its sales ma[d]e possible."[41]

This new drug and similar ones became "wonder drugs" to the press and nurses and physicians working with previously intractable patients in large public mental hospitals. H. Angus Bowes M.D., clinical director of psychiatry at a large mental hospital in Quebec, and on the faculty of McGill University in the same city, described the effect of the use of another new drug, Frenquel, the brand name for azacyclonolan, an ataractic or tranquilizing drug, at his mental hospital.

> Within two weeks of commencing treatment a striking change had taken place. The patients on Frenquel had become more sociable, they were neater, cleaner, and tidier. … They stopped responding to their hallucinations. This was so encouraging that all the patients on the ward were given 40 mg. t.i.d. [three times a day] and within one week the ward became quiet and orderly. For the first time, patients would read books and magazines instead of tearing them apart. Curtains could be left up instead of being pulled down. [The patients] appeared much more sociable and interested in their environment. Some who had previously banged their heads against the walls and covered their heads with their overcoats stopped responding to their hallucinations. It was most impressive.[42]

Gerald Grob argues, "The spectacular success of antibiotic drugs in the postwar era undoubtedly created a climate that was sympathetic to the introduction of Thorazine."[43] The new drugs had their most pronounced impact in facilities where "patients were receiving a minimum of individual attention from nursing and medical staff."[44] That indeed characterized the public hospitals in the United States in the 1950s where

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[41] Ibid: 161.

[42] Angus H. Bowes, "The Ataractic Drugs: The Present Position of Chlorpromazine, Frenquel, Pacatal, and Reserpine in the Psychiatric Hospital," *American Journal of Psychiatry* 113, no. 6, (1956): 532, 535.

[43] Grob (1991): 148.

[44] Hordern and Hamilton: 506.

"admissions were rising, budgets were falling, [and] staff was becoming ever more difficult to recruit."[45] In Texas, each of the state hospitals began using chlorpromazine and reserpine[46] the first year they were available. The result was that many long-term, chronic patients were so improved that they could go on furlough and make visits outside of the hospital. There were also dramatic changes within the hospitals. These included "quieter wards;" less "soiling" by the patients; "less destruction of mattresses and clothing;" reduced injuries; more patients who were "accessible to psychotherapy;" much less use of restraints; less "need for electroconvulsive therapy and insulin therapy;" and there was much less use of barbiturates.[47]

In 1956, Bowes told the American Psychiatric Association (APA) meeting in Chicago, "I have attended conferences on these drugs where the atmosphere approached that of a revivalist meeting."[48] Kinross-Wright stated in 1956, "Reference to the psychiatric literature of the past year leaves one in no doubt that the chemotherapy of mental diseases has come of age."[49] Winfred Overholser (1892-1964), past president of the APA and superintendent of St. Elizabeth's Hospital in Washington—a massive federal mental hospital—writing in 1958, highlighted the improvement of staff morale in psychiatric hospitals: "A hopeful attitude has come about as patients who had been previously troublesome were [now] noted to be cooperative and helpful, and to show

[45] Ibid: 504.

[46] Reserpine is a chemical from Rauwolfia serpentia [Indian Snakeroot] used in India for centuries to treat insanity introduced in the United States in 1954. Https://en.wikipedia.org/wiki/Reserpine, and was accessed March 13, 2018.

[47] *BTSH&SS Report September 1, 1954 – August 31, 1955,*: 23.

[48] Bowes: 530.

[49] Vernon Kinross-Wright, "A Review of the Newer Drug Therapies in Psychiatry," *Diseases of the Nervous System* 17, no. 6 (June 1956): 187.

signs of improvement." He also emphasized that the impact of the new medications extended beyond the hospital.

> These drugs have again made the mental hospital a medical institution in the minds of the public. Physicians in general practice are more co-operative and more willing to refer patients for hospital or other psychiatric treatment. … Legislative bodies have shown a greater interest in the problems of mental illness now that a positive and easily administered therapy appears to be available. … Families have not only become more helpful but more demanding … insistent that the drug be administered. … It seems not too much to say too that the community is at last developing an attitude of far greater tolerance toward the discharged mental patient, a greater readiness to accept him back into the community.[50]

In 1955, Harold E. Himwich (1894-1975), director of research at Thudicum Psychiatric Research Laboratory in Galesburg, Illinois from 1951 to 1975, stated in his presidential address to the Society for Biological Psychiatry, "We are living in a moment of excitement, rich in potentialities that can be realized by increased interaction between psychiatrists and pharmacologists. … We cannot help but feel that the advances made by chlorpromazine and reserpine, important as they are, represent only the initiation of a new era in psychiatry."[51] *Time* and *Life* magazines published several articles in 1955 and 1956, hailing the success of the new drugs and suggesting that research would produce significant breakthroughs in the next ten years.[52]

The marketing of Thorazine by SK&F played a crucial role in promoting its sale and use and indirectly that of other new drugs as well. When the company began to

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[50]Winfred Overholser, "Has Chlorpromazine inaugurated a new era in mental hospitals?" in Hirsch L. Gordon, ed. *The New Chemotherapy in Mental Illness* (New York: Philosophical Library, 1958): 214-215.

[51] Harold E. Himwich, ed., *Tranquilizing Drugs: A Symposium … December 27-28, 1955* (Washington, D. C., 1957). Quoted in Grob: 150.

[52] "Medicine. Pills for the Mind," *Time* Magazine 65, no. 10 (March 7, 1955): 63-64. "Return to Sanity in 12 Weeks: Reserpine, Chlorpromazine Restore Two Mental Victims to Normal Life," *Life* Magazine 41, no. 16 (October 15, 1956): 149-159. Fritz Goro, "New Avenues into Sick Minds—Part II," *Life* Magazine 41, no. 17 (October 22, 1956): 119-124. Eric Hodgins, "The Search has only Started: In next 10 years doctors may learn much about mind as in past 2,000," *Life* Magazine 41, no. 17 (October 22, 1956): 126-142.

market Thorazine, it found that while state hospitals were interested in using it, they did not have the money to buy it. Deciding that its 300-person sales force across America could not handle the job, SK&F created a 50-person task force that became the "Hospital Sales Service."[53] This group worked intensively with state legislatures and with mental hospitals and their staff. Their lobbying efforts worked with mental health activists in all 50 states. An example of their efforts was that:

> In one state … through the efforts of SK&F and other interested groups, a special legislative session took place at one of the state mental hospitals, with the governor's and the legislative leaders' blessings. The entire session was filmed by the "Today" show, and, in that state, it was the breakthrough that eventually committed the legislature to funding an intensive-treatment program for the state hospital system.[54]

State legislatures proved amenable to funding resources that could reduce the number of persons in state hospitals.[55] In 1950, in a study for the National Governor's Conference of State Hospitals, the Council of State Governments had stated, "Overcrowding is the most extensive problem in state hospitals."[56] Texas had approved an extensive rebuilding program of its institutions in 1950, but it could not keep up with the growing need. All states faced critical questions of how to replace old institutions and build new ones for what was a growing hospitalized population that reached its zenith in 1955 with over 550,000 in state mental hospitals. The use of the new drugs allowed some patients to function outside of the hospital. In addition, with the new drugs, patients were better able to respond to therapeutic programs within the hospitals. Lengths of stay began

[53] Swazey: 202, 205.
[54] Ibid: 203.
[55] Grob: 148-149.
[56] Brevard E. Crihfield, *The Mental Health Programs of the Forty-Eight States: A Report to the Governor's Conference* (Chicago: The Council of State Governments, 1950): 4-13.

to decrease dramatically for new patients, but at the same time, there was a significant increase in the numbers of people committed to treatment in state hospitals.

Despite the excitement about the new drugs and the hope that they would decrease the population of the hospitals, William Gronfein, a professor of sociology who has studied the deinstitutionalization of the mentally ill in America, argued that the drugs alone did not lead to the deinstitutionalization movement in the United States. He noted that while some states saw a decrease in the census of state hospitals, others, including Texas, saw a rise in the population of mental hospitals after 1955, as an increasing number of new patients replaced those discharged. He cites "the short supply of alternative facilities in the community for state hospital patients" as the reason for the failure to discharge more individuals.[57] He believed that the new drugs did lead "to the emergence of a new philosophy regarding what was possible and desirable in the provision of mental health care for the seriously mentally ill." He asserted, however,

> To the extent that drugs "led" to a policy of deinstitutionalization, they did so because they converged with the interests and needs of several different groups, including fiscal conservatives determined to save money and civil libertarian lawyers intent on attacking what they viewed as a repressive institution.[58]

While the advent of the new drugs did not directly lead to deinstitutionalization, it served as a medical breakthrough that held the most promise for the mentally ill. Other influences played a role in deinstitutionalization, as well.

Community Mental Health Programs Developed in Several States in Response to Funding from the NIMH

[57] NIMH funding in the 1950s had increased community resources for mental health, but few of those resources created appropriate alternative placements for those leaving state hospitals.

[58] William Gronfein, "Psychotropic Drugs and the Origins of Deinstitutionalization," *Social Problems* 32, no 5, (June 1985): *450*.

The NIMH grants to the states for "establishing and maintaining adequate public health services, including grants for demonstrations and for the training of personnel" [59] required the states to submit plans for how they would use the funding. Every state developed a plan, and many states encouraged the development of community mental health outpatient clinics with the support of the NIMH. By 1951, funding from the NIMH had created 342 such clinics around the nation.[60]

The mental health authority in most states encouraged the development of community mental health clinics, relying mainly upon local community resources. In Texas, the Health Department, the designated mental health authority for the state, worked with the NIMH in 1956 to begin tracking existing psychiatric outpatient clinics and to encourage the development of new clinics in the state. These clinics operated under a variety of auspices.[61] In 1956, there were 15 such clinics, and the number grew to 36 by 1964. Funding for the clinics grew from $288,650 in 1956 to $640,813 in 1964. These funds came primarily from local funds, including local taxes, state-federal funds, and community chest funds.[62] Patient fees based upon the family's ability to pay provided only limited funding.[63]

Some states passed legislation to create state-supported community mental health systems that went beyond offering psychiatric clinics. The first state to do so was New York, which passed its Community Mental Health Services Act in 1954 that created the

[59] National Mental Health Act of 1946: 424.

[60] Eva S. Moskowitz, *In Therapy We Trust: America's Obsession with Self-Fulfillment* (Baltimore: The Johns Hopkins University Press, 2001: 155.

[61] *A Nine-Year Report on Mental Health Clinics 1956-1964 and some Trends in Community Mental Health in Texas* (Austin: Texas State Department of Health Division of Mental Health, June1965): 4. These auspices included community clinics, medical school clinics, general hospital clinics, and beginning in 1959 clinics operated by the state hospital system.

[62] Ibid: 18-19.

[63] Ibid: 19, 25.

New York Mental Health Commission (NYMHC). The act also offered the opportunity to local cities or counties to receive funding from the state to provide services to those who could not afford to pay for them. The state would fund 50 percent of the cost of psychiatric outpatient services, psychiatric inpatient services in a general hospital, psychiatric rehabilitation services, and consultant and educational services up to a total of $1.00 per capita for each county or city that voluntarily established services under the guidelines of the state.[64] In 1956, the state provided over $4 million to local entities in a 50-50 match of their approved expenditures, and in 1959 that number had grown to almost $11 million.[65]

New York's state hospitals established some community services in their areas, but the effort was limited because they received no additional staff or funding to do so. The NYMHC had recognized that the hospital locations were too distant from the significant areas of the population to center the state's community work on them.[66] This essentially deprived the state hospitals of the new growth area for mental health and meant there was limited coordination of services between hospitals and community centers. One of the problems encountered with the new division of responsibilities in New York was "the lack of integration between community programs and state hospitals."[67] This would prove to be a critical issue in future federal community mental health center legislation, for those laws required no coordination of services between the

[64] Hyman M. Forstenzer and Robert C. Hunt, "The New York State Mental Health Services Act: Its Origins and the First Four Years of Development," *Psychiatric Quarterly, Supplement* 32, part 1 (1958): 43, 51. Essentially, a county with 50,000 citizens was eligible to receive up to $50,000 in matching funds for the approved services it provided.

[65] Ibid: 56

[66] Ibid: 63-64.

[67] Lucy D. Ozarin, "Recent Community Mental Health Legislation—A Brief Review," *American Journal of Public Health* 52, no. 3 (March 1962): 441.

hospitals and future community mental health centers when passed in the 1960s and 70s. Chapters VI and VII identifies some of the problems in Texas of integrating state hospitals with community mental health centers.

Some other states followed New York's lead. Indiana and Connecticut passed authorizing legislation in 1955. California, Minnesota, New Jersey, and Vermont in 1957, and Wisconsin and Maine passed similar legislation in 1959. The organizational structures, the amount of state funding for local services, and the specific services reimbursed varied between the states, but all mostly followed New York's model.[68] When the new Short-Doyle Act of 1957 created the community mental health center program in California, a significant shortage of trained staff resulted, which only grew as more counties opened facilities. California also found the centers "overwhelmed by demands for assistance from all quarters." Referrals flooded every clinic.[69]

The new programs showed a demand and need for services for the mentally ill in the community. Of particular note was that the new services included short-term (up to 90 days in some cases) psychiatric inpatient care in community hospitals for voluntary patients. As they left the local hospitals, these patients could receive aftercare through local outpatient centers. California, however, did not allow funding to the centers for those committed by a court to the state hospitals.[70] Care for those individuals remained with the state hospitals. This prohibition ensured that the new system would develop separately from the existing state mental health system.

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[68] Ibid: 436-440.

[69] Alfred Auerback, "The Short-Doyle Act: California Community Mental Health Services Program: Background and Status after One Year," *California Medicine* 90, no. 5 (May 1959): 337.

[70] Ibid: 335.

Open Hospital Care in Great Britain Encouraged Mental Hospitals in the States to Explore Community-Based Care

Another innovation that brought about change came from work in Great Britain. In 1953, New York's Ernest M. Gruenberg (1915-1991), executive director of the state's Mental Health Commission, became aware of the development of some open hospitals in Great Britain, which, while serving the same level of patients as the New York state institutions, had moved away from locked wards and opened their doors to the community. Most of their patients "were actually living outside of the hospital grounds." Patients had responded so positively to the new treatment that there was no longer a need for restraints, and patients were doing much better than they previously had in the hospitals.[71] In 1954, Gruenberg arranged for consultants from Great Britain to share their work with staff from the New York state hospitals, and in 1955, he and others from the United States visited the British hospitals to see for themselves. They saw that the basis of the new way of treating patients was "increased respect for the patients." The British hospitals worked to protect "the patient's self-respect and sense of personal responsibility for his or her own behavior." To accomplish this, the hospitals had developed relationships with service providers in local communities to assist the patients. When that was not possible, "the hospital staff itself set up outpatient clinics in general hospitals and, in some instances, general hospital psychiatric observation and treatment wards."[72] The direct support by the hospitals within the community and the ability to bring patients back as needed in a crisis were critical to the success of the programs in Great Britain.

[71] Ernest M. Gruenberg, "Mission to Britain," *International Journal of Mental Health* 11, no. 4 (Winter 1982/83): 27.

[72] Ibid: 31-32.

The organization and funding of health care in Great Britain was and is quite different from the United States. Hospitals and community centers are all part of the public National Health Service, and in 1959, Britain did away with the distinction between psychiatric and general hospitals. Because of the funding and organizational difference, what was possible in Great Britain was not possible in New York or anywhere in America. The state hospitals across America, however, did begin to see their patients differently. In 1979 Gruenberg and Archer noted,

> By the early 1960s, many state hospitals in the United States were operating as open hospitals, and some were providing comprehensive services to most of their patients in the community. This movement toward *state-hospital-based-community care* for the seriously mentally ill had little connection with the rapidly proliferating *community-based mental health services,* which rarely served people with severe mental disorders who often needed inpatient care.[73]

The Texas hospital system had opened ten community psychiatric clinics by 1964 to serve discharged patients primarily in the larger cities away from the hospitals.[74] They did not open a center in Houston because the State Psychiatric Institute for Research and Training (HSPI) located in Houston met that need. Many of the public psychiatric hospitals in America, built in the previous century in communities with the most influential political lobbying efforts, were too often far from the places that were appropriate for community centers. The prohibitions established by federal funding barred any new federal funds from going to state hospitals for the care of patients, thus requiring the states to build and maintain two different systems of care to serve two different populations of the mentally ill. Both systems had too many patients and far too few staff to serve those with SMIs or even less debilitating mental illnesses.

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[73] Gruenberg and Archer: 492-493.

[74] *A Nine-Year Report on Mental Health Clinics 1956-1964 and some Trends in Community Mental Health in Texas*: 11.

While the first federal legislation creating and funding community mental health centers did not become laws until the mid-1960s, states were already providing community mental health under two different models. First, some states created systems separate from their state hospitals, and second, state hospitals created community mental health centers to serve patients leaving their hospitals. Because of the bias of the NIMH against state hospitals, the federal legislation, drafted with significant influence from the NIMH, choose to support the creation of separate systems rather than one that supported patients leaving the state hospitals. In essence, their choice would serve an entirely new, less ill population than those served in the state hospitals.

The Antipsychiatry Movement

Another critical factor in the growing storm that changed the treatment of mental illness in the United States was the disparagement of psychiatry. In the 1950s and 60s, following the significant onslaught of criticism of mental hospitals, a growing anti-psychiatry movement challenged psychiatry, the existence of mental hospitals, and previously accepted assumptions about mental illness. Michel Foucault (1926-1984), a French philosopher and social critic, questioned the historical concept of moral treatment for the mentally ill that advocated treating them with compassion, calling it a "religious and moral milieu … imposed from without; in such a way that madness was controlled, not cured."[75] In his work *Madness and Civilization* in 1961, he challenged the lack of scientific medical understanding of mental illness and saw the medical leadership within mental health as a "personality," "whose powers borrowed from science only their

[75] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. by Richard Howard (New York: Vintage Books, 1965): 244.

disguise, or at most their justification."[76] Thomas Szasz (1920-2012), a psychiatrist and psychoanalyst, in his work *The Myth of Mental Illness* (initially published in 1960), said that mental illness was a myth, for psychiatrists dealt "with personal, social, and ethical problems in living" and not with "mental illnesses and their treatments."[77] In *The Manufacture of Madness* (1970), Szasz compared "the belief in witchcraft and the persecution of witches with the belief in mental illness and the persecution of mental patients."[78] As a Libertarian, Szasz favored personal responsibility and not locking people up if they were not criminals. Szasz became a supporter of the Scientologists' anti-psychiatry organization Citizens Commission on Human Rights (CCHR),[79] which in Texas and across the nation still lobbies politicians, physicians, and the public against the support of psychiatry and the treatment of mental illness. Thomas Scheff (b. 1929), a sociologist, saw significant harm coming from the label of mental illness itself. In *Being Mentally Ill* (1966), Scheff argued against the validity of the medical model to serve the mentally ill, noting that there is no rigorous knowledge, cause, cure, or even symptoms of the illness.[80] Another sociologist Erving Goffman (1922-1982), with a grant from the NIMH, observed patients and operations within the 7,000-bed St. Elizabeth Hospital in Washington, D.C. In his work *Asylums* (1961), he used the term "total institution" to describe the hospital's power over the life of patients and compared it to other "total

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[76] Ibid: *271.*

[77] Thomas Szasz., *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct, Rev. Ed.* (New York, Harper, and Row, Publishers, 1974): 262.

[78] Thomas Szasz, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (Syracuse: Syracuse University Press, 1970): xv.

[79] Benedict Carey, "Dr. Thomas Szasz, Psychiatrist Who Led Movement NIMH against His Field, Dies at 92," *The New York Times*, September 11, 2012, accessed November 27, 2017, http://www.nytimes.com/2012/09/12/health/dr-thomas-szasz-psychiatrist-who-led-movement-against-his-field-dies-at-92.html.

[80] Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory, 3rd ed.* (New York: Aldine De Gruyter, 1999): 3.

institutions" such as prisons and concentration camps; in the asylum, there was complete authoritarian control with the psychiatrist in total charge.[81] Goffman concluded that the medical model of psychiatry within the large psychiatric hospitals was not appropriate for the needs of patients.[82]

This challenge to psychiatry and the psychiatric hospital also had significant input from Texas. Ivan Belknap (1914-1984), a sociologist at the University of Texas, completed a three-year case study focused on the organization of both the Texas state psychiatric hospital system and the Austin State Hospital.[83] In his book *Human Problems of a State Mental Hospital* (1956), using pseudonymous names for the hospital and the state to protect the institution,[84] he stated that the hospital from the time it began in 1861 had two conflicting tasks: to treat the mentally ill and to serve "as a more efficient poor farm."[85] He saw the large, central, and self-sufficient institution as incapable of providing an environment where the concepts of the treatment of mental illness would work. He stated:

> Most professional psychiatrists will not accept the conditions posed by the state hospital. … Of the eighty certified psychiatrists in the state in 1950, only three were employed in the state hospitals and only one of the three was in actual ward practice. Eighty-four percent of the specialists concerned with psychiatry in the United States are not practicing in the agency which treats eighty-five percent of the resident mental cases in the country.[86]

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81 Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*, (Garden City: Anchor Books, Doubleday & Company, Inc., 1961): 3-6.

82 Ibid: 350-366.

83 Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: Blakiston Division, McGraw-Hill, 1956): 1-6.

84 Presumably, Belknap's attempt to preserve the anonymity of the state and institution was to maintain his relationships within the hospital and perhaps his standing within the state. As a professor at the University of Texas, he always had students working at the hospital only two miles away. Both were located in the state capital, and likely, he did not want to stir the political winds in the conservative politics of Texas. Irving Goffman in his review of the book identified the state as Texas, but not the specific hospital.

85 Ibid: 204.

86 Ibid: 207.

The hospital's large population and centralized structure required the hospital administration to be impersonal, with no allowance for individualization.[87]

The American Medical Community Joins Forces to Create the Joint Commission on Mental Illness and Health (JCMIH)

The attack on psychiatry brought a strong response from that specialty in particular and the medical community in general. There was recognition that the state hospitals were remnants of an old era that many believed were doing more harm than good for the patients they served. The new drugs, on the other hand, held much more promise for the future, and "they sparked intense clinical excitement and produced significant improvements in staff morale."[88] The new drugs brought psychiatry closer to the mainstream of medicine with medications that worked miracles for people who had endured years within institutions. As studies showed that mental illnesses were growing exponentially, those who practiced community psychiatry saw the need and opportunity to focus on prevention where people lived rather than bringing them into an institution.[89] Psychiatry had a political voice, thanks to Robert Felix and the NIMH. The time was ripe for change, and psychiatry and other physicians were ready to lead it.

Joining with Felix in the 1950s, the American Medical Association (AMA) added a Council on Mental Health that worked in partnership with the American Psychiatric Association (APA) and others to form a national study group on mental illness. Working with a $5,000 grant from the Field Foundation of Illinois in 1954, and in 1955, a

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[87] Ibid: 208.

[88] Gronfein: 449.

[89] Musto, "Whatever Happened to 'Community Mental Health?"): 54. David F. Musto, "The Community Mental Health Center Movement in Historical Perspective," in *An Assessment of the Community Mental Health Movement*, ed. Walter E. Barton and Charlotte J. Sanborn (Lexington: Lexington Books, 1975): 8, 54.

sustaining grant of $10,000 from SK&F (the marketers of Thorazine in the United States), the two entities and their political supporters successfully lobbied Congress to pass the Mental Health Study Act of 1955.[90] The law authorized the formation of a non-governmental entity and provided some funding to develop "an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness."[91] That entity became the Joint Committee on Mental Illness and Health (JCMIH), and it was composed of members from the APA, the AMA's Council on Mental Health, and representatives from several other organizations influential in the treatment of mental illness. Most of the membership of the JCMIH were from the Northeast and Midwest, with very little representation from other parts of the country. Texas had limited representation on the Commission. However, the director, Jack R. Ewalt M.D., had served on the faculty at the University of Texas Medical Branch in Galveston, Texas, and directed the Psychopathic Hospital there in the 1940s. He moved from Texas to Massachusetts in the early 1950s, and in 1955, he was a professor of psychiatry at Harvard University and served as Commissioner of Mental Health for that state. Others from Texas included the consultant for scientific studies Fillmore H. Sanford Ph.D., a professor of psychology at the University of Texas, and Bernice Moore, Ph.D., the associate director of the Hogg Foundation from Austin, Texas who served on the Advisory Committee on the Role of Religion in Mental Health.[92] The Commission

[90] Connery: 38-39. Marshall Field III created the Field Foundation of Illinois in 1940. He was the grandson of Marshall Field, who founded the Marshall Field Department Store. The founder of the Foundation supported "a few ideas and social techniques (that may) germinate and eventually prove to be of enough value to be adopted by the community." https://fieldfoundation.org/about/history/. Accessed March 14, 2018.

[91] Public Law 84-182-July 28, 1955, https: //www.gpo.gov/fdsys/pkg/STATUTE-69/pdf/STATUTE-69-Pg381.pdf. Accessed March 14, 2018.

[92] Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health 1961 (New York: Science Editions, 1961): 306-315.

worked over the next seven years, funding several studies on the status of mental health in America, and it was instrumental in leading to the passage of the Community Mental Health Centers Act in 1963. Its work ended in 1961 with the publication of a final report, *Action for Mental Health: Final Report of the Joint Committee on Mental Illness and Health* (*AMH*).

That report called for the federal government to take on increased responsibility for mental health in the nation, including significant new funding. It called for a doubling of expenditures for services to the mentally ill in the next five years and a tripling of outlays in the next ten years. Stating that the states "[had] defaulted on adequate care for the mentally ill," it called for "revolutionary changes" in the tax structure. "Only the federal government has the financial resources" to raise the care of the mentally ill to even "the minimum standard of adequacy," it stated.[93] *AMH* advocated for an increase in recruitment and training of personnel and for an expansion of services beyond the SMI to "mentally troubled people," which meant "the emotionally disturbed. …, those under psychological stress that they cannot tolerate."[94]

Although advocating for an expansion of services to the "mentally troubled," *AMH* recognized that the focus of the nation's mental health program should be on those with an SMI. It stated,

> Major mental illness is the core problem and unfinished business of the mental health movement, and … the intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully trained members of the mental health professions.[95]

[93] Ibid: xx.
[94] Ibid: viii, ix-x, xii.
[95] Ibid: xiv.

It also called for the expansion of mental health resources beyond the state mental hospitals. It recommended the creation of new community mental health centers for each 50,000 of the population (catchment areas) to serve children and adults to reduce the need for hospitalization from significant mental illness. It also suggested that general hospitals add psychiatric units to provide care for the same population. *AMH* called for a reduction in the size of state mental hospitals to no more than 1,000 beds, so they could become intensive treatment centers to serve those needing longer-term intensive treatment in a hospital setting. It suggested a moratorium on building any hospitals larger than 1,000 beds and the gradual conversion of existing hospitals of larger size "into centers for the long-term and combined care of chronic diseases, including mental illness." *AMH* noted that the goal of treatment was that a person with a significant mental illness would eventually be able to sustain "himself in the community in a normal manner." To do so, *AMH* called for the development of aftercare, intermediate care, and rehabilitation services to become a standard part of the services for the mentally ill.[96]

Kennedy's Inter-Agency Task Force on Mental Health Refocuses the *AMH* Recommendations

President John F. Kennedy (president 1961-1963) came into office shortly after the publication of *AMH*. His sister Rosemary Kennedy's (1918-2005) intellectual disability and his sister Eunice Kennedy Shriver's (1921-2009) advocacy on behalf of her sister and the intellectual disability community was fortuitous for expanded federal support for the mentally ill. *AMH* and the other JCMIH publications had received mixed reviews. One reviewer, Elaine Cumming Ph.D., a sociologist with the New York

[96] Ibid: xiv-xvii.

Department of Mental Hygiene, in a book review article that examined *AMH* and other JCMIH publications, highlighted the incongruities of the recommendations of the reports to the reasons provided for them. The most challenging criticism was that

> The Joint Commission [had] attempted both to pinpoint an evil *and* to set forth a blueprint for the future. The evil they found was the large hospital, and the blueprint they produced was a range of community services. But in both of these things they have been unfortunate, for the real evil [was] surely the stubborn, complex manpower problem, and the blueprint in essence suggests diverting still more manpower to the community services not always able, nor always willing, to tackle the core problem. … It has failed to attack what is, by its own confession, the main problem facing psychiatry today, treatment of the acutely mentally ill. [97]

In addition to the criticisms of *AMH*, it did not contain a specific legislative agenda or the financial information on which to make decisions about future recommendations. Kennedy appointed the Inter-Agency Task Force on Mental Health with representatives from several federal departments to consider the *AMH* proposals and varying task force reports, including a report from the NIMH, to determine what role the federal government should assume.

Officially, the Secretary of the Department of Health Education and Welfare (HEW), Abraham Ribicoff (1910-1998), chaired the task force, which included representatives of the Secretary of Labor, the administrator of Veterans Affairs, and representatives from the Bureau of the Budget and the Council of Economic Advisors. The representatives appointed to work on this project had an interest in and knowledge of the critical issues, and most saw expanding non-institutional resources as necessary. While others likely met with the group, there were five key individuals. They were Boisfeuillet Jones (1913-2001), a special assistant to the assistant secretary for health and

[97] Elaine Cumming, "A Review Article—The Reports of the Joint Commission on Mental Illness and Health," *Social Problems* 9, no. 4 (Spring 1962): 399.

medical affairs in the HEW who "was a medical administrator of renown" on loan from Emory University, who served as chair. Jones had served on Eisenhower's National Advisory Health Council and had recently chaired a group that produced the report, *Federal Support of Medical Research,* for the Senate Appropriations Committee. The representative from the Department of Labor was Daniel Moynihan (1927-2003), the future New York Senator, who, in his previous work in New York State, had seen the decrease in residents at state hospitals and "thought there was a need for treatment programs in the community." Robert Manley came from the Veterans Administration (VA), Robert Atwell from the Bureau of the Budget, and Rashi Fein (1926-2014) from the Council of Economic Advisors.[98]

The VA was the largest provider of mental health treatment in the nation, and Atwell and Fein had significant knowledge of the mental health programs of the nation and the economic and financial issues involved. Fein had written *The Economics of Mental Illness* for the JCMIH, in which he supported the nation's need for increased spending on mental illness and health. Atwell served as the budget examiner for the National Institute for Health (NIH), of which the NIMH was a part. He had detailed knowledge of the overall agency's programs and budgets. He saw the various JCMIH publications, including *AMH,* as "totally discrediting the system of state mental hospitals. He believed there was a need for more support for the institutions, but he thought, "It was even more crucial to develop new non-institutional services."[99] Robert Felix M.D., the director of the NIMH, and Stanley Yolles, M.D. (1919-2001), his deputy, also met

[98] Henry A. Foley and Steven S. Sharfstein, *Madness and Government: Who cares for the mentally ill?* (Washington DC: American Psychiatric Press, 1983): 45-46.

[99] Ibid: 46-47.

regularly with the group, and Jones asked the NIMH to "develop specific proposals for consideration." Felix told his staff "that assisting the president's interagency committee was the most important job the institute faced."[100]

The NIMH, at Felix's direction, rejected the views of the *AMH* statement that the most significant need for mental health in the nation was to treat those with SMI. [101] The NIMH's position was that "the proper focus for any mental health program should be upon the improvement of the mental health of the people of the country through a continuum of services, not just the treatment and rehabilitative aspects" of treating the mentally ill.[102] In essence, the NIMH saw the *mental health* of the total population and not the treatment of *mental illness* of individuals as the critical need of the nation. The NIMH wanted the focus to be on prevention and the creation of treatment resources in the community. The NIMH mostly left the state hospitals out of their plans. It assumed that those with an SMI would be treated appropriately within the community with the new medications. Its lack of consideration of the existing system and planning for appropriate transitions would prove to be a significant error that sanctioned the rapid deinstitutionalization movement. With no planning or standards created for movement from hospital to community, this lack of concern allowed the discharge of thousands of mentally ill persons to highly inappropriate living situations, often with little or no care for their mental illness.

[100] Ibid: 45.

[101] Grob (1991): 221.

[102] National Institute of Mental Health Position Paper on the Report of the Joint Commission On Mental Illness from November 1961, passim, NIMH Records, Miscellaneous Records 1956-67, Box 1, Washington National Record Center, Suitland, Md., Quoted in Grob (1991): 221.

Without regard to the real need of those with an SMI, the task force's plan called for the creation of comprehensive community mental health centers. The plan presented these centers as local rather than state-based and providing a full range of diagnostic and treatment services. The new centers were seen not necessarily as one entity, for they could be several organizations in a local community that worked together to provide a range of services. The plan called for federal funds to go directly to the local centers, bypassing the states, which members of the task force viewed as obstructions in remaking the treatment of mental health in the nation.[103] The President's task force specifically recommended, "That federal grants assist in the construction of such centers and that a decreasing federal subsidy cover initial operating costs." It established a goal of 500 such centers by 1970 and another 1,500 by 1980. The task force also called for state planning grants for support to improve state inpatient hospital care, for voluntary health insurance plans to provide more coverage for psychiatric care, for increased federal aid for training of the needed workforce, and expanded research.[104] The recommendations from this task force became President Kennedy's new plan for mental health.

Kennedy's Bold New Plan and the Beginning of the Deinstitutionalization Movement

In President Kennedy's "bold new" plan calling for a law to support the building of community mental health centers, he stated,

> I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. This approach relies primarily upon the new knowledge and new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society.

[103] Foley and Sharfstein: 45-46.
[104] Grob (1991): 224.

> These breakthroughs have rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals where they were out of sight and out of mind.[105]

Kennedy went on to state, "If we launch a broad new mental health program now, it will be possible within a decade or two to reduce the number of patients now under custodial care by 50 [percent] or more."[106]

The NIMH and other advocates wanting to replace the hospitals with community-based treatment for mental illness had a major political victory when President Kennedy agreed to combine the treatment of mental illness with his interest in the intellectual disabled. The information he received from advisors and other advocates; however, argued that the obsolescence of the hospitals was a reality because of the new medicines and new knowledge. While it was true that new medicines and new knowledge held promise for the future, the reality was that the total movement to the community was an untested and unproven model of care. The wholesale abandonment of the hospitals with no plan to coordinate the movement of patients to the community was fraught with potential danger for the mentally ill. With the President's buy-in and support, Congress and ultimately, the public accepted the new direction. This first bill only provided funding for partial support of the construction of the new centers. It was not until 1965

[105] Papers of John F. Kennedy. Presidential Papers. President's Office Files. Legislative Files. Special Message on mental illness and mental retardation, February 5, 1963: 3, accessed February 20, 2017, https://www.jfklibrary.org/asset-viewer/archives/JFKPOF/052/JFKPOF-052-012. The plan and recommendations in Kennedy's speech came directly from the work of his Inter-agency Task Force. However, given the President's family history with intellectual disability, and the personal experience of Ted Sorenson, his primary speechwriter whose mother became mentally ill when he was a teenager, I believe that the speech reflects some of their personal experiences.

[106] Ibid: 4.

when President Johnson used Kennedy's support for the bill and his legacy to pass the second bill that funded the cost of staffing the new centers on a decreasing annual basis.

Kennedy's new legislation called for the federal government to fund comprehensive community centers to serve the intellectually disabled and the mentally ill.[107] The federal funds and the ongoing federal role was to "'stimulate' State, local and private action" to implement the new policy.[108] He also called for the appropriation of $10 million for state hospitals for demonstration projects and training that became the Hospital Improvement Plan and provided limited funding to state hospitals to help patients move out of the hospitals.[109]

The AMA Council on Mental Health endorsed Kennedy's plan. Hamilton C. Ford M.D. (1908-1990) of the University of Texas Medical Branch in Galveston and chair of the AMA's Council on Mental Health stated the following:

> Institutional Care may have seemed the only solution at one time, but we know now that it can be more of a detriment than a help. There has been a revolution in the treatment of the mentally ill in the past decade and this in turn has revolutionized our way of looking at mental illness. In the language of this missile age, it's time to start phasing out many of our centralized mental hospitals, just as these hospitals phased out the ancient concept of insane asylums not so many years ago.[110]

However, the AMA's Council on Legislative Activities opposed that portion of the bill that provided funds to pay a share of the initial staffing costs of the centers

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[107] Ibid: 4-6.

[108] Ibid: 3.

[109] Ibid: 4. Better *Care for Mental Patients: A Progress Report the First 5 Years of a Hospital Improvement Program 1963-1968* (Chevy Chase, MD. U.S. Department of Health, Education and Welfare Public Health Service Health Services and Mental Health Administration National Institute of Mental Health, Public Health Service Publication no. 1896, February 1969, PIB OC20M-01.

[110] "Mental Health Bill Endorsed by the American Medical Association," *Texas State Journal of Medicine* 59 no 4, (April 1963): 370-371.

because of their strong opposition to government funding of medical care and their longtime fear of "socialized medicine."[111] The final bill in 1963 did not contain the staffing provision. Without staffing support, the grants would primarily appeal only to hospitals that could use existing staff in new facilities. Its reach was therefore quite limited; nevertheless, Kennedy's speech and the actions of Congress in 1963 launched the national deinstitutionalization of mental hospitals in the United States.

Conclusion

World War II, with its exposure of conditions within state psychiatric hospitals and with its elevation of psychiatry in importance due to its role in the treatment of soldiers on the battlefield, ultimately changed the treatment of the seriously mentally ill in the United States. The creation of the NIMH and the growing role of the federal government in the treatment of mental illness in the 1940s launched a relentless movement for change. The discovery of new antipsychotic medications provided a catalyst for the change, the NIMH's support for community mental health programs in the states in opposition to the institutions, and the rise of a strong antipsychiatry sentiment pushed psychiatry and the medical community to lead the way for the change. A supportive President, the NIMH's focus on mental health and the prevention of mental illness versus the treatment of mental illness would lead to a rapid restructuring of the way the nation viewed the severely mentally ill and its responsibility for their treatment. These efforts would lead to the creation of new federally and locally funded community mental health centers across the nation.

[111] Grob, (1991): 231-232.

IV. DEINSTITUTIONALIZATION AND THE ULTIMATE ABANDONMENT OF THE SEVERELY MENTALLY ILL BY THE NATION

Introduction

The 1963 and 1965 legislation passed by Congress with the advocacy of the NIMH and the medical community created an entirely new community mental health center program that did not focus on serving the SMI they hoped would exit the state hospitals. Instead, following the lead of the NIMH, the new legislation created an ultimately inadequate public system to treat mentally ill persons in the community with outpatient services and limited inpatient services in general hospitals. The new funding streams of Medicare, Medicaid, and Supplemental Security Income (SSI) led the states eagerly to move many of those with an SMI to other venues without ensuring that the care was appropriate for them. Federal court decisions made during the Civil Rights movement, and at a time of much public criticism of public mental hospitals, dramatically changed requirements for the commitment process the states had long used for those with an SMI. Also, the court decisions required significant new safeguards for the hospitalized mentally ill. While many of these had a positive effect on the care of individual patients, they led to even fewer placements in the state hospitals, leaving insufficient resources for those suffering from an SMI who needed a daily structured environment. These changes led to the rapid, dramatic reduction in the number of severely mentally ill served in state hospitals, and to the abandonment of those patients by the nation.

The federal government's leadership role in the treatment of severe mental illness was short-lived. By the 1980s, with a new, more conservative President and Congress, the direct funding of community mental health centers ended, and the federal courts' interest in finding new federal rights for the mentally ill waned. The medical specialty of psychiatry went through significant changes as it moved from its psychoanalytic focus on long-term treatment to one that focused on diagnosis with a checklist of behaviors and treatment through the prescription of medication while delegating shorter-term psychotherapy to others. Funding for treatment and care changed as well as Managed Behavioral Healthcare Organizations (MBHOs) now oversee much of the treatment of mental illness in the United States. Their focus is on limited treatment and care that is much less than those with a severe mental illness need. The reality is that today, with inadequate or no treatment, those with severe mental illness are jailed and imprisoned for behaviors they cannot control. Our nation has criminalized mental illness.

The Short Life of Community Mental Health Centers (CMHCs) Directly Funded by the Federal Government

Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act on October 31, 1963. It authorized the federal expenditure of $150 million over three years as matching funds for the construction of community mental health centers (CMHCs) and facilities for the intellectually disabled. Each state had to submit an approved plan for the operations of the new centers in that state.[1] A

[1] Mental Retardation Facilities and Community Mental Health Centers Act of 1963, Public Law 88-164, October 31, 1963. Under Title II of the Act, the authorization totaling $35,000,000 was available for appropriation as grants for construction of public and other nonprofit community mental health centers for the fiscal year 1966, $50,000,000 for 1967, and $65,000,000 for 1968. A second act expanded the allocations in 1965. The funds were allocated based on population, the extent of the need for such centers, and the financial need of the respective states.

subsequent law, passed in 1965, provided limited short-term funding for the initial staffing costs of the centers, which decreased over time and required significant increases in matching funds from the funded entities throughout each grant.[2] Congress extended the length of new awards to eight years in 1970, and the percentage of federal funding increased for centers located in impoverished areas.[3] In 1975, a subsequent amendment to the Act provided additional funding but increased the required services from five to twelve.[4] In 1977 and 1978, Congress passed laws extending funding for one and two years, respectively.[5] In all of these instances, federal community health funding to the CMHCs decreased over time, requiring increased local or state funding to sustain the centers.

Following a lengthy study by President Jimmy Carter's Commission on Mental Health, the Mental Health Systems Act passed in 1980, which would have made significant increases in funding for community mental health and state mental health systems. However, appropriations to fund the act never passed.[6] Instead, President Ronald Reagan and the new Congress elected in 1980 passed the Omnibus Budget Reconciliation Act in 1981 that cut funding for community mental health by 20 to 25

[2] "Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965," Public Law 89-105, August 4, 1965.

[3] David L. Cutler, Joseph Bevilacqua, and Bentson H. McFarland, "Four Decades of Community Mental Health: a Symphony in Four Movements," *Community Mental Health Journal* 39, no. 4 (October 2003): 386.

[4] Public Law 94-63, July 29, 1975. This law required that CMHCs provide a wide range of services for children and the elderly in addition to the originally required services of inpatient, outpatient, day care, partial hospitalization, and emergency services. It also mandated expanded education and consultation services for a variety of community organizations, assistance to courts and other agencies in screening residents for a referral to state mental hospitals, follow-up care from state hospitals, and transitional halfway house services for their catchment areas. Previous expansion in 1968 had added program requirements to include prevention and treatment services for alcoholism and drug addiction.

[5] Public Law 95-83, August 1, 1977. Public Law 95-622, November 7, 1978.

[6] Public Law 96-398, October 7, 1980.

percent and sent it directly to the states as block grants.[7] This action effectively ended the direct federal role in community mental health, with approximately 650 community mental health centers in operation, far short of the 2,000 initially forecast for the year 1980.[8] The states were required to use the block grants to support community mental health centers, so they now assumed responsibility for the centers' continued funding, direction, and oversight.

Direct federal funding for CMHCs built only 768 centers, instead of the planned 2,400 by 1989.[9] The funding was marginal compared to the resources spent by the states' on their hospitals. That early funding began facing cutbacks immediately after passage, with only 40 percent of the amount of funding authorized for the first two years appropriated.[10] One study found that "The total federal expenditure for community mental health centers [from 1964-1968] average[d] out to thirty cents per capita per year—or slightly less than five percent of the annual per capita expenditure by the states for state mental hospitals alone ($6.64 in 1966).[11] The design of the federal CMHC funding was mainly to prime the pump. The national planners assumed that other funds from states, localities, and private sources would continue the programs. Congress never appropriated enough federal matching funds to launch the program as planned, and funding from the states, localities, and private sources never materialized at the level to sustain the services needed by those with an SMI. The states accepted the federal funding

[7] Public Law 97-35, August 13, 1981.

[8] Gerald N. Grob and Howard H. Goldman, *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?* (New Brunswick: Rutgers University Press, 2006): 63.

[9] Grob: (1991) 251.

[10] Ibid: 250.

[11] Raymond M. Glasscote, James N. Sussex, Elaine Cumming, and Lauren H. Smith, *The Community Mental Health Center: An Interim Appraisal* (Washington DC: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1969): 6.

for CMHCs because initially, it cost them little since the matching funds came from the local communities through the organizations applying for funds. The local community organizations applied for funding, assuming that both federal and state funding would continue to support the programs they created. Three organizations in Houston and others in Texas, primarily hospitals, applied for and received federal funding to build and staff community mental health center programs in the late 1960s.

Aside from Lack of Appropriate Funding, Why did CMHCs Fail?

While lack of appropriate funding for CMHCs was a critical reason for their lack of achieving the goals of the program, Gerald Grob points to serious shortcomings of the community mental health legislation and its implementation. He notes that the leadership at the NIMH did not seek "comments, criticism, nor alternative views" in the writing of the regulations for the CMHC Acts of 1963 and 1965, and they specifically provided a minimal role for state governments in the new centers. The rules created by the leadership of the NIMH detailed no specific ways in which the traditional state hospitals, as they discharged patients, would work with the new centers. In both the limited role for state government and the lack of any linkage to the state hospitals, Grob argues that the NIMH wanted a "decentralized system that enhanced the role of communities." He questioned how the new mental health system, as called for in the act, could "provide comprehensive services and continuity of care … in isolation from a state system that still retained responsibility for most of the nation's severely and chronically mentally ill population." The perception by the NIMH was that the state hospital systems were an entrenched institutional system that would oppose attempts to change. They saw

bypassing the states and working directly with communities as a more promising means of transforming mental health.[12]

Shortly after the passage of the first CMHC Act in 1963, Raymond M. Glasscote et al. (1964) noted that the community mental health center program was an untested model. While individual elements of what the new law required fit the medical and social thinking of those who pushed for the movement of the treatment of mental illness to the community, no single model existed as to how the centers should operate.[13] In 1969, Glasscote and another group of researchers issued an interim appraisal of the community mental health center movement. They looked in depth at eight centers of the 50 operational in 1967. Their examination revealed that most were experiencing problems just in getting started. Looking at all eight sites visited in the study, they stated that thousands of persons in state hospitals could function in the community if they had the proper support, including housing, job training, and activity centers. The new antipsychotic medications that emerged in the 1950s would enable many mentally ill patients to function outside of the state hospitals with such supports. Glasscote et al. (1969) pointed out, however, that federal regulations recognized these types of services as optional—not essential—services for community mental health clinics. However,

[12] Grob, (1991): 245-246.

[13] Raymond M. Glasscote, David S. Sanders, H. M. Forstenzer, and A. R. Foley, *The Community Mental Health Center: An Analysis of Existing Models* (Washington D.C.: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1964): xv. No single model, structured as the new law required, existed. New York, California, and other states had developed limited statewide community mental health programs. Still, the new federal program, though drawn from those experiences, differed in several ways, including scope and funding mechanisms. Several states, including Texas, had created outpatient centers to serve as aftercare facilities for state hospitals, and in a limited way to provide community resources to prevent hospitalization.

these were services exactly necessary to "accomplish the original goal of transferring the care of the mentally ill from the state hospital to the community."[14]

Robert H. Connery's edited work, *The Politics of Mental Health*, written in 1968, examined the readiness of six large communities in the United States, including Houston, Texas, for community mental health and assessed the pitfalls and problems that the move to community-based mental health services would likely face. The work provided an understanding that while most spoke positively about the movement, the communities would face many problems in putting the federal legislation into place.[15] Writing of the issues in Houston, a political scientist from the University of Texas, Clifford McCleskey found issues that would require a constitutional amendment to allow public funding of the CMHCs. He also identified the fragmentation of services between agencies, and the lack of workforce to staff new facilities as potentially critical shortcomings the community would face in launching the new centers.[16]

Looking back on the CMHCs in later decades, others point to the problems that those with an SMI faced as the CMHCs came into existence. Steven Segal, a professor of social welfare at the University of California at Berkeley, suggested as early as 1979 that the problems of inadequate services for persons with an SMI came in part from invalid assumptions made in the planning for community mental health care. The planners, he argued, assumed that families would provide the supplemental support that previously

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[14] Raymond M. Glasscote, James N. Sussex, Elaine Cumming, Lauren H. Smith, *The Community Mental Health Center: An Interim Appraisal* (Washington D.C.: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1969): 2-13.

[15] Robert H. Connery, *The Politics of Mental Health: Organizing Community Mental Health in Metropolitan Areas*, (New York: Columbia University Press, 1968).

[16] Clifton McCleskey, "Houston," in *The Politics of Mental Health: Organizing Community Mental Health in Metropolitan Areas,* ed. Robert H. Connery (New York: Columbia University Press, 1968): 161-163.

institutionalized mentally ill persons would need as they moved into care in the community. He noted that little planning and effort went into this critical point, let alone a retrospective study to determine the validity of these assumptions.[17]

In 1990, Uri Aviram, also a professor of social work, described the crisis that arose in community mental health centers around the care for the seriously mentally ill population. He noted that while part of the problem was financial and organizational, there were broader issues. One of those wider issues was the public's concern about having those with an SMI living in their communities. The public's fears led them to push for greater social control rather than the endorsement of public policies that placed persons with an SMI into the regular community.[18] One acronym that grew out of the era and is still present today is "nimby"—not in my back yard. People favored policies and programs that fostered those with an SMI living in communities as long as it was not their community.

In a further examination, Aviram, also in 1990, showed that rather than seeing the seriously mentally ill population as presenting structural and organizational problems for which it should have planned, the mental health community chose to see them merely as persons needing medical care. The institutionalized patients had received 24-hour care, including food, a place to live, and a supportive system of care, however inadequate. In choosing to see the deinstitutionalized individual with an SMI as only needing medical support and served by the medical marketplace, the CMHCs and the states that discharged the patients failed to develop the necessary organizational structures in the

[17]Steven P. Segal, "Community Care and Deinstitutionalization: A Review," *Social Work* 24, No. 6 (November 1979): 521-527.

[18] Uri Aviram "Community Care of the Severely Mentally Ill: Is Social Control a 'Necessary Evil' in Policy-making Considerations?" *Psychiatric Quarterly* 61, No. 2, (Summer 1990): 77.

community, including liaison and transitional living services, to provide adequately for them. Often these individuals had no families, and, when they did, the return of those with an SMI to the community placed increased burdens on their families and led to an increase in homelessness among the seriously mentally ill because their families were unsuccessful in providing for them.[19] H. Richard Lamb and Leona L. Bachrach suggested that the problems of this population grew more acute as a new generation of persons came into care who were not as passive as those who first left the institutions. This group presented unique challenges, including denial that they were ill, refusal to take medications, and an unwillingness to see themselves as part of the mental health system, which to them was "tantamount to admitting failure and some basic defect."[20]

Saul Feldman, the NIMH associate responsible for the CMHC program in the first decade of its existence, writing on the 40th anniversary of the passage of the CMHC Act of 1963, acknowledged that the community mental health center movement failed to create the system of care necessary for those exiting the psychiatric hospitals. However, he declared the community mental health center approach was "an attempt to build a network, an unprecedented system of care in a way that had never before been tried. … [It] was no small task but it was a time of adventure, of a 'bold new approach,' of great aspirations."[21]

David and Sheila Rothman's *The Willowbrook Wars* (1984) found a historian and his social worker wife, both with strong anti-institutional views, giving a firsthand

[19] Uri Aviram, "Community Care of the Seriously Mentally Ill: Continuing Problems and Current Issues," *Community Mental Health Journal* 26, No. 1 (February 1990): 69.

[20] H. Richard Lamb and Leona L. Bachrach, "Some Perspectives on Deinstitutionalization," *Psychiatric Services* 52, No. 8, (August 2001): 1040-1041.

[21] Saul Feldman, "Reflections on the 40th Anniversary of the Community Mental Health Centers Act," *Administration and Policy in Mental Health* 31, no. 5 (May 2004). 376-377.

account of the closing of the Willowbrook State School. This school on Staten Island in New York City, was one with which they were closely involved. While the facility cared for children who were developmentally disabled and not persons with an SMI, their work provided a lesson in the extraordinary legal and practical challenges faced in closing an institution with 5,400 residents and moving the residents into the community. They chronicled the difficult task of creating group homes for children that most people did not want in their neighborhoods.[22]

The laws creating and funding CMHCs did not cause deinstitutionalization. Grob points out that Medicaid and Medicare led to a rapid decrease in the "number of aged chronic patients" in the mental hospitals. Also, the new therapies, medications, and the improved circumstances within the hospitals with the decreasing population of chronic patients led to more rapid discharges and shorter lengths of stay.[23] The passage of the CMHC laws, however, signaled to the nation that the federal government was moving from institutional care of the mentally ill to a community-based system of care. Unfortunately, funding did not move from the hospitals to the community, as new federal court decisions would require tremendous improvements in the existing hospitals. These improvements used up available funding. They would lead ultimately to the states reducing the number of hospital beds available to those with severe mental illness, and sending more of those individuals to CMHCs that were not funded appropriately to provide for them.

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[22] David J. Rothman & Sheila M. Rothman, *The Willowbrook Wars*, (New York: Harper & Row, 1984).

[23] Grob (1991): 240.

Federal Funding of Medicare, Medicaid, and Supplemental Security Income (SSI) Incentivized States to Save Money by Deinstitutionalizing

While the Community Mental Health Center Acts signaled the beginning of the deinstitutionalization movement in the United States, three other federal funding streams provided the resources and incentives for the states to remove many of the mentally ill from their state hospitals. Medicare and Medicaid passed as part of Johnson's Great Society in 1965. Supplemental Security Income (SSI) passed in 1972. It began in 1974 as part of President Nixon's effort to centralize and standardize the different state payment systems to support the aged and the disabled. Medicare, funded by a charge on social security funds drawn over the working career of individuals, provides hospital and health insurance for those 65 and older. Medicaid, funded jointly by the federal and state governments, but administered by the states, provides health insurance on a means-tested basis for qualifying individuals who cannot afford medical care. Today, it is the funding mechanism for most of the public mental health care in the nation. The federal to state payment rate varies with each state reimbursed based upon the per capita income of the state. The federal government requires a lower matching rate from less wealthy states. The states determine what federally approved services they will provide, the eligibility rules, and they set the payment rates that providers will receive for the services provided. SSI, also a means-tested program, funded by federal general tax revenue, provides limited income support for the aged and disabled who cannot work. Medicare provides only limited care (190 lifetime days) in an inpatient psychiatric hospital, but it will pay for 100 days of skilled-nursing care for each occurrence of mental or physical illness. Medicaid does not cover care in an inpatient psychiatric hospital for adults 22 through 64,

but it does fund care in a nursing home for anyone meeting the eligibility criteria. SSI provides limited support for the blind, disabled, or aged poor.[24]

Federal Medicaid funding for CMHCs only began after 1981, and only in those states that had added Medicaid plans that included several optional services such as case management services, rehabilitation services, and clinic options that provided funding for community-based services.[25] States could fund their portion of these optional services by increasing state appropriations or by transferring funding from existing "fully funded state or local programs" to the newly approved optional programs that were then funded jointly by the federal and state governments.[26] The Texas Legislature, before 1986, had not approved any of the eight Medicaid options that could support outpatient mental health services, and it was the "only state of the ten largest that did not participate in any of these [eight] Medicaid plan amendments" at that time.[27] However, by 1990, the Texas Legislature had approved the acceptance of Medicaid plan amendments for the services

[24] William Gronfein, "Incentives and Intentions in Mental Health Policy: A Comparison of the Medicaid and Community Mental Health Programs," *Journal of Health and Social Behavior* 26, no. 3, (September 1985): 200. "Supplemental Security Income," *Wikipedia*, https://en.wikipedia.org/wiki/Supplemental_Security_Income. Accessed March 16, 2018.

[25] While mental illness alone does not qualify individuals to receive Medicaid, the majority of those with an SMI begin receiving Medicaid when they qualify for federal Supplementary Security Income (SSI) cash assistance based upon their disability, which prohibits them from gainful employment. SSI began in 1974, and individuals receiving Medicaid qualify automatically for it. It was not until 1981 that Congress passed legislation authorizing the states to use Medicaid funding "to provide home and community-based services to people who would otherwise qualify for institutional care." Diane Rowland, Rachel Garfield, and Risa Elias, "Accomplishments and Challenges in Medicaid Mental Health," *Health Affairs* 22, no. 5 (September/October 2003): 77, 79.

[26] Rebecca Tarkington Craig and Barbara Wright, *Mental Health Financing and Programming: A Legislator's Guide* (Denver: National Conference of State Legislatures, 1988): 86-87.

[27] *Financing Community Care for the Chronically Mentally Ill in Texas* (Austin: Lyndon B. Johnson School of Public Affairs Policy Research Project Report Number 89, 1990): 333-334.

of psychologists supervised by a physician, drugs, targeted case management, and rehabilitation.[28] Texas has had limited expansion in the number of services since 1990.[29]

Medicare and Medicaid led to a significant expansion in the growth of nursing homes. These federal acts provided nursing home operators with low-interest loans to get them started in the business. They subsidized the cost of care that "sharply stimulated demand for nursing home services." The number of nursing homes in the United States increased from 16,701 in 1963 to 22,558 in 1971. The number of nursing home beds, however, more than doubled over the same period from 568,560 to 1,234,405. Overall, the nation's expenditures for nursing home care increased from $500 million in 1960 to $7.5 billion in 1974.[30] The United States Senate Subcommittee on Long-Term Care concluded in 1976, "Cost Savings … is undoubtedly the primary reason for [the] removal of thousands of patients from State hospitals into nursing homes and other facilities." The subcommittee noted that states averaged spending $12,000 a year from state budgets to care for each person in a state hospital bed.[31] If states discharged a patient and enrolled them into Medicaid, the state at most spent only half of the cost of a nursing home bed. From 1969 to 1974, the total number of inpatients in state hospitals dropped from 427,799 to 237,691. In Texas, the total number of inpatients dropped from 14,253 in 1969 to 8,588 in 1974.[32] A study focused on Texas found that from 1968 to 1978, the

[28] Ibid: 299.

[29] See *Behavioral Health and Case Management Services Handbook* (July 2019) for the current services covered by Medicaid. Accessed July 24, 2019, http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Behavioral_Health.pdf

[30] Financing Community Care: 200.

[31] U. S. Senate Subcommittee on Long-Term Care of the Special Committee on Aging United States Senate, "*Nursing Home Care in the United States: Failure in Public Policy*-- Supporting Paper No. 7-- *The Role of Nursing Homes in Caring for Discharged Mental Patients (And The Birth of a For-Profit Boarding Home Industry,* March 1976, 94th Cong., 2d Sess.,: 723.

[32] Ibid: 719.

number of state hospital inpatients decreased from 15,035 to 5,260. Though the process started shortly after 1965, from 1971 to 1977, over 5,000 patients went directly from the state hospitals to nursing homes.[33] A study in 1980 showed that those moved to "the nursing homes were receiving significantly fewer services that those [who remained] in the state hospitals."[34]

The U. S. Senate Subcommittee on Long Term Care also noted another way states could save money. "If the State release[d] the patients unconditionally and maintain[ed] the fiction that they [were] simply indigent elderly, the federal government [would] pay 100 percent of the cost through the new Supplementary Security Income (SSI) program."[35] SSI provided $157 a month to a blind, disabled, or elderly poor individuals. The payment would reduce by a third if the person lived with a relative, thus dis-incentivizing that arrangement. This payment gave rise instead to the "for-profit board home industry" that provided no medical services. States discharged thousands of patients from their hospitals, signed them up for SSI, and placed them in boarding homes that typically "offer[ed] nothing more than board and room" and charge[d] the amount of the SSI payment.[36] "Good food, good care, recreation and habilitative services [were] virtually nonexistent in many boarding homes. …Unlicensed and unregulated old hotels and boarding homes … [became] the depositories of so many mentally impaired aged."[37] In the nation from 1969 to 1974, the total number of inpatients over age 65 in state

[33] Nancy D. Dittmar and Jack L. Franklin, "State Hospital Patients Discharged to Nursing Homes: Are Hospitals Dumping Their Patients?" *Hospital and Community Psychiatry* 31 (April 1980): 251.

[34] Nancy D. Dittmar and Jack L. Franklin, "State Hospital Patients Discharged to Nursing Home: How are They Doing?" *Hospital and Community Psychiatry* 31 no. 4, (April 1980): 258.

[35] U. S. Senate Subcommittee on Long-Term Care: 724.

[36] Ibid: 725.

[37] Ibid: 726.

mental hospitals dropped from 135,322 to 59,685. In the Texas public psychiatric hospitals, the number of inpatients over age 65 decreased from 5,464 to 1,447 between 1969 and 1974.[38] The Subcommittee concluded, "Many factors come together to force the mentally impaired out of State hospitals into nursing homes, boarding homes, old hotels—and sometimes into the streets. The desire to save State dollars [was] clearly the most important reason."[39] The Subcommittee's lumping licensed and medically staffed nursing homes in with unregulated boarding homes, old hotels that offered single room occupancy, and the street, fails to recognize that the nursing homes at least provided some medical treatment. The others provided only a place to live and food, with virtually no oversight or care. They, of course, were better than the streets, which offered perhaps a sense of "freedom," but nothing in the way of housing, support, care, or treatment.

How Federal Court Decisions in the 1960s and 1970s Dramatically Changed the Treatment of those with an SMI

Paralleling in time and purpose, the federal courts joined the deinstitutionalization movement with several decisions that significantly reduced and changed placement alternatives for those with an SMI. Historically, the various states' commitment laws had given broad discretion to mental health professionals to make decisions concerning the commitment and discharge of individuals in public psychiatric hospitals. However, as the antipsychiatry movement began to question whether a mental disorder was a medical illness, that wholesale discretion to the professionals came into question.[40] The civil rights movement also led to calls for change as "advocates for the

[38] Ibid: 719

[39] Ibid: 726.

[40] Murray Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press, 1981), 106. Thomas Szasz's *Myth of Mental Illness* (1961), *Law, Liberty and Psychiatry*

mentally ill viewed institutionalized care not as an asylum to protect the mentally ill, but as an intrusion on the liberty and autonomy of the mentally ill."[41] Commitment of the mentally ill became an emotionally charged issue, with many seeing it as putting people away who were not sick but merely different from others.

In 1967, California became the first state to change significantly the laws governing legal commitment for mental illness with the passage of the Lanterman-Petris-Short Act. The act set specific requirements for legal notice, representation, lengths of time for evaluation and treatment, and it explicitly stated that the mentally ill individual did not lose legal rights because of his/her illness. The law allowed a person's loss of liberty temporarily only if he or she posed a danger to someone else or to himself or herself. It mandated treatment in the community with institutional care only for evaluation and intensive treatment with specific time limits on the treatment and required ongoing judicial review.[42]

In 1972, the federal district court of Eastern Wisconsin found in *Lessard v. Schmidt*, that the state had violated federal law when it took away the freedom of Alberta Lessard whom two police officers had taken into custody and filed an order for her emergency detention. She received no notice of hearings and had no access to counsel as the doctors filed additional emergency detention orders and determined that she had schizophrenia and recommended "permanent commitment." Ms. Lessard, through her

(1963), and *Manufacture of Madness* were strong attacks on mental hospitals and psychiatry, and the latter was cited in the Supreme Court decision *O'Connor v. Donaldson* (1975).

[41] Bernard E. Harcourt, "Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s," *Ohio State Journal of Criminal Law* 9, no. 1 (Fall 2011): 70.

[42]. The Lanterman-Petris-Short Act [5000-5500] Welfare and Institutions Code-Wic, Division 5. Community Mental Health Services, Part 1, "*California Legislative Information* (Accessed November 1, 2018).
http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=1.&chapter=1.&article=.

efforts, was able to obtain legal counsel from Milwaukee Legal Services. She filed suit on behalf of herself and other adults detained without the benefit of a hearing to determine the "necessity of detention." Her legal counsel argued that the state's ability to hold her for a maximum of 145 days without a public hearing, its failure to provide adequate and timely notice, and its failure to provide the mandatory notification of the right to a trial by a jury violated her legal rights. The court found that the civil commitment procedures of Wisconsin were "constitutionally defective." It ordered new systems put in place, guaranteeing the legal rights of the individuals. It also required the review of all cases of those committed under the old process within 90 days using the new procedures. Moreover, it ordered that those improperly committed, based on the new procedures, be released, and it required the state to aid the reentry of those individuals into society.[43]

Both of these actions restricted the power of the states to commit persons involuntarily to a mental hospital. Following California's lead, "the majority of states legislatively reformed commitment laws." After *Lessard*, many other court cases "found state commitment laws unconstitutional and applied stringent substantive and procedural due process protections to the involuntary commitment process."[44] Changes in the 1950s with new medications and more open hospital settings had allowed the release of chronic patients over time and the earlier release of new patients, thus increasing those exiting the hospitals. These actions on changing the commitment laws led to closing the entrance to

[43] 349 F. Supp. 1078 – Dist. Court, ED Wisconsin 1972, Alberta Lessard et al., Plaintiffs, Wilbur Schmidt et al., Defendants Civ. A. No. 71-C-602, United States District Court, E. D. Wisconsin, October 18, 1972, accessed November 1, 2018, https://scholar.google.com/scholar_case?case=16374362071956566586&hl=en&as_sdt=6&as_vis=1&oi=scholarr.

[44] Stephen J. Morse, "A Preference for Liberty: The Case against Involuntary Commitment of the Mentally Disordered," *California Law Review* 70, no. 1 (January 1982): 54-55.

the hospitals as states dramatically changed the criteria for the admission of new patients into their state hospitals. California and other states' legislative actions and subsequent federal court decisions led to "the rapid phase-down of state institutions."[45] It is essential to recognize that the new commitment laws did rectify a system that had ignored the legal rights of individuals and institutionalized persons who did not require that level of care. However, with the new procedures, the states gained the ability to deny services to the mentally ill that they could not do before. They no longer had to provide services to persons unless they were a specific danger to themselves or others. This change, however, left out those suffering from an SMI who were not dangerous, but whose illness prevented them from receiving the care they needed to sustain themselves. The impoverished among these individuals and those without families to support them suffered the most.

The states went along readily to decrease hospital admissions as the promoters of civil liberties pushed for changes in the commitment laws. Fiscal conservatives also supported the new laws as they had seen the admission rates of state hospitals increase by 52 percent from 1955 to 1972, and they foresaw "the looming inevitability of large-scale capital construction costs for new institutions to house the growing number of inpatients."[46] For the states

> the cost of overhauling buildings and providing programs for institutions which had been underfinanced for 50 years would be immense. At a time when state budgets were tightly squeezed and increased taxation was politically unpalatable,

[45] Joseph P. Morrissey, "Deinstitutionalizing the Mentally Ill: Process, Outcomes, and New Directions" in *Deviance and Mental Illness,* ed. Walter R. Gove (Beverly Hills: Sage Publications, 1982): 153, 157.

[46] Stephen M. Rose, "Deciphering Deinstitutionalization: Complexities in Policy and Program Analysis," *Milbank Memorial Fund Quarterly. Health and Society* 57, no. 4 (Autumn 1979): 435.

> the millions of dollars necessary for improved psychiatric services to the chronically mentally ill and retarded were simply unavailable.[47]

The *Lessard* ruling set the federal standard for the commitment of an individual by a state to a mental hospital. The new standard became "'imminent danger to one self or others' based upon some 'recent overt act, attempt or threat to do substantial harm to one's self or others.'"[48] It also required "that the state must prove beyond a reasonable doubt all facts necessary to show that an individual is mentally ill and dangerous."[49] In 1979, the Supreme Court of the United States altered the last criteria in *Addington v. Texas*. The Texas State Appeals Court had ruled that the standard in civil commitment proceedings should be "beyond a reasonable doubt" as set in *Lessard* and invalidated the ruling by the district court that the determination should be based upon "clear, unequivocal and convincing evidence." The Texas Supreme Court ruled that neither standard was appropriate for a civil commitment case, calling instead for one typically used in civil matters of "the preponderance of the evidence." The U.S. Supreme Court, however, noted, "The uncertainties of psychiatric diagnosis … may impose a burden the state cannot meet, and thereby erect an unreasonable barrier to needed medical treatment." They changed the standard to "clear and convincing" evidence.[50] This standard kept the burden of proof higher than required in civil cases, but lower than that required in criminal cases.

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[47] Robert Reich and Lloyd Siegel, "Psychiatry under Siege: The Chronically Mentally Ill Shuffle to Oblivion," *Psychiatric Annals* 3, no. 11 (November 1973): 38-39.

[48] Levine: 123.

[49] Ibid: 123.

[50] Addington v. Texas, 441 U.S. 418 (1979), accessed January 25, 2018, https://supreme.justia.com/cases/federal/us/441/418/case.html.

The federal courts identified other civil rights that further curtailed the availability of resources for those with an SMI. *Lake* v. *Cameron* in 1966, *Covington v. Harris* in 1969, and *Welsch v. Likins* in 1974 established the right for placement of committed individuals to the least restrictive alternative.[51] *Rouse v. Cameron* in 1966 found that a publicly committed patient had a right to treatment "appropriate to their individual needs." The ruling, technically based upon a District of Columbia law, did not establish a federal constitutional precedent. A federal district court in Alabama in *Wyatt v. Stickney* in 1972, however, did create the precedent stating that anyone committed involuntarily to a state institution had a constitutional right to treatment.[52] The court found that patients in two Alabama state hospitals were not receiving the minimum care needed and gave the state six months to correct the problems. When the state did not make the corrections to the judge's satisfaction, he sought expert testimony from several national groups.[53] From that testimony and precedents established in other court decisions, a set of standards "to achieve a humane psychological and physical environment" was created. These standards became the criteria by which other states, including Texas, had to improve the treatment conditions within their state hospitals.[54] Rather than allocating significant new funding to provide the treatment specified in court rulings, many states, including Texas, chose to promote the discharge of patients into the community.

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[51] *Lake v. Cameron*, 364 F. 2d 657 - Court of Appeals, Dist. of Columbia Circuit 1966, accessed January 29, 2018, https://law.justia.com/cases/federal/district-courts/FSupp/267/155/1895865/. 419 F. 2d 617 - *Covington v. W Harris*, accessed January 29, 2018, https://openjurist.org/419/f2d/617/covington-v-w-harris. *Welsch v. Likins* No. 4-72-Civ. 451, 73 F. Supp. 487 (1974, accessed January 29, 2018, https://www.leagle.com/decision/1974860373fsupp4871790.xml.

[52] *Wyatt v. Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971). Accessed January 25, 2018, https://www.leagle.com/decision/19711106325fsupp7811948.xml.

[53] Levine: 131. The experts represented the APA, the American Civil Liberties Union, the American Association on Mental Deficiency, and the American Orthopsychiatric Association.

[54] Levine: 131-134.

Another right upheld by the courts was the right to refuse treatment in many instances. In *Rennie v. Klein* (1983), John Rennie, an inpatient in a state psychiatric hospital in New Jersey, had varying diagnoses of paranoid schizophrenia and manic-depression. As his illness progressed, "he became increasingly abusive and assaultive." As he became homicidal and his condition deteriorated, he received an injectable psychotropic drug, and "his condition improved markedly." Rennie, however, sued in Federal district court to keep the hospital from administering any psychotropic drugs to him except in an emergency. After a lengthy trial in which the judge overruled the medical decisions of the psychiatrists and a procedure developed by the state to ensure the medical review by other psychiatrists when involuntary patients refused to take medications, the appeals court ordered the district court to accept the state's new policies. Essentially the decision ruled that involuntarily committed persons had a right to refuse specific treatments, but that "professional judgment" by medical providers could override the refusal if the circumstances presented a danger for the individual or others. It noted, however, that the decision to override was valid only as long as it was not a "substantial departure from accepted professional judgment, practice, or standards."[55]

Citing the "drastic reduction" in "the number of civilly committed patients" in state hospitals, Alan A. Stone M.D. (b. 1929), an emeritus professor of law and psychiatry at Harvard and former president of the APA, challenged the use of criminal court procedures and requirements in the civil courts. He argued that the decision in the

[55] *Rennie v. Klein, 462 F. Supp. 1131(D.N.J. 1978), suppl., 476 F. Supp. 1294 (D.N.J. 1979), modified, 653 F.2d 836 (3d Cir. 1981), vacated and remanded, 458 U.S. 1119(1982), on remand, 720 F.2d 266 (3d Cir.1983).* Accessed November 1, 2018, https://mentalillnesspolicy.org/legal/refuse-medication-rennie-klein.html. U.S. Court of Appeals for the Third Circuit - 720 F.2d 266 (3d Cir. 1983**)**, accessed November 1, 2018, https://law.justia.com/cases/federal/appellate-courts/F2/720/266/425748/.

courts are not over innocence or guilt, but over illness and the medical needs of patients. Writing specifically about the right to treatment, but with a statement that covers the impact of changing commitment laws and mandating the least restrictive placement, he noted in 1977,

> These lawsuits have hastened the precipitous discharge of thousands of patients from hospitals across the country. This process of rapid deinstitutionalization has occurred without provision of adequate aftercare or alternative treatment facilities.
>
> The inescapable problem is that legally the right to treatment exists only when the state assumes responsibility for confining the patient. Thus the state can control the escalating costs of providing the right of treatment by rejecting the responsibility of confining patients.[56]

Deinstitutionalization's Impact on Those Suffering from an SMI

Murray Levine (b. 1928), professor of psychology at the State University of New York–Buffalo, stated, "The theory behind the Kennedy legislation was that resources would follow the patients to provide community-based services. Instead, some states discharged patients to local communities in the hopes that necessity would become the mother of invention and local resources would be found."[57] The new local community centers did not provide services for patients with an SMI leaving the hospital because they had no incentive to do so. "Their charge was to provide community-based services, and in the absence of particular benefits to be derived from the treatment of the more difficult and expensive-to-care-for chronic patient," they saw nothing to be gained by serving them.[58] The CMHCs mostly served a new population of the non-hospitalized mentally ill, individuals suffering from milder forms of mental illness that do not involve

[56] Alan A. Stone, "Recent Mental Health Litigation: A Critical Perspective," *American Journal of Psychiatry* 134, no. 3 (March 1977): 276.

[57] Levine: 84.

[58] William Gronfein, September 1985: 199.

a loss of touch with reality nor involved an organic disease. A study by the NIMH in 1974 found that only 29,300 of the 780,400 admissions to CMHC care that year came as referrals from public hospitals.[59] A survey in 1972 found that CMHCs ranked "the goal of decreasing state mental hospital utilization … next to last" among their priorities.[60] The state hospital census fell by 65 percent from a high of 559,000 in 1955 to 193,000 in 1975.[61] In examining the fate of patients leaving state hospitals in 1979, Stephen M. Rose, Ph.D., a professor of social work, noted

> the apparent failure of deinstitutionalization policies to provide even minimally adequate aftercare and community support services anywhere in the nation. … Evidence indicates that the new policy has brought … gross inadequacies in community resources for aftercare and rehabilitation; large-scale scandal, exploitation, and abuse in the new industry of operating community facilities; increased drug and alcohol dependency among released patients; and an apparent social and psychological decay among patients released into nursing homes, adult homes, or "welfare hotels."[62]

In reality, many of those discharged had nowhere to go. Rose quotes C.J. Hynes' New York Deputy General's Report from 1977: "The discharge of mental patients from psychiatric hospitals without insuring the delivery of aftercare services makes deinstitutionalization a procedure for patient abandonment, rather than a progressive program of patient care."[63]

The Federal Government Stepped Aside

[59] Report to the Congress by the Comptroller General of the United States, Returning the Mentally Disabled to the Community: Government Needs to Do More, HRD-76-152, 1977: 69.

[60] Ibid: 72

[61] Ellen L. Bassuk and Samuel Gerson, "Deinstitutionalization and Mental Health Services," *Scientific American* 238, no. 2 (February 1978): 49.

[62] Rose: 440.

[63] Ibid: 440-441. Quoted from C. J. Hynes, *Private Proprietary Homes for Adults: An Interim Report* (New York: New York Deputy Attorney General's Office, 1977), 41.

Federal court decisions brought dramatic change to the treatment of those with an SMI from the mid-1960s to the early 1980s. By the 1980s, Barbara R. Grumet, law professor and dean at Russell Sage College, notes that the U.S. Supreme Court had "effectively closed the federal courts as a forum for advancing the rights of the mentally disabled." Since that time, the federal courts have deferred to the state courts' decisions related to mental disability based upon state laws.[64] Each state determines its mental health policies, and the federal courts no longer serve as the mechanism for weighing the rights of and services provided to those with an SMI. Just as the Reagan presidency and the election of a more conservative Congress in 1981 altered federal community mental health funding, the federal courts have deferred to the state courts. They are no longer finding new rights and issues related to the mentally ill. Despite a fast-growing population, the numbers of public beds for the mentally ill have continued to decline or remain static across the nation, including Texas, where the number of available beds has remained constant since 1990 substantially maintaining the deinstitutionalization focus from the 1960s and 1970s.

American historian John Ehrman, who writes about the conservative movement in America, states that the age of Reagan replaced the era of Franklin D. Roosevelt (FDR) after what Ehrman believed were the failures of government in the late 1960s and 1970s. Reagan's conservative proposals of turning to the private sector and cutting taxes caught the attention of the middle class and professionals.[65] Sean Wilentz, professor of history at Princeton University, agrees with Ehrman that in the 1980s, with the decline of the

[64] Barbara R. Grumet, "The Changing Role of the Federal and State Courts in Safeguarding the Rights of the Mentally Disabled," *Publius* 15, no. 3 (Summer 1985): 67, 77-78.

[65] John Ehrman, *The Eighties: America in the Age of Reagan* (New Haven: Yale University Press, 2006).

Democrats and liberalism, the nation turned to the conservatism espoused by Ronald Reagan who, like FDR before him, put his name on a new political direction that would extend far beyond his presidency.[66] His new direction reduced federal expenditures, particularly in what his conservative base saw as liberal social service programs.

Political scientist Mark A. Smith of the University of Washington notes that since the mid-1970s, Reagan and the Republicans have succeeded in changing the political discourse in the nation from the "Great Society" to the "Economic Society." The attention of the Economic Society is on becoming more fiscally responsible, cutting taxes, and reducing the nation's deficit while maintaining policies that favor business. They have also coined the inherently negative term "entitlements" to refer to any federally funded means-tested program, even including Social Security, for which the individual has been paying his or her whole working life. Rather than working to improve the circumstances of those left out in the growing economy, the Democrats have accepted the Republican's premise. Instead of arguing for the nation to provide more funding and policies to improve health care and expand the resources for other needs, they have accepted the premise of the shrinking pie by cutting taxes and fiscal restraint.[67]

This conservative movement by the federal government has focused on limiting and challenging the federal funding of Medicare, Medicaid, and (SSI) instead of increasing the resources needed for publicly funded mental health care in the nation. Gerald N. Grob and Howard H. Goldman, M.D., the latter, a professor of psychiatry at the University of Maryland, identify this change as going from "radical reform" to

[66] Sean Wilentz, *The Age of Reagan: A History, 1974-2008* (New York: HarperCollins, 2008).

[67] Mark A. Smith, *The Right Talk: How Conservatives Transformed the Great Society into the Economic Society* (Princeton: Princeton University Press, 2007).

"incremental change." Federal mental health policy improvements have only occurred "within the realities of an essentially conservative political process" since the era of radical reform.[68] One must note that the era of radical reform was a time of drastic change in the treatment of mental illness. Reform implies an improvement in a system. However, in reality, there was never enough funding to improve public psychiatric hospitals nor to create the programs needed by the mentally ill in the community. The system worsened radically with deinstitutionalization, leaving hundreds of thousands of individuals without adequate services.

Changes in Psychiatry Affected the Treatment of Those with Serious Mental Illness

While legislation in the 1960s prompted significant changes in the location of treatment, change also came in the understanding of diagnosis and treatment of mental illness itself. Historian Lawrence J. Friedman chronicled the leadership role that William Menninger, M.D. (1899-1966) played in making psychoanalysis a significant means of treatment in the United States during and following World War II. He also played a key role in the development of the first Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association based, to a significant extent, on psychoanalytic thinking.[69] From its adoption in 1952 and revision in 1968, DSM-I and DSM-II used psychoanalytic terminology as the basis for the diagnosis of mental illness. While not all psychiatrists or mental illness treatment professionals were psychoanalysts, the DSM's language and psychoanalytic views served as the standard means of

[68] Grob and Goldman: 181.
[69] Lawrence J. Friedman*, Menninger, The Family and the Clinic*, (New York: Alfred A. Knopf, 1990).

understanding that formed an increased emphasis on community psychiatry and away from institutional care.

Even during its popularity, questions about the effectiveness of psychoanalysis began with a review of several studies by Hans Eysenck (1916-1997) in 1952. He compared the recovery rates of individuals with neuroses (not severe mental illnesses), who did not receive psychoanalysis or any psychotherapy, with those who did. His work revealed that "roughly two-thirds of a group of neurotic patients [would] recover or improve to a marked extent within about two years of the onset of their illness, whether they [were] treated using psychotherapy or not."[70] Even though questions arose about its effectiveness, psychoanalysis' dominance of psychiatry continued as the basis of the diagnoses in the DSM system until a key study published in 1973.

D. L. Rosenhan (1929-2012), a psychologist and a lawyer, experimented by having eight individuals with no history of mental illness attempt to gain acceptance to different psychiatric hospitals, claiming they had heard voices but displaying no other symptoms. All gained admission with a diagnosis of either schizophrenia or manic depression.[71] The report of this study, though from a seemingly small basis, appeared in *Science*, a publication that gave it considerable influence. It became the latest of a growing number of criticisms of psychiatry from the antipsychiatry movement. Shortly

[70]Hans Eysenck, "The Effectiveness of Psychotherapy: An Evaluation," *Journal of Consulting Psychology* 16, no. 5, (October 1952): 322. It is important to note that the study was with neurotic patients and not psychotic patients suffering from severe mental illness. Sigmund Freud, the founder of psychoanalysis, never used nor advocated the use of that treatment with patients with an SMI.

[71] D. L. Rosenhan, "On Being Sane in Insane Places," *Science* 179, no. 4070 (January 19, 1973): 250-258.

after it appeared, the Board of Directors of the American Psychiatric Association (APA) met and decided to revise DSM II, then only in existence for five years.[72]

Historian Hannah Decker chronicles the political struggle within the APA led by Robert Spitzer M.D. (1932-2015) to move away from the dominance of psychoanalytic theory in the development of DSM III, the third edition of the diagnostic manual. The new manual, which based diagnosis on behavioral observation instead of theory, returned the diagnosis of mental illness to the thinking of Emil Kraepelin, M.D. (1856-1926). Kraepelin's pioneering work in the diagnosis of dementia praecox (schizophrenia) and manic-depressive psychosis (bipolar disorder) a century before had placed it more clearly within the empirical medical community versus the theoretical psychological sphere.[73] In the years since the publication of the DSM-III, two new editions continue the focus away from that of psychoanalytic theory to specific behaviors and symptoms. This understanding provides a clearer framework for diagnosis and treatment strategies but no better understanding of the etiology of mental illness.

Nancy C. Andreasen's, M.D. (b. 1938) *The Broken Brain* (1984) and *Brave New Brain* (2001) show the dramatic change that has occurred in psychiatry in the last few decades.[74] Andreasen was a member of the DSM-III Task Force of the APA, and she championed the anti-psychoanalytic approach. She is an empirical psychiatrist with a specialization in schizophrenia. She notes that today, psychiatrists primarily diagnose mental illness and prescribe medications that influence the brain's functioning to bring

[72] Hannah S. Decker, *The Making of DSM-III: a Diagnostic Manual's Conquest of American Psychiatry*, (Oxford: Oxford University Press, 2013): 141.

[73] Ibid: 53-55, 98-104.

[74] Nancy C. Andreasen, *The Broken Brain: The Biological Revolution in Psychiatry*, (New York: Harper & Row, 1984). Nancy C. Andreasen, *Brave New Brain: Conquering Mental Illness in the Era of the Genome*, (Oxford: Oxford University Press, 2001).

relief of the symptoms and to allow the mentally ill to live healthier lives. Psychiatry is also engaged in ongoing research to find new answers and solutions regarding mental illness based upon studies of genetics and biology and their potential role in treating mental illnesses. The treatment of mental illness today relies on medication and, at times, short-term or long-term psychotherapy, including cognitive-behavioral therapy, which helps individuals better understand their illness and develop coping strategies for dealing with it.

While Andreasen was a significant player in the creation of the DSM-III, she admits that the group's actions had unintended consequences. The work was not a "comprehensive description" of a specific illness. Still, it has become the primary training and diagnostic tool for all mental health clinicians leading to many of them not being aware of "other potentially important or interesting signs and symptoms that are not included in the DSM." She sees the DSM has having a "dehumanizing impact on the practice of psychiatry," where it has become a "checklist." It "discourages clinicians from getting to know the patient as a person because of its dryly empirical approach."[75] Most psychiatrists no longer provide psychotherapy to their patients. Instead, individuals receive it from social workers, psychologists, or other therapists trained to provide the therapy. Significant problems can arise for individuals when there is a lack of coordination between the psychiatrist prescribing medications and the therapist providing the treatment. One of the significant shortcomings of today's treatment for persons with an SMI is that they may need far more than medications and short-term psychotherapy, which is often all that is available to them.

[75] Nancy C. Andreasen, "DSM and the Death of Phenomenology in America: An Example of Unintended Consequences," *Schizophrenia Bulletin* 33 no. 1, (2007): 111

Funding Changes Dramatically Affect the Treatment of those with an SMI

A critical component in the treatment of severe mental illness is funding. David Mechanic (b. 1936), a sociologist and director of the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, points out that the treatment of mental illness is quite different from physical illness in the United States. Since the 1980s, private insurance companies most often contract with Managed Behavioral Healthcare Organizations (MBHOs) to provide treatment of mental illness for those in their plans. Through "carving out" mental health from other health care, the MBHOs receive a fixed sum for every person in the plan and assemble a controlled and limited network of providers to deliver services. For the purchasing entity, usually the employers through their contracted insurance provider, the MBHOs provide a means of controlling costs—but at a potential cost to the mentally ill by limiting available service providers and closely monitoring, managing, and limiting the services provided. This system does not ensure the adequacy of the treatment, particularly for those suffering from severe mental illness.[76]

Adequate treatment of severe mental illness requires extensive and ongoing services, and MBHOs have little incentive (or resources) to provide that kind of treatment because doing so cuts into profit margins. The MBHOs claim that mental illness requires a much higher degree of specialization of providers. They dramatically reduce the number of providers available to individuals and closely monitor the provision of care. These systems also incentivize high-volume practices. In these, there is corner-cutting,

[76] David Mechanic, *Mental Health and Social Policy: Beyond Managed Care*, 5th ed. (Chicago: The University of Chicago Press, 2008): 152-158.

such as not having full-time psychiatrists or psychologists on staff, but instead brought in once a week or once a month to sign off on the work of lower-paid allied health professionals (still maintaining state compliance standards). Their purpose is to reduce costs, not improve services. Several states use MBHOs to manage their Medicaid population with SMIs. Often in this arrangement, the contract calls for the MBHO to manage the care, but the financial risk may be shared with the state, meaning that if the cost reaches a certain point, the patient may move to the state system or the state may pay more for the services needed. In a system driven by controlling the state and MBHO expenditures, the focus is not on the optimal care of the severely mentally ill person.[77]

In Texas, MBHOs manage virtually all of the private insurance markets, and managed care organizations (MCOs) oversee almost all of Medicaid funded resources for both physical and mental health. On the back of all private insurance cards, one finds a separate number to call for behavioral healthcare, which is another name for mental healthcare with the addition of substance abuse treatment. That number is to the MBHO managing that carved out portion of care. Those in the public system receive services in several different ways. Local mental health authorities (LMHAs), which are the state-funded and locally-led community mental health centers, are the state's primary service delivery system for those with SMI. They receive funding from the state and provide services with funding from Medicaid via contracts with MCOs. Medicaid is the largest funder of mental health care in the state through MCO contracts and Federally Qualified

[77] Mechanic: 173-174.

Health Care providers. Publically funded hospital districts in the larger communities also provide services for the uninsured. [78]

David Mechanic, in *The Truth about Health Care* (2006), focuses on the failure of the nation to serve the severely mentally ill effectively. He argues that we lost sight of the most seriously impaired "when psychodynamic therapies dominated and interest and resources were directed commonly to those who were less sick and, in the view of therapists, more attractive and compatible clients."[79] To Mechanic, "the criminalization of the mentally ill represents perhaps the greatest scandal of our health care system, and a situation that should embarrass all thoughtful citizens."[80] As a nation, our failure to treat the mentally ill properly did not deinstitutionalize the mentally ill; it substituted prisons and jails for state hospitals. It also gave each of those housed therein a criminal record and provided a woefully inappropriate environment to treat their illness. Mechanic states that he fears that as the scope of mental health continues to expand, "we will neglect even more of those who should be our primary charge."[81] His statement betrays the ultimate truth that our nation treats mental illness differently from other diseases. We never suggest limiting the treatment of cancer, heart disease, or any other major physical illness because we provide care to a growing number of less severe illnesses. Yet as diagnoses

[78] "Review of Harris County Mental Health Systems Performance—Final Report," Texas State of Mind—The Meadows Mental Health Policy Institute for Texas, May 2015: 9, Accessed June 12, 2016, https://www.texasstateofmind.org/wp-content/uploads/2016/02/1-Review-of-Harris-County-Mental-Health-Systems-Performance.pdf.

[79] David Mechanic, *The Truth about Health Care: Why Reform is not working in America*, (New Brunswick: Rutgers University Press, 2006): 83.
Several factors led to the nation losing sight of the most seriously impaired. Psychodynamic therapies, as noted by Mechanic do not apply to the SMI. Some relevant factors, however, include: the growing backlash to the state mental hospitals following WWII, the rising antipsychiatry movement, and the search by psychiatry itself to stand against these forces all contributed to the nation's betrayal of the SMI.

[80] Ibid. 80.

[81] Ibid: 83.

for mental illnesses have expanded at lesser levels, we have dramatically reduced services for the SMI.

Richard G. Frank, professor of health economics at Harvard Medical School, and Sherry A. Glied, professor of Health Policy and Management at Columbia University (b. 1961), in *Better but Not Well* (2006) point to changes in mental health care policy as the most critical factor in providing services to the mentally ill. They note that the nation has changed "from a centralized planned activity run by the states to a pluralistic, market-oriented system of care." This transformation has meant moving from "bureaucratic failures and tight budgets" for services to the severely mentally ill to one in which more funds are spent on mental illness. However, it has created a "decentralized system of care that suffers from market failure and allows some people with significant impairments to fall through the cracks."[82] Essentially, funds and treatment are more readily available for the less seriously ill, while those with a chronic, severe mental illness do not receive the level of services they need. Adequately funded resources for the SMI have never been plentiful in our nation. State hospitals depended upon the whims of the political systems in each of the states. Today, as states have abandoned their previous commitment to caring for the SMI, they rely upon a healthcare marketplace not designed to serve individuals who have severe mental impairments. These individuals' illness leads them to stop taking their medications, to live in unsafe and unhealthy situations, and to lack the ability to access health care as others do.

Those with an SMI Have Few Places to Turn for Help

[82] Richard G. Frank and Sherry A. Glied, *Better But Not Well: Mental Health Policy in the United States since 1950*, (Baltimore: The Johns Hopkins University Press, 2006): 69.

With state hospital beds reduced from 550,000 in 1955 to 37,478 beds in 2016,[83] and perhaps less today, to serve a national population base that has virtually doubled from 166 million to 323 million over the same period, there are few resources available to provide for those who need institutional care. Funding from private insurance or Medicaid essentially provides only a few days of care in a psychiatric hospital or a general hospital psychiatric ward. Such care cannot deliver the extensive services that many of those with an SMI need. While the number of CMHCs in the nation has grown to 2,538 today, their funding comes from a variety of sources, including Medicaid, Medicare, private insurance, and state and local public funding.[84] They primarily provide medication and therapy, but offer little housing and additional support needed by those with an SMI. In Harris County, Texas, several different groups provide community mental health services to those with an SMI in the county. The county CMHC, with several locations, serves 16,000 individuals annually. Harris Health, the public hospital district, offers mental health services through its specialty clinics. Twelve federally qualified health centers and three managed care networks bring the total served to approximately 65,000 (about 75%) of those in poverty who have severe needs. While these agencies serve 75 percent of the legally mandated individuals in the county, a

[83] Services Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2016 Data on Mental Health Treatment Facilities*, BHSIS Series-98, HHS Publication No. (SMA) 17-5049: Substance Abuse and Mental Health Services Administration, 2017, accessed on March 15, 2018. https://www.samhsa.gov/data/sites/default/files/2016_National_Mental_Health_Services_Survey.pdf

[84] Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2017. Data on Mental Health Treatment Facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. Accessed November 2, 2018, https://wwwdasis.samhsa.gov/dasis2/nmhss/2017_nmhss_rpt.pdf.

recent study found the services provided were woefully inadequate for their needs.[85] Today, individuals suffering from an SMI are far more likely to find themselves in prison or jail, for that is the only place they can be "committed" for long-term removal from society or receive any care. Their crime is doing something against the law that is beyond their power to control. Though they may receive mental health treatment while incarcerated, the primary focus is punishment for their crime of being humans unable to control their illness. Many who manage to avoid jail or prison find themselves homeless or living in poverty conditions and unable to access and use the fragmented mental health system.

The nation has moved a long way from the concept of the asylum that provided the mentally ill a sanctuary from incarceration in jail. The perfect storm that led to federal intervention in the nation's mental health left a broken, uncoordinated system where the federal, state, and local entities utilize limited resources to provide mostly outpatient treatment to those who have the understanding and assistance to access it. For those who do not, they often can receive it only while incarcerated.

Conclusion

For a relatively brief time, America focused on the treatment of mental illness in a way it had not done since the mid-1800s when Dorothea Dix challenged state legislatures and the federal government to build asylums for the mentally ill. The political power of the NIMH under the leadership of Robert Felix, who was committed to a public health approach to mental health, fueled this new movement. The euphoria created by "wonder

[85] "Review of Harris County Mental Health Systems Performance: Final Report," *The Texas State of Mind--The Meadow Mental Health Policy Institute for Texas*, (May 2015): i.

drugs" that made a dramatic improvement in state hospitals fed the nation's excitement for change. Those concerned about increasing numbers of the mentally ill and the costs for each state approved of the change. Its champion was a new President who knew about mental disability from his own family, but who was assassinated in 1963 shortly after signing the new law. The federal courts in the Civil Rights era, found new rights for the mentally ill, providing better care for some while dramatically altering the existing system and taking away many resources needed by those with an SMI. The vehicle for change, community mental health centers, were never funded as planned and did not became centers of caring for those leaving state hospitals. Ultimately, Medicare, Medicaid, and SSI provided the states the incentive to move people out of their hospitals to facilities not adequate for their needs. In reality, there was no planned coordination for the change. The concept of deinstitutionalization became the movement that consumed the nation with little regard for those previously housed in the mental institutions, and who often had nowhere to go.

The national interest in mental health waned with the changing political tide in Washington in the 1980s. Today the only real catalyst for concern for the mentally ill comes in response to the growing public shootings in schools and other venues. America is a nation awash with guns with no apparent ability even to discuss the ramifications of too many guns. It has become more politically correct to blame the mentally ill person who, lacking treatment, finds readily available weapons and at times, uses them to tragic effect. Will concerns for public safety refocus the nation on improving care for the mentally ill? Or will its response be one that blames the mentally ill person for whom no appropriate treatment is provided and leads to even greater use of jail and prisons for

them? The needs of the severely mentally ill and, indeed, those with any mental illness—are great in this nation, and it will take a national effort to change the situation. One hopes that the solution is grounded in a real understanding of the problem and with the resources to meet the critical needs of hurting individuals.

V. AS CHEAP AS POSSIBLE: THE ASYLUMS AND HOSPITALS FOR THE MENTALLY ILL IN TEXAS, 1860 TO 1950

This chapter focuses on the early history of the treatment of severe mental illness in Texas to 1950. In Texas, as in other states, those who had mental illness received treatment in facilities built specifically for that purpose. While the treatment of physical illness was most often in the patient's home or the office of the physician, the asylum was the critical component for the moral treatment of mental illness in the eighteenth century. Except for general hospitals in Philadelphia, New York, and Boston that primarily served indigent patients or selected patients who did not have access to a home, the facilities for the mentally ill predate virtually all hospitals in the United States. In Texas, the first general hospitals did not open until the 1880s, and by that time, there were 2 asylums for the mentally ill open in Texas, and third opened in 1892.

While it did appropriate the funds to build the first asylum in Texas in 1856, from the beginning, the Texas Legislature was parsimonious in providing funds and facilities to serve the mentally ill. Its citizens and the Legislature recognized the need to provide for these individuals. However, its history will show that excellence in the provision of that care was never the goal in Texas. The first asylum opened within a month of the start of the Civil War. Despite the war and the difficult days of the Reconstruction that followed, this small facility of sixty patients, with 11 leadership changes in its first 15 years, survived and helped several to regain their sanity. As the population of the state grew, however, the Legislature refused to build or expand facilities fast enough to keep up with the need, leaving many to languish in county jails while waiting for an opening.

Eventually, the state created one board to oversee all of its eleemosynary (charitable) institutions, but that board's primary mission focused on saving money, not on quality care. By the mid-twentieth century, Texas earned the label "the worst mental hospitals in the United States."[1]

Today, the Legislature continues to appropriate far fewer resources than are needed, so Texas still fails to meet the needs of the mentally ill, who are now in jail as criminals.[2] Texas allocates 1.2 percent of its state expenditures to mental illness, which places it 40th in the ranking of states with Maine the highest at 5.6 percent and Arkansas the lowest at 0.7 percent.[3] In 2014, the last formal study of mental health expenditures per capita by state, including the District of Columbia, Texas ranked 48th out of 51 with only Arkansas, Florida, and Idaho, lower. At that time, Texas spent $45.23 per capita, while Maine was the highest at $362.75 per capita expenditures for mental health.[4]

Texas Uses Federal Funds to Build Its First Asylum

Texas Historian Rupert Richardson observed, "The people [of Texas] learned to look to outside sources rather than to taxation as the means of supporting their

[1] James S. Mahon to Robert Sutherland, Copy of a mail-out from Mahon, the state chair of the Texas Junior Chamber of Commerce Committee on Mental Health, received Sutherland, Executive Director of the Hogg Foundation on March 16, 1951, Box MAI 9/U27, Hogg Foundation for Mental Health Papers, Briscoe Center University of Texas, Austin, Texas.

[2] Edgar Walters, "State Spending More on Mental Health Care, but Waitlist Grows," *The Texas Tribune, May 1, 2016, accessed October 12, 2017, https://www.texastribune.org/2016/05/01/despite-state-spending-dearth-pysch-hospital-beds/.*

[3] "Funds for Treating Individuals with Mental Illness: Is Your State Naughty or Nice?" Mental Illness Policy.Org, accessed September 11, 2019, https://mentalillnesspolicy.org/national-studies/funds-for-mental-illness-is-your-state-generous-or-stingy-press-release.html.

[4] "SMHA Expenditures per Individual Served, FY 2014," *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015* (Rockville, MD: Substance Abuse and Mental Health Services Administration) HHS Publication No. SMA-17-5029, 2017): 116.

government."[5] When Texas entered the United States, it had much land but was deeply in debt from its Republic days. The federal government allowed Texas to retain its public lands and gave the state $5 million to settle its debts. It also provided the state proceeds from federal bonds in excess of $23,000,000 over ten years. This funding allowed Texas to pay off its debts and have $4 million in reserve. Texas used the extra money to circumvent raising taxes by using federal funds to avoid requiring the counties to pay taxes for several years.[6] At the urging of Gov. Elisha M. Pease (1812-1883), a "Connecticut-born Unionist,"[7] in 1856, the Legislature passed a bill to construct the state's first asylum for the mentally ill, using proceeds from the federal bonds and setting aside 100,000 acres of land to sell to help fund future costs.[8] The city of Austin paid 90 percent of the land cost for the asylum facility located two miles north of it.[9]

[5] Quoted in T. R. Fehrenbach, *Lone Star: A History of Texas and the Texans* (1968; repr., New York: Open Road Integrated Media, 2014): 346.

[6] Fehrenbach: 345-346. Texas used the funding to pay off debts to its citizens, leaving debts to out of state bondholders unpaid. Thanks to the Missouri Compromise in 1850, Texas received $10 million from the Federal Government in payment for land that would eventually become Colorado and New Mexico. In 1855, it received $7,750,000 from the federal government to settle all outstanding debts and payments for frontier protection.

[7] Randolph B. Campbell, *Gone to Texas: A History of the Lone Star State* (New York: Oxford University Press, 2003): 236.

[8] *Gammel's Laws of Texas (GLT), Volume IV*, 478-479, 494. During construction, two subsequent legislatures approved an additional $65,000 for land, furnishings, and other structures on the property. 1123, 1441. *GLT* available through the University of North Texas, Portal to Texas History, https://texashistory.unt.edu/ark:/67531/metapth5872/.

[9] *BTSH&SS Report September 1, 1950 through August 31, 1951,* Texas State Library and Archives Austin: St 2. The purchase price was $2,500, and Austin paid $2,250 of that cost.

Figure 1 Governor Elisha M. Pease[10]

Governor Pease appointed J.C. Perry M.D. to the position of superintendent with the annual salary of $2,000 (equivalent to $57,725.71 in 2018) to begin planning for the new facility.[11] Perry's brief term in office ended with the election of the next governor in 1858, who appointed a new superintendent. During Pease's term, Perry visited other states' asylums to learn the plans for buildings and gather suggestions for operations.[12]

[10] From Wikipedia article on Governor Pease, accessed July 19, 2019 https://en.wikipedia.org/wiki/Elisha_M._Pease.

[11] In comparison to other physicians in this era of no medical licensure, "superintendents of insane asylums were among the highest-paid physicians in the field of medicine. … [They] almost always earned at least two thousand." "Insanity is Lucrative," Indians, Insanity, and American History Blog: Asylums and Insanity Treatments 1800-1935, August 23, 2015, accessed September 13, 2019, cantonasylumforinsaneindians.com/history_blog/tag/salary-for-asylum-superintendent/. One of the more highly paid Superintendents was John P. Gray M.D., superintendent of the Utica State Insane Asylum in New York, was paid more than $7,000, including perquisites. J. Edward Turner, *The History of the Inebriate Asylum in the World* (New York: Self Published, 1888): 173-174. Published on Line by Google Books, accessed September 13, 2019, https://books.google.com/books?id=lBlOAAAAMAAJ&pg=PA173&lpg=PA173&dq=Annual+salaries+of+Superintendents+of+Insane+asylums+in+the+1950s+in+the+US&source=bl&ots=THFNMhoqoJ&sig=ACfU3U08VYkMBpR5bwN3g5hgmCxmLpKExg&hl=en&sa=X&ved=2ahUKEwjusJiMsM7kAhUQOq0KHebSAk8Q6AEwFHoECAsQAQ#v=onepage&q&f=false.

[12] Perry recommended that the state follow the plan of Dr. Thomas Kirkbride, superintendent of the Pennsylvania Hospital for the Insane in Philadelphia, a plan popular in the U.S. in the mid-century. In addition to providing "natural ventilation … spacious corridors, lofty ceilings, and large windows and transoms," it allowed for "indefinite extensions," which the law required, *Superintendent's Report Austin,* November 27, 1857: 4-5.

Perry also examined the Texas census data from 1850 and surveyed the counties for the number of individuals who would qualify for admission. He recognized that the data were incomplete, but he concluded that upon completion of the asylum, "not one-fourth of those requiring prompt assistance could be served."[13] The Legislature did not vote to expand the original scope of the facility as he hoped.

Management and Funding Systems Created

The Legislature created a management structure for the new asylum that consisted of a non-compensated, five-member board of managers appointed by the governor that "shall have general direction and control of the property and business of the Asylum." The board would work with the governor-appointed superintendent, who was required to "be a married man and a skillful physician, experienced in the treatment of the Insane." The superintendent was supposed to serve a four-year term, subject to removal from office by the governor for "incompetency, refusal to fulfill his duties, or misconduct." However, it became the practice for each governor, elected to a two-year term at that time, to appoint or reappoint the superintendent, so it became a political office, which was damaging to the ongoing treatment and care of the patients.[14]

Patients' entry into the asylum came via three venues. First, a trial by jury in the individual's home county would determine whether he/she was an "idiot, or lunatic, or *non compos mentis* [not of sound mind]." If the jury found an individual mentally ill, the

[13] Ibid: 13.

[14] *GLT, Volume IV,* 987. Governors made 11 appointments to the position of superintendent between May 27, 1857 and February 10, 1874. These were, in order: J.C. Perry, 1857 to 1858; C.G. Keenan, 1858 to 1860; Beriah Graham, 1860 to March 1861; C.G. Keenan, March 1861 to November 1861; J.M. Steiner, November 1861 to 1865; Beriah Graham,1865 to 1866; W.P. Beall, 1866 to 1867; Beriah Graham, 1867 to 1870; J.A. Corley,1870 to 1871; G.F. Weisselberg,1871 to 1874; and David R. Wallace, 1874 to 1879.

court ordered him/her to jail to await placement in the asylum. If a friend or relative agreed to be responsible for the individual and provided a bond, the mentally ill person could avoid jail.[15] In the years to come, this law would place large numbers of the mentally ill in jails awaiting an opening at this or later asylums in the state. However, it would also provide an impetus for the expansion and building of new asylums to move the mentally ill out of the jails. Second, when a court found a person charged or convicted of a crime to be insane, the law required that court to send the person to the asylum, and only the court sending him or her there could remove the individual.[16] Counties were required to pay $2 a week for the care of individuals they sent to the asylum.[17] A third means of admittance was at the request of a guardian, family member, or friend who would pay for the individual's care. Such referrals required a physician's certification that a person was insane and a letter from the chief justice of the county of origin vouching for the credentials of the physician. These private referrals required the payment of $5 a week for six months of care in advance at placement.[18] The Legislature authorized counties to levy a tax to pay the cost incurred for the care of indigents, and it required families or the estates of individuals to reimburse the counties for the costs incurred by the county when resources were available.[19] The Legislature mandated preference for individuals ordered by a court over private referrals, and it required that those ill for less than a year obtain admittance over "chronic" ones.[20]

[15] Ibid: 988- 989.
[16] Ibid: 989.
[17] Ibid: 990.
[18] Ibid: 990.
[19] Ibid: 991.
[20] Ibid: 990. Superintendents had the right to discharge chronic patients to make room for more recently ill ones, but this was something most of the superintendents found hard to do. They often had no place to send them, and one suspects they found it easier to serve the patients they knew rather than

The Asylum Opens in a Time of Governmental Change and the Start of War

The Texas State Lunatic Asylum (TSLA) opened in March 1861 as the Civil War began amidst a tremendous governmental change in Texas and the nation. A fire at the main contractor's mills had destroyed a significant portion of the building materials set aside for the facility, delaying the 1860-planned opening to 1861.[21] TSLA opened at the same time as the governor was changing in mid-March 1861.[22] Texas had seceded from the Union in February and joined the Confederacy on March 2, 1861. Governor Sam Houston (1793-1863) favored remaining in the Union. When he refused to swear allegiance to the Confederacy on March 16, 1861, the Secession Convention of Texas declared his position vacant, and Lt. Gov. Edward Clark (1815-1880) became the governor. Clark held the position until the election in November of 1861. Clark appointed Dr. C.G. Keenan (1813-1870) to succeed the Houston-appointed superintendent at TSLA, Dr. Beriah Graham (1804-1879), after the asylum had opened under Graham's leadership. Within a few days of its opening, TSLA had a new superintendent and, six months later, following the election of Gov. Francis Lubbock (1815-1905), a third

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new, possibly more troubling ones, given the crowded conditions of the small asylum built for 60, which rose to 96, before expansion occurred in the mid-1870s..

[21] *Superintendent's Report Austin* of B. Graham January 28, 1861," *Senate Journal: 8th Legislature, First Called Session*, Legislative Reference Library of Texas: 56. Accessed September 2, 2017: http://www.lrl.texas.gov/scanned/Senatejournals/8/01301861_53.pdf.

[22] Though recent publications, without citation of source, state that the asylum opened formally in May 1861 with 12 patients, Beriah Graham in his superintendent's report for 1867-1868 states that it was organized and opened in March 1861 and that he was "superseded" after the opening, *Superintendent's Report Austin* 1867 and 1868: 18. A document from 1904 recognizes March 11, 1861, as the date the asylum opened. It states, "About March 11, 1861 the institution was formally opened and during that month five or six patients were admitted." *Statistical Report 1904* by W. J. Clay Commissioner Texas Board of Insurance Commissioners, (Austin: Von Goeckmann-Jones Co. State Printers, 1904): 190. Accessed September 6, 2017, https://play.google.com/books/reader?id=V4TJAAAAMAAJ&printsec=frontcover&output=reader&hl=en&pg=GBS.PA1.

superintendent took over in its first year of operation. That individual was Josephus Murray (J.M.) Steiner M.D. (1823-1873), who was Gov. Lubbock's physician.[23] Though the war years were difficult for Texas, the patients at TSLA were fortunate to have Steiner as superintendent. His connection to the governor, his financial resources, and perhaps his previous problems of having killed his commanding officer while serving in the Army[24] made him the right person to lead at that time. He served as superintendent for the remainder of the war, maintaining the position even after the election of Gov. Pendleton Murrah (1824/1826-1865) in 1863 when Lubbock decided not to run for re-election. Steiner "supported the institution a great deal," and he paid for "considerable improvements" "out of his private means."[25]

[23] C.W. Raines, editor, *Francis Richard Lubbock, Six Decades in Texas or Memoirs of Francis Richard Lubbock*, (Austin: Ben C. Jones & Co. Printers, 1900): 373. Accessed on September 6, 2017, https://books.google.com/books?id=0RDc5eNjr-cC&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false.

[24] After killing his commanding officer, Steiner faced a court-martial and fled, but later surrendered to the authorities. The court-martial had disbanded by the time he surrendered, and he was discharged from the Army. Later, a civilian court cleared him of the charges. M. L. Crimmins, "Captain Jack Elgin's Last Story," *Frontier Times* 16, no. 4, (December 1938): 100-103. Edd Miller, "Steiner, Josephus Murray," *Handbook of Texas Online*, accessed September 08, 2017, http://www.tshaonline.org/handbook/online/articles/fst29.

[25] *The Texas Almanac for 1867 with Statistics, Descriptive and Biographical Sketches, Etc.* The Galveston News: W. Richardson & Co., 1866): 191. Accessed on May 15, 2017, https://texashistory.unt.edu/ark:/67531/metapth123772/m1/193/.

Figure 2 Joseph M. Steiner M.D.[26]

Thanks to Steiner, a joint Senate and House committee appointed to visit TSLA in 1866 for the 11th Legislative Session found it to be "in a prosperous condition" with the financial, management, and individual records of the patients well documented "as far as the facts [were] known." They did note the crowded facility and stated that unless enlarged, it could not serve more patients. However, due to "the financial embarrassments of the State," the committee could not recommend expansion at that time. While the committee stated that the asylum was in a "prosperous condition," it recommended that funds be set aside to improve the water closet system that was "exceedingly defective." It also noted the need to repair the roof that in heavy rains leaked so much that "the wards are flooded" and the upper floors become "quite uninhabitable."

The Integration of the Treatment of Mental Illness in Texas

[26] "Murder at Fort Graham," Heart of Texas Tales: True Tales of Hill County, Texas, accessed September 20, 2019, http://www.heartoftexastales.com/murder-at-fort-graham.html.

The Legislature did endorse the building of an additional structure to house "insane negroes,"[27] and it approved the purchase of land adjacent to the asylum grounds for that purpose.[28] That construction did not take place. In his 1866 report, Superintendent Graham did state that the admission of insane Negroes would require a separate facility, "in order that no compulsory association between the two races might exist." He did note that if they were admitted, he would "give them the same attention and treatment as others receive."[29] In his report for the next year, however, he noted that there were 69 persons in the asylum, of which, "one female and two males [are] colored," so did he accept Negroes into the existing facility.[30] This statement was the last reference to the race of patients in the superintendent reports until Superintendent A. N. Denton, in 1884, stated, "I deem it my duty to call your attention, and that of the Legislature, to the anomalous mixing of blacks and whites in one of the wards of the Asylum. This reprehensible, but unavoidable condition of affairs under existing circumstances, I found when I took charge of the institution."[31] Subsequent reports from Austin began to note the numbers of persons from different races in the annual reports, along with periodic calls against mixing the races in the same wards. In 1918, the superintendent's report from Austin heralded the Legislature's plan to convert the Rusk prison to a segregated facility for Negroes that would allow the removal of 587 Negroes and the conversion of the space for 500 more white admissions.[32] As noted later, Rusk prison became a facility

[27] "Senate Journal: 11th Legislature, Regular Session," Legislative Reference Library of Texas, September 25, 1866: 249-251. Accessed September 6, 2017, http://www.lrl.texas.gov/collections/journals/journalsSenate11.cfm

[28] *GLT,* Volume 5: 1125.

[29] *Superintendent Report Austin for the Year 1866*: 10.

[30] *Superintendent Report Austin for the Years 1867 and 1868:* 12.

[31] *Superintendent Report Austin for the Year 1884:* 9.

[32] Superintendent Report for the Year 1918: 11.

for the mentally ill open to all races. Although undoubtedly, there were segregated wards, neither Austin nor any of the other asylums or hospitals ever became segregated facilities.

Moral Treatment at TSLA

Superintendent Beriah Graham, who had opened the asylum, returned to the leadership position at TSLA at the close of the war, serving from 1865 to 1866. He then served for the third time from 1867 to 1870. Graham was the first superintendent to provide a listing of the forms of insanity of those under treatment at TSLA as part of his annual report in 1866. He identified acute and chronic mania as the most prevalent mental illnesses, with melancholia the second and dementia the third.[33] Though the numbers varied in subsequent annual reports, these remained the primary forms of mental illness identified for the patients until the twentieth century.

For those who gained admission to TSLA, the first protocol was to assess their physical health and then to treat the physical illnesses found. Superintendent Graham noted, "There are very few patients admitted to the Asylum whose physical health is good." Although it was a crowded facility, the staff made it as "pleasant and home-like" as they could. One key for treatment was "to guard against excesses of all kinds." The superintendent and staff encouraged the development of regular habits. They also urged the patients "to take exercise in the open, or to engage in some light work or amusement." The most fundamental aspect of treatment, however, was "unvarying kindness."[34] Given

[33] *Superintendent Report Austin for the Year 1866*: 15. Nancy Andreasen notes that classical Greeks first used the terms mania and melancholia. She states that mania corresponds to today's schizophrenia and mania and melancholia to depression. Nancy C. Andreasen, *The Broken Brain: The Biological Revolution in Psychiatry* (New York: Harper & Row, 1985): 143.

[34] *Superintendent Report Austin for the Years 1867 and 1868:* 14.

the crowded conditions, the meager pay,[35] and continual turnover of leadership, one must question if unvarying kindness towards patients who exhibited many trying behaviors was reality or the public hope of a superintendent in his published report.

Superintendents Turned People Away as the TSLA Appealed in Vain for Resources to Expand

Though the superintendents managed to keep the asylum's work going, funds for TSLA and other Texas government operations were not plentiful following the Civil War. From 1866 through 1873, during Reconstruction, the Republican-led federal government dominated politics in Texas. Because Texas did not gain readmission to the union until 1870, the Legislature did not meet between 1866 and 1870. When it did meet from 1870 to 1873, a strong governor backed by President Grant overshadowed it. In 1867, the federal government had divided the defeated South into five military districts. The military leadership appointed the governors and provided military support to them.[36] The military leader in Texas cut the annual appropriations for TSLA from $20,000 to $15,000 in 1869.[37] Moreover, Superintendent Weisselberg noted that in 1871, the counties owed TSLA over $12,000 for care of their patients, and private patients owed $3,000.[38] Decreased funds for ongoing operations caused difficulty in hiring staff, and in providing some of the needs of the facility and patients.[39] Superintendents Graham, Corley, and Weisselberg, pleaded with the Legislature for more funds, not just for those

[35] The annual salary for a ward attendant in 1886 was $240. Assuming it was near the same dollar amount in 1868, it would be equivalent to $4,319.12 in 2019. *Superintendent Report Terrell* (1886):20.

[36] Campbell: 275.

[37] *Superintendent Report Austin* (1870): 4.

[38] *Superintendent Report Austin October 1, 1871*: 33, 36.

[39] Superintendent Graham, in his report for 1865-1866, noted the difficulty in hiring staff "either black or white," *Superintendent Report Austin 1866*: 7. Superintendent Corley in 1870 noted the impact of lower appropriations on hiring staff, clothing for patients, and furnishings and upkeep in the building. *Superintendent Report Austin* 1870: 4-5,

in care, but to increase their capacity to serve those they were turning away daily.[40] Weisselberg, writing in 1871, stated that due to the state's failure to provide more room at TSLA, a large number of the insane were "being confined in prisons and laden with chains, as there are no alms houses in the State."[41] The superintendents had the difficult task of turning people away or trying to find room in a crowded facility because there was a growing number of insane in Texas.

Yet, moral treatment at TSLA with its small, intimate setting produced results. During its first 11 years of operation, 60 percent of those admitted left the facility recovered or improved. Weisselberg noted in 1872 that of the 428 patients treated by TSLA since 1861, 232 had regained their sanity, another 25 had left improved, 30 had left with no improvement, 45 had died, and 96 were still patients in the asylum on October 1, 1872.[42] However, he expressed his concern about the growing number of incurables at TSLA. Though he could discharge chronic cases in preference for recent ones, he found it difficult to send them away, for there was no other place for them to go. With each passing year, the facility was filling with chronic cases, so there were fewer and fewer opportunities for new patients to receive treatment. He pleaded for more room to serve the 1,000 to 1,200 untreated cases existing in the state at that time. He stated, "A State that can expend millions of dollars for public purposes, such as railroads, etc., should well be able to spend sixty thousand dollars to found a home for this unfortunate class of humanity."[43]

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[40] *Superintendent Report Austin 1869,* 13. *Superintendent Report Austin* 1870: 3. *Superintendent Report Austin* 1871: 7.

[41] *Superintendent Report Austin*, 1871: 7.

[42] *Superintendent Report Austin*, *1872*: 14.

[43] Ibid: 6-7.

Adoption of the Texas Constitution in 1876 Leads the Way to Expansion

The adoption of the Texas Constitution of 1876, the fourth since 1865, followed the end of Reconstruction and federal oversight in the state. It made the state rather than counties responsible for all indigent mentally ill persons in Texas.[44] Trials by juries in an individual's home county to determine sanity and certify indigence were still the means of entry, but now all were state patients, and preference at all times was for indigent patients over, paying patients.[45] Expansion of TSLA started in 1874,[46] and by October 1884, its resident population had reached 555 patients.[47] The 18th Texas Legislature, in 1883, authorized and appropriated resources to build a "Branch Asylum" in North Texas, which became the North Texas Hospital for the Insane in Terrell soon after opening.[48]

These and subsequent expansions were funded by the growing population and economy of Texas. Between 1870 and 1890, the population of Texas grew by 173% from 818,579 to 2,235,527.[49] The economic growth came about from railroad building, which increased from less than 500 miles in 1870 to 8,000 miles in 1890. The state gave the railroads land, which they sold to new settlers in exchange for building railroads to

[44] The Texas Constitution of 1876, Article 16, Section 54, states, "It shall be the duty of the Legislature to provide for the custody and maintenance of indigent lunatics, at the expense of the State, under such regulations and restrictions as the Legislature may prescribe." Accessed September 13, 2017, https://tarltonapps.law.utexas.edu/constitutions/texas1876/a16. HJR 3 repealed this section in 1969 because of the obsolete language, but with the intent that the repeal made no change in the policies of the state.

[45] GLT Volume *8*: 976.

[46] When D.R. Wallace and the new board took over TSLA following the ouster of Gov. Davis from office, they found a contract in place for construction of an additional building on the campus. They renegotiated the contract and began work again. Possibly the funding for this building came from savings from earned income. *Superintendent Report Austin* from 10th of February 1874 to September 30, 1874: 11.

[47] *Superintendent Report Austin,* 1884: 14.

[48] GLT Volume 9: 315-316.

[49] Campbell: 290.

connect the cities within Texas to the rest of the nation.[50] The railroads fueled growing urbanization and industrialization in the state. In 1870, 2,399 mills and factories produced $11.5 million worth of goods. By 1890, the number of manufacturing enterprises had grown to 5,260, but their output increased by over 500 percent to over $70 million.[51] This economic expansion provided resources to expand the asylums as the number of mentally ill also grew with the increasing population.

The 1883 Legislature dramatically changed the role of the board of managers of TSLA, the new Terrell hospital, and future such facilities. The governor, subject to the "advice and consent" of the Senate, would appoint individuals to vacancies as they occurred on each board. The board members' terms were staggered so that vacancies occurred every two years; thus, most governors would appoint only part of each board.[52] The legislation required three board members to be from the local area of the facility, the board to meet monthly at the facility, and a committee to inspect the facility monthly and document their observations from the visits. The boards now had "general control and direction of the affairs of the Texas asylums … subject to only such rules and regulations as may be prescribed by the Legislature." Each board would elect its superintendent, removing that office from a constant turnover as the governors changed.[53]

With their new powers in 1885, the board of managers of the North Texas Hospital for the Insane realized that the hospital was not large enough and began work to

[50] Ibid: 306.

[51] Ibid: 309.

[52] The governor's term at this time was for two years, but he was eligible for reelection.

[53] GLT Volume 9, Austin, 1898: 409-411, 629. The legislation required the superintendent to have three years of resident experience in the management of a mental institution. Two years later, when finding an individual with such qualifications proved difficult, the Legislature dropped the requirement. It required the individual only to be "experienced in the treatment of insanity."

double its size from 400 to 800. The expansion opened in 1890.[54] The Legislature authorized a third state asylum in 1889; it opened in San Antonio in 1892 as the Southwestern Insane Asylum, and its population increased rapidly.[55] In 1851, the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) had set 250 as the optimal size of an asylum. Still, by 1865, half of the nation's public asylums had much larger populations.[56] In 1875, the total population of public asylums in the nation was almost 20,000, and by 1900, it was 150,000.[57] Virtually all of the institutions had exceeded the recommendation of 250 by this point, and most would grow to house thousands of patients. Small, public hospitals providing intimate, moral treatment were no longer available.

In 1899, Gov. Joseph D. Sayers (1841-1929) stated in remarks to the state Legislature, "There are at least 1,000 insane persons in the jails, upon the poor farms, and under private care and restraint in the State."[58] That year, the Legislature increased the number of asylums by approving the construction of an asylum for the "epileptic insane" in Abilene, which would later become the Abilene State School.[59] Completed in 1904, it reached full capacity in only five months with transfers from the other asylums and new

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[54] Benny Britton, *Terrell State Hospital 1883-2008* (Terrell: Terrell State Hospital Volunteer Services Council, 2008): 5.

[55] HB 150, 21st Legislature, 1889, Chapter 69, accessed October 4, 2017, http://www.lrl.texas.gov/scanned/sessionLaws/21-0/HB_156_CH_69.pdf. William R. Geise and James W. Markham, "San Antonio State Hospital," *Handbook of Texas Online*, accessed September 20, 2017, http://www.tshaonline.org/handbook/online/articles/sbs04.

[56] Constance M. McGovern, *Masters of Madness: Social Origins of the American Psychiatric Profession* (Hanover: University Press of New England, 1985): 152.

[57] Ibid. 166.

[58] Texas House of Representatives 26th Regular Session, *Texas House Journal* Joseph D. Sayers, "Message from the Governor to the Senate and House of Representatives," (January 23, 1899): 122, accessed February 2, 2016, http://www.lrl.state.tx.us/scanned/Housejournals/26/01231899_12_118.pdf.

[59] HB 22, 26th Legislature, 1899, Chapter V, accessed October 4, 2017, http://www.lrl.texas.gov/scanned/sessionLaws/26-0/HB_22_CH_5.pdf

patients.[60] As the nineteenth century closed, a new addition at San Antonio opened to bring its capacity to approximately 600.[61] At the end of 1899, Terrell had 1,041 patients in residence,[62] and Austin had 734 patients.[63] At that point, the hope was that with the newly expanded capacity, "all of the county jails in the state [would] be relieved of the insane inmates."[64]

The New Century Brings Change but Continued Overcrowding

With the facilities for the mentally ill in Texas required to serve the indigent first, and with the requisite of an open trial by jury to gain admission to the public facilities, the wealthier, private-paying patients sought other possibilities for treatment. This opportunity created a market for small private hospitals, most often called sanitariums, to develop in the larger towns and cities. In most cases, physicians owned and staffed these hospitals. These included Dr. John Pope's Valleloma in Marshall in 1892, Moody Sanitarium in San Antonio in 1903, Arlington Heights Sanitarium in Fort Worth in 1906, Timberlawn Sanitarium in Dallas in 1917, and Greenwood's Sanitarium in Houston in 1925.[65] This bifurcation of care for the mentally ill continues today. The wealthy who can pay for private psychiatric care have access to psychiatrists and facilities that do not accept health insurance, on which most Americans rely. Menninger's Clinic is such a

[60] *The New Handbook of Texas in Six Volumes, Volume 4* (Austin: The Texas State Historical Association, 1996): 624.

[61] "More Asylum Room," *Dallas Morning News*, October 15, 1899: 5.

[62] *Superintendents Report Terrell*, 1899: 19.

[63] *Superintendents Report Austin* 1899: 5.

[64] "More Asylum Room:" 5.

[65] Handbook of Texas Online, Dan L. Creson, "Mental Health," accessed September 15, 2017, http://www.tshaonline.org/handbook/online/articles/smmun.

facility in Houston. They take no insurance payments for full payment of treatment, and they require funding per day far more than most individuals or families can afford.

C.S. Yoakum's report on the *Care of the Feeble-minded and Insane in Texas* in 1914, at the start of World War I, reported that the population of the mental institutions in Texas had grown to 5,439 in four facilities. In comparing the care provided to the needs of the insane in Texas, Yoakum concluded that there was "insufficient care and incomplete treatment" for those in the asylums. Because of the overcrowded asylums, "large numbers that its courts have already said should be in these institutions are kept out." He stated there were "471 insane persons in the county jails and on the poor farms of the State, or at home adjudged insane, waiting for a place to be given them in our State institutions." Perhaps in an acknowledgment to the nascent mental hygiene movement, Yoakum also noted the state's lack of efforts to prevent mental illness, though he did not identify any specific steps.[66]

A study in 1915 of Texas asylums by Dr. Thomas Salmon of the National Committee for Mental Hygiene found the conditions within the asylums and local jails deplorable and recommended the creation of a central authority over the mental institutions.[67] Salmon's recommendation was for a central board composed of persons who understood the needs of the population served. He opposed state boards of control

[66] C. S. Yoakum, "Care of the Feeble-minded and Insane in Texas," *Bulletin of The University of Texas*, Humanistic Series No. 16, no 369, (November 5, 1914): 108-109, accessed September 15, 2018, https://archive.org/details/careoffeeblemind00yoak/page/n1.

[67] Sarah C. Sitton, *Life at the Texas State Lunatic Asylum 1857-1997* (College Station, TX: Texas A&M University Press, 1999): 36-37.

that focused on efficiency and exhibited no "evidences of any feeling of personal responsibility" for the needs of those in care.[68]

The New State Board of Control: Extreme Efficiency, Extremely Poor Care

The concept of a state board of control had first emerged in Wisconsin in 1891 when that state abolished local boards for its institutions and placed them under the new State Board of Control to which it gave the power to "maintain and govern" all of the charitable institutions. Gerald Grob states, "The intent of the legislation was to reduce the costs of welfare by creating a more efficient administrative structure."[69] It accomplished its purpose, and, by 1914, 17 more states had created state boards of control. Salmon stated, "Almost without exception, the only qualifications required for members of Boards of Control [were] those which relate to their political affiliations."[70]

In Texas, the board of managers of the North Texas Hospital for the Insane in Terrell began the movement toward the creation of a state board of control in 1909. They recommended that Texas create a board that would manage the business of the mental institutions of the state "as any successful business man should." They proposed a full-time board of five over the four institutions instead of four part-time boards. They also proposed that this new board should receive a total sum to spend rather than specific amounts for each line item in the budget. This proposal would allow the board to spend resources as needed rather than being restricted to the specific directions of the

[68] Thomas W. Salmon, "The Care of the Insane under State Boards of Control," *State Hospital Bulletin* (New York), n.s., 7, February 15, 1915: 465.

[69] Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983): 204.

[70] Salmon: 458.

Legislature.[71] In 1912, they expanded their recommendation for such a board to be over "all State charitable and eleemosynary institutions."[72]

Ultimately, in 1919, the Legislature passed a game-changing law creating the State Board of Control (SBOC) for all eleemosynary institutions.[73] Significantly, this full-time board of three had no requirement for expertise in mental illness nor any of the work of the institutions under its oversight. The legislation forming the SBOC abolished all local boards that had previously inspected the facilities, made decisions for the local asylums, and advocated for them to the governor and Legislature. The SBOC appointed superintendents of each facility who were answerable to no one except it. In addition to philanthropic institutions, this board also took over the responsibilities of the following divisions for the state: Public Printing, Purchasing, Auditing, Design, Construction and Maintenance, and Estimates and Appropriations.[74]

By including the state administrative divisions along with the eleemosynary institutions, the powerful SBOC became the budget planning, budget monitoring, and ultimately the auditing arm of the state. The Legislature did not agree to grant the board a

[71] *Superintendent Report Terrell* from September 1, 1908 to August 31, 1910: 4. The board's reason for wanting to create this new board was that it would be more economical for the state and that a full-time board would provide "more efficient control" than multiple part-time boards could. Undoubtedly, the Progressive Era concept of greater government efficiency influenced the board, as did learning that other states were adopting them.

[72] The board's proposed expansion to all eleemosynary institutions also included the concept that a percentage of state revenue would be set aside by which the new board would fund all operations and upkeep without the line-item appropriations of the legislature each year. In the end, the legislature accepted the concept of efficiency, but maintained the line-item appropriations. *Superintendent Report Terrell* from September 1, 1911 to August 31, 1912: 3.

[73] SB 147, 36th Regular Session, (1919), Bill Files, Texas Legislature, Archives and Information Service, Texas State Library. The eleemosynary institutions under this three-member board were: "all of the asylums of the State, including the Blind Asylum, Lunatic Asylums, the Deaf and Dumb Asylum, State Orphans' Home, the Asylum for the Deaf, Dumb and Blind for Colored Youths, the State Colony for Feeble-Minded, … the Confederate Home, the State Epileptic Colony, the Confederate Women's Home, the Home for Lepers, and the Anti-tuberculosis Colony, … the State Juvenile School and the Girls' Training School:" 327. Others added later included the State Parks and an Indian Reservation.

[74] Ibid. Section 3: 324.

sum of money and allow them to spend it as needed. The legislators, rather than local administrators, would continue to determine the salaries of every employee and set the authorized number of personnel regardless of the local needs. Individual departments and institutions sent their budget requests for each biennium to the SBOC, which held hearings on the budgets and determined amounts that it recommended to the Legislature based upon anticipated revenues for the state, which it also determined. The SBOC's proposed budget went to the Legislature, which could make changes, but now the SBOC was the voice for the institutions since there were no separate boards.[75]

The appropriations approved by the Legislature for each line item in the budgets of the institutions remained the maximum expenditures allowed. Still, the SBOC could—and most often did—work to limit expenditures to less than the appropriations as it focused on fiscal management and efficiency. In effect, the SBOC served to insulate the Legislature from the institutions serving people. It made the hard decisions of what to cut before the budget went to the legislators, asking only for sums within the expected revenues of the state. Its stated purpose was to save the state money. Once the Legislature appropriated the budget, the SBOC worked to make sure, particularly in the lean years of the Depression, that funds would lapse back into the state treasury rather than meet the significant needs of the patients. In the first three SBOC Biennial Reports from 1920 to 1926, the board highlighted the appropriations, the amount expended, and the balance not spent that reverted to the State Treasury for each institution. There were no biennial reports printed for the years 1926 to 1930. Beginning with the 1932 report and forward to 1940 (Sixth through Tenth Biennial when the last full report was printed), the board

[75] Ibid. Section 8: 327.

highlighted the total amount saved for all institutions. During the Depression when the facilities were overcrowded, salaries cut, and major repairs ignored, the board allowed the following amounts to lapse: 1931-32, almost $1 million; 1933-34, over $770,000; 1935-36, over $320,000; 1937-38, over $450,000; 1939-40, over $1 million.[76] The mental institutions had the largest budgets, and they normally had the largest lapses. The amounts appropriated by the Legislature and approved by the Governor were not to exceed amounts, so it is plausible that the Board of Control had to make sure expenses never exceeded the amount appropriated. However, these lapsed fund amounts were excessive. One assumes that perhaps the Legislators and Governor wanted to be able to report the amounts they had appropriated, while counting on the Board to keep the expenses well below the amounts to insure a surplus in revenue over expenses for the overall budget.

Expansion and Name Changes but Studies Find Inadequate Treatment of the Mentally Ill

With new revenue from the oil production tax of $1 million in 1919,[77] the Legislature that year expanded the number of asylums, creating a new state hospital at Rusk in east Texas by taking over a facility built in 1883 as a prison. Initially, the

[76] SBOC Biennial Reports from 1920, 1922, 1924, 1926, 1932, 1934, 1946, and 1940.

[77] The state of Texas created the oil production tax in 1905, and 1919 was the first year its revenue topped a million. Oil production tax is a revenue source for the state of Texas. Oil production also provides support to local counties through property taxes. Local independent school districts also receive support from property taxes on oil wells, and the University of Texas and Texas A&M University systems benefit from the oil-producing properties held by the Permanent Education Fund. "Oil and Texas: A Cultural History," *Texas Almanac: A Source for All Things Texan Since 1857*, Texas State Historical Society, accessed November 14, 2017, http://texasalmanac.com/topics/business/oil-and-texas-cultural-history. "Texas Oil and Natural Gas Industry Paid $13.8 Billion in Taxes and Royalties in 2015, Second Most in Texas History," Texas Oil and Gas Association, accessed November 14, 2017, https://www.txoga.org/texas-oil-and-natural-gas-industry-paid-13-8-billion-in-taxes-and-royalties-in-2015-second-most-in-texas-history/.

planning called for it to house the "Negro Insane;" however, before it opened, that designation changed, and it opened to all races, becoming the East Texas Hospital for the Insane.[78] In 1922, an institution authorized in 1917 opened as the Northwest Texas Insane Asylum in Wichita Falls.[79]

In 1924, The Texas State Medical Association (TSMA) passed a unanimous resolution calling for action to improve conditions for the mentally ill in Texas. That year, prompted by the TSMA, the Rotary Club of Houston, one of the earliest Rotary clubs in the state and the nation, issued a report on the conditions they found in an examination of the care for the mentally ill in Texas. Their work pointed to the continual growth in the number of patients in the state facilities for the mentally ill, and the Legislature's lack of funding for them. The report concluded that in Texas, "an effort is being made to make it as cheap as possible" to serve the mentally ill. It stated that the superintendents of the state asylums had to "actually beg the Legislature for the bare necessities."[80] Though there were no longer local boards to represent the asylums, the superintendents used their legislative connections to plead for what their patients needed.

The prior year, in response to concerns about the "constant increase" in the number of patients needing care in the eleemosynary institutions of the state, the Legislature created a short-term, nine-member, non-salaried Eleemosynary Commission. The commission's purpose was to examine ways to prevent "insanity, feeble mindedness,

[78] James W. Markham, "Rusk State Hospital," *Handbook of Texas Online*, accessed October 14, 2017, http://www.tshaonline.org/handbook/online/articles/sbr03.

[79] HB 465, 35th Regular Session (1917), Bill Files, Texas Legislature, Archives and Information Service Texas State Library. James W. Markham, "Wichita Falls State Hospital," *Handbook of Texas Online,* accessed September 20, 2017, http://www.tshaonline.org/handbook/online/articles/sbw03.

[80] The Rotary Club Houston Texas, *Investigations of the Care of the Insane in Texas* (Houston: Herbert C. May Co., 1924): 7, Briscoe Center.

delinquency, and the increase of State dependents," along with other issues.[81] To find means of preventing these illnesses and conditions would have been impossible with funding. Still, the Legislature authorized no funds for the study or even the operation of the commission.[82] The commission, chaired by State Representative Clifton E. Beasley from Sulphur Springs, however, raised its funds and received services from outside the state to examine the treatment of mental illness in Texas.[83]

The commission's 1925 report on the mental institutions noted with faint praise that the patients in the hospitals were "on the whole" treated "humanely," "kindly," and "are fairly well nourished and housed." The study stated, however, that the staff "struggle[d] with the impossible tasks assigned to them" and, given the "wages paid and conditions of service imposed," is "about as competent" as one can expect. The report concluded, "Anything approximating even moderate efficiency in the problem of handling the insane is out of the question until radical changes are made in the present Texas plan."[84] The report further noted that there is "nothing being done for prevention" in the state, and "the four primary essentials of effective handling of the insane [are] all practically absent." These primary essentials included "early recognition" of mental

[81] The other issues included how to address the criminally insane, what revisions in the laws were needed regarding "commitment, parole, discharge, care and custody of inmates," and the investigation of an official in one of the state Insane Hospitals who had employed inmates for his personal service. H.C.R. 15, 38th Legislature, 3rd Call Session, Bill Files, Texas Legislature, Archives and Information Service Texas State Library.

[82] *Report of the Texas Eleemosynary Commission to the Governor and the Members of the Thirty-ninth Legislature of Texas,* printed by order of the House of Representatives of Texas, 1925: 5, (Briscoe Center-Hogg Foundation Papers).

[83] The Commission secured $3,000 from the Buchanan Foundation of Texarkana, Texas, for a mental hygiene survey of 3,300 Texas schoolchildren. Also, the National Committee for Mental Hygiene donated $10,000 and provided "impartial, thoroughly trained psychiatrists, psychologists, social workers, and institution managers to complete several surveys, including an "institutional management survey" of the state mental facilities. Ibid: 6.

[84] Ibid: 8-9.

illness, the "careful diagnosis by skilled psychiatrists and psychologists," "prompt treatment … by mental and occupational therapy," and the use of psychiatric social workers to develop case histories to aid in diagnosis and treatment and to follow cases to prevent a return to the hospital.[85] It explicitly stated, "There is practically no organized mental therapy along modern lines attempted in any of [the] asylums; and, of the more than eight thousand patients, only about forty in the asylum at San Antonio receive any organized occupational therapy." It did specify that some patients helped with the routine work of the asylum. However, this work was limited to a small number, and it did not provide for the individual needs of the patients.[86]

The Legislature, unfortunately, failed to approve and fund any of the recommendations, all of which cost money. It did officially change the name of all of the institutions, dropping the words lunatic and asylum so that the official name of each facility would be the name of the city of its location, followed by the phrase "state hospital." It also approved building 2 state psychopathic hospitals, one in Galveston and one in Dallas.[87] Psychopathic hospitals, working in conjunction with medical schools, focused on observation, diagnosis, and brief treatment of mental illness. They differed from state hospitals in that they served persons who were not formally committed as the patients in state hospitals were, and the psychopathic hospitals did not provide long-term custodial care.[88] Unfortunately, it did not fund the one for Galveston until 1930, and the

[85] Ibid: 9.

[86] Ibid: 10.

[87] *1925 Revised Civil Statutes and Revised Criminal Statutes of Texas* (Austin: A.C. Baldwin & Sons, 1925), Chapter 2, Articles 3185 and 3192: 885, 887, accessed February 20, 2019, https://www.sll.texas.gov/library-resources/collections/historical-texas-statutes/bookreader/1925/#page/958/mode/2up.

[88] Grob, (1983): 135-140.

one in Dallas never received funding.[89] The Galveston State Psychopathic Hospital opened in 1931 with a capacity of 49 patients and an affiliation with the University of Texas Medical Branch (UTMB), the first public medical school in Texas.[90]

Under the SBOC, the number of patients in the state hospital's care rose from 7,248 in 1921 to 19,430 (15,000 residents and the remainder on leave from the institutions) in 1949. That year, a new board took over the responsibility for the management of the mental institutions.[91] The cost per day per patient in 1921 was $.63, and in 1949, it was $1.41. In 2017 dollars, Texas was spending $8.62 per day per person in 1921 and $14.50 per day per person in 1949.[92] Costs per day included the basics of food, clothing, shelter, medical care, and supervision before any specific mental illness therapy costs.

Texas was not alone among the States with Inadequate Facilities for the Mentally Ill

[89] *SBOC Seventh BR*, 60.

[90] *The University of Texas Medical Branch at Galveston: A Seventy-five Year History by the Faculty and Staff* (Austin: University of Texas Press, 1967): 150.

[91] *SBOC Sixth BR 1932*:55. "Average number of inmates actually present in Texas eleemosynary, Eleemosynary-Educational, and Correctional Institutions (Not including State Prison) for each of the fiscal years ended August 31." For 1921 Institutions included in the number cited are Rusk, Terrell, San Antonio, Austin, and Abilene State Hospitals. The number of patients in 1949 included some patients who were away from the institution on a trial basis. By the time the SBOC's role ended in November 1949, there were nine hospitals under its responsibility. *BTSH&SS Report from September 1, 1949 through December 1, 1950*: App.6.

[92] "Annual Per Capita Cost of Appropriation Expenditures of Eleemosynary Institutions for Following Years," *SBOC Sixth BR,* 58, For 1921 Institutions included in the number cited are Rusk, Terrell, San Antonio, Austin, and Abilene State Hospitals. The total annual per capita costs of $1,159.64 were divided by 365 to yield the per-day cost of .63 cents. Schedule M-6 shows the 1949 annual expenditures per patient in state hospitals for the 48 states; the per-patient, per-year cost for Texas was listed at $516.14, which divided by 365 equals $1.41. BTSH&SS Report from September 1, 1949 through December 1, 1950, App. 13. $.63 in 1921 was equivalent to $8.62 in 2016 and $1.41 was equivalent to $14.50 in 2017. "Inflation Calculator," accessed on October 16, 2017, http://www.in2013dollars.com/1949-dollars-in-2017?amount=1.41.

Although never highly ranked, Texas was not unique among the states. While the Texas state hospitals for the mentally ill needed to improve facilities and to pay for additional staffing and improved operations, it was not the only state in such a situation. As Table 1 below shows the 1939 annual costs for maintenance per resident patient in Texas was $228.92, which ranked the state 28th. Despite increasing its expenditures by 125.5 percent to $516.40 in 1949, the state dropped to 38th. In 1949, Tennessee ranked last with expenses of $323.65 annually per patient, and Wisconsin ranked first with annual costs of $1,089.01.

The 1949 National Governor's Conference directed the Council of State Governments to complete "a comprehensive, factual study" of the several states' programs for the care and treatment of mental illness, which was one of the "most important social and financial problems confronting the states today.[93] That study presented at the 1950 Governor's Conference documented the dramatic rise in the numbers of mentally ill, the need for additional space, and the dramatic shortage of psychiatrists and other staff for serving the mentally ill.[94] The study revealed that there were 462,859 patients in the state hospitals in 1949, but the actual need for public psychiatric beds in the nation was 725,203. At the time of the study in 1949, Texas had 14,004 beds, but the study determined that it needed 35,765 beds to serve its mentally ill population adequately.[95]

[93] Brevard E. Crihfield, *The Mental Health Programs of the Forty-Eight States: A Report to the Governor's Conference* (Chicago: The Council of State Governments, 1950): v.

[94] Ibid: 4-5.

[95] Ibid: 39.

Table 1 Annual Expenditures for Maintenance per Resident Patient in State Hospitals for the Mentally Ill by State Fiscal Years 1939 and 1949

State	1939	Rank	1949	Rank	% Change
Alabama	$189.92	36	$526.17	35	177.0 %
Arizona	*	..	755.81	12	*
Arkansas	206.29	33	473.81	42	129.3
California	265.13	20	830.05	5	213.1
Colorado	268.37	18	767.35	10	185.9
Connecticut	355.54	8	901.04	4	168.5
Delaware	362.09	7	720.63	14	99.0
Florida	258.52	21	640.52	23	147.8
Georgia	194.83	35	383.04	46	96.6
Idaho	127.00	46	627.81	26	394.3
Illinois	254.90	22	768.40	9	201.4
Indiana	*	..	505.61	39	*
Iowa	184.27	37	556.25	31	201.9
Kansas	296.21	34	498.89	40	141.9
Kentucky	141.54	45	382.93	47	170.5
Louisiana	241.96	24	464.61	43	92.0
Maine	273.14	17	634.04	25	132.1
Maryland	231.61	27	674.19	19	191.1
Massachusetts	412.06	3	789.26	7	91.5
Michigan	326.93	9	917.94	3	180.8
Minnesota	233.09	26	521.25	37	123.6
Mississippi	296.20	12	560.90	30	89.4
Missouri	285.09	14	536.90	34	88.3
Montana	177.90	38	595.29	29	234.6
Nebraska	224.26	29	649.71	21	189.7
Nevada	273.43	16	724.04	13	164.8
N Hampshire	372.91	5	821.12	6	120.2
New Jersey	772.55	6	779.23	8	109.2
New Mexico	172.08	40	694.68	17	301.4
New York	422.48	2	960.84	2	127.4
No Carolina	164.73	43	689.83	18	312.8
North Dakota	397.45	4	695.01	16	74.9
Ohio	207.05	32	624.01	27	201.4
Oklahoma	219.62	31	443.22	44	101.8
Oregon	164.82	41	542.54	32	229.2
Pennsylvania	295.80	13	643.51	22	117.5
Rhode Island	316.67	10	755.95	11	138.7
So Carolina	255.71	19	540.78	33	102.8
South Dakota	249.85	23	429.51	45	71.9
Tennessee	164.81	42	323.65	48	96.4
Texas	**228.92**	**28**	**516.4**	**38**	**125.5**
Utah	278.26	15	696.61	15	150.3
Vermont	297.57	11	619.07	28	108.0
Virginia	177.51	39	488.10	41	175.0
Washington	233.46	25	659.30	20	182.4
W Virginia	156.61	44	523.09	36	234.0
Wisconsin	507.30	1	1089.01	1	114.7
Wyoming	223.02	30	638.02	24	186.1

From: *The Mental Health Programs of the Forty-Eight States*, by the Council of State Governments[96]

[96] *BTSH&SS AR, 1949 – August 31, 1950*: Appendix 13.

Hospitals Were Custodial Institutions with Little Effective Treatment for Mental Illness

As the Eleemosynary Commission reported, the mental institutions provided virtually no occupational or mental therapy for the patients. With the opening of the Galveston Psychopathic Hospital in 1931, the SBOC highlighted its success in restoring a greater number of people to health by providing "intensive," "individual treatment" to a small number of patients who were admitted quickly without the need for a jury trial. It stated that this was probably "the State's most economical disposition" of care.[97] In 1932, the SBOC recommended that each of the state hospitals add "a psychopathic unit or separate building for receiving inmates."[98] It was not until 1936, however, that expansion for these types of facilities received funding by the Legislature. That year, the construction of a new addition at Galveston began that increased its capacity from 52 to 96.[99] San Antonio State Hospital also converted several wards to psychopathic care and constructed a new psychopathic ward building in 1936.[100] Wichita Falls State Hospital noted in 1936 that its "psychopathic clinical work" was limited, but a new psychopathic ward building was under construction.[101]

In 1938, the SBOC stated that its mental institutions were moving forward toward becoming treatment rather than custodial facilities. It reported that the mental hospitals had adopted new, modern treatments for mental illness and had added new equipment. They now used "insulin, metrazol, benzedrine, photodyne, and [had] expanded the use of

[97] SBOC Sixth BR: 40.
[98] SBOC Sixth BR: 31.
[99] SBOC Eighth BR: 75.
[100] Ibid: 84.
[101] Ibid: 87.

electrically-induced fever." In addition, its report noted that its program using "malarial treatment for general paresis" was one of the best in the nation.[102] This claim was part of the SBOC's general report. Still, in examining the reports of each institution for that year, only the Galveston State Psychopathic Hospital stated that they were experimenting with Metrazol and insulin. They added, however, that insufficient time had elapsed to allow them to evaluate the results of their experiments.[103] Austin State Hospital pointed out that they had "much work in paresis and Neuro-syphilis" and were sharing malarial blood with the other institutions.[104] The SBOC also highlighted that they had added several new "hydro- and physio-therap[ies]," and they had expanded occupational therapy and were looking to increase the space available for those services.[105]

The use of electroconvulsive therapy (ECT), a highly effective form of treatment for severe depression, began in the 1940s in the state hospitals. The patients had no memory of the treatment (although they could awake with injuries), but it was a violent therapy to witness as patients "jerked violently and turned blue" while they were held down by four people.[106] J. P. Porter, in his reporting on the hospitals, described its

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[102] SBOC Tenth BR: 47. Insulin and Metrazol were used to treat patients with some forms of mental illness by inducing convulsions that left the patient in a coma. Metrazol caused a more violent reaction than Insulin, and the patient retained memories of the treatment. The patients had no memory of the insulin-induced shock. Enoch Callaway, *Asylum: A Mid-Century Madhouse and Its Lessons about Our Mentally Ill Today* (Westport: Praeger, 2007): 22-25. Benzedrine is an amphetamine used for the treatment of narcolepsy, a neurological disorder that causes excessive sleeping. By the term "photodyne," the report was presumably referring to Hematoporphyrin, for which another name was Photodyn. The "photodynamic effects" of the chemical, which was a dye, helped those with" severely inhibited cases" of melancholia and endogenous depression to relax. Their "inhibitions regressed" and their "movements, facial expressions, and vocal expressions [became] livelier." J. Huehnerfeld, "The Hematoporphyrin Treatment of Melancholia and Endogenous Depression," *The American Journal of Psychiatry* 92, no. 6 (May 1936): 1324. Both malaria and electrically induced fever were used to treat paresis associated with the late stage of syphilis. P. M Lictenstein and S. M. Small, *A Handbook of Psychiatry* (1944: repr., London: Routledge, 2001): 261-263.

[103] Ibid: 65.

[104] Ibid: 55.

[105] SBOC Ninth BR: 63.

[106] Sitton: 95.

administration in 1949, "The charge of electricity convulses the patient; the body becomes rigid, eyes dilate, face flushes, and sometimes there is nosebleed and frothing at the mouth." Because of a lack of space at Austin State Hospital, patients waiting to receive the therapy watched as they stood by to receive their treatment. In some cases, they assisted the doctor "because of a shortage of attendants."[107] ECT is still one of the most effective therapies for patients suffering from significant states of depression, and the therapy has improved greatly from the early days described above. While patients still have no memory of the therapy, they no longer experience the extreme effects described by Porter. Today, brief electrical impulses stimulate the brain while the patient is under anesthesia. The primary usage of ECT today is when medications and psychotherapy have not produced positive results. In about 80 percent of patients, it "produce[s] substantial improvement."[108]

A more controversial therapy, the prefrontal lobotomy, began in the 1940s at Austin State Hospital and presumably the other state hospitals as well. This psychosurgical procedure consisted of severing the connections to and within the prefrontal cortex of the brain. These connections do not regenerate, so the surgery was not reversible.[109] With the development of new antipsychotic medications in the 1950s,

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[107] J.P. Porter, "Because of Conditions Mental Patients See 'Shock Treatments,'" *Dallas Morning News*, March 22, 1949: 17.

[108] "What is Electroconvulsive Therapy (ECT)?" *American Psychiatric Association* accessed September 13, 2019, https://www.psychiatry.org/patients-families/ect.

[109] In the early 1950s, the justification for the surgery was that the patients had a "hopeless prognosis under prevailing conditions and facilities for treatment," and one-half or more benefited of those receiving the surgery gained a benefit from it. Milton Greenblatt, Richard H. York, and Esther Lucile Brown, *From Custodial to Therapeutic Patient Care in Mental Hospitals* (New York: Russell Sage Foundation, 1955): 102-103 While the surgery did tend to "tranquilize the raving patients who were management problems, it generally deprived them of their judgment and social skills." Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, Inc., 1997): 227.

there was less call for this surgery and the irreversibility of the procedure lessened its use.[110] It was a part of the acceptable therapies within the Texas mental hospitals, at least until 1960.[111]

Aside from the overcrowded facilities, the state hospitals' key problem in providing treatment services was the lack of funds to hire competent staff. The Legislature authorized only limited funds ($1,200 a year) for the SBOC to hire a physician to serve as the Chief of the Eleemosynary Institutions, so instead of a full-time administrator to supervise all of the institutions, the SBOC settled for a part-time former hospital administrator who made periodic inspections.[112] The SBOC in 1932 and 1934 stated in its biennial reports, "The urgent need of the hospitals for the insane which has existed for a number of years is for a physician who has been specially trained in psychiatry and who has had several years' actual experience in a first class psychopathic hospital." The Board envisioned this person traveling from hospital to hospital to assist each of them.[113] In 1936, the report argued that the problem went beyond the need for a trained psychiatrist. The report, pointing to the medical staff salary scale, highlighted that the salaries for physicians had never been sufficient "to retain … the best trained men." Almost all young physicians left after 12 to 18 months when they found "more lucrative stations." The report stated, "In recent months, one of our largest State mental hospitals carried only three physicians on its staff when eight physician's salaries had been appropriated: doctors could not be secured for the small salaries available."[114] Not just

[110] Shorter: 228.
[111] Sitton: 96.
[112] *SBOC Sixth BR*: 12. *SBOC Seventh BR*: 48
[113] *SBOC Sixth BR*: 31.
[114] *SBOC Eighth BR*: 64.

doctors received low salaries. The edition of the SBOC's Thirteenth Biennial Report published in December of 1944 stated that during the depression, the Legislature had reduced virtually all state salaries, and "very few of them have ever been restored."[115]

In 1937, the Legislature acknowledged that there were a "large number of insane persons in the jails," for whom the state hospitals could not appropriately care, and that "it was not to the public interest that such unfortunate people be confined in the jails of Texas." The Legislature approved new state hospitals, one each for both East and West Texas.[116] The governor, however, vetoed the funds for the East Texas facility, because the Board of Control had only asked for the new West Texas hospital and money was very tight.[117] The SBOC selected Big Spring for the new location, and it opened in 1939.[118] In 1938, the SBOC believed that its focus on increasing the capacity of the state hospitals would be sufficient to allow all of the insane housed in local jails to move to hospitals by June 1939. However, it acknowledged that it would still leave the institutions "over-crowded."[119] The publics' drive to remove the mentally ill from the jails pushed the state to build another hospital, but that drive did not extend to a push to improve the quality of care within the institutions. In Texas and the rest of the nation, there was an assumption that the hospitals provided the treatment needed. That belief would change dramatically in the next decade.

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[115] "Thirteenth Biennial Report of the State Board of Control," *The Lone Star* 66, no, 7, Austin, Texas, December 15, 1944: 3.

[116] HB 397, 45th Legislature, Regular Session (1937) Bill Files, Texas Legislature, Archives and Information Services Texas State Library.

[117] James V. Allred, Governor of Texas, "Message from the Governor to the Members of the Forty-fifth Legislature, May 21, 1937, *House Journal,* Line Item Veto of HB 397, 45th Legislature, Regular Session, (1937), Bill Files, Texas Legislature, Archives and Information Services Texas State Library.

[118] *SBOC Ninth BR*: 78.

[119] SBOC Ninth BR: 62.

World War II and the Impact of Decades of Poor Funding

The SBOC's hope of having enough space to move all of the mentally ill from the jails proved wrong, but they chose to empty the jails nevertheless. "Mentally ill were removed from jails [to hospitals] and stacked in double-deck beds." The SBOC used every space in the hospitals for beds or pallets and mattresses when the beds ran out.[120] In 1943, the Texas House of Representatives received a report from a committee investigating the institutions under the SBOC. This report noted "food shortage[s]," "inefficient management," and "cruelty beyond belief" that "authorities in direct control of the institutions had allowed."[121] The Hogg Foundation, in a report published in 1945, identified "serious personnel shortages … due to inadequate compensation," and "crowded conditions and inadequate facilities"[122] within the state hospitals. The "standards for custodial care during World War II became about as bad as they had been in Texas history."[123]

The situation during the war did not improve after its close. In a series of newspaper articles that appeared across Texas in 1949, a young college student reporter, John Paul (J.P.) Porter (1924-2014), working under the auspices of the University of Texas Hogg Foundation for Mental Hygiene, visited each of the state hospitals. He talked

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[120] J.P. Porter, "Texas Mental Hospitals Said among the Worst," *Dallas Morning News*, March 20, 1949: 4.

[121] "Report to the Honorable Price Daniel, Speaker of the House of Representatives," 48th Session of the Legislature, and all Members thereof by M. A. (Bill) Bundy, Chairman of the Committee to Investigate Eleemosynary and Reformatory Institutions labeled Resolution 236, 1943. Typed copy in the Sitton Papers housed at Austin-Travis County Collection, Austin Public Library, Austin, Texas.

[122] *The Care of Mental Patients in Texas* (Austin: The Hogg Foundation for Mental Hygiene), The University of Texas, January 1945: 10. Housed at the Texas State Library and Archives Collection, Austin, TX.

[123] Kenneth D. Gaver, MD, "A Look Backward," in Mental Illness and Mental Retardation: The History of State Care in Texas (Austin, TX: Texas Department of Mental Health and Mental Retardation, 1975: 5.

with staff about the care of the mentally ill following 30 years of oversight by the SBOC. He noted, "The state hospital system now contains 15,000 mentally ill persons with facilities for half that number. Halls, basements, porches and bathrooms are jammed with beds to catch the overflow." Porter also noted that quarters for staff required to live on campus were "overcrowded and outmoded." He quoted Hall H. Logan, chair of the SBOC, "If you provide slum quarters for your help, you'll either get the type of people who live in slums or break the hearts of those whose zeal has kept them on the job."[124]

In Austin, Porter found that the first hospital building, constructed in 1857, still housed several hundred patients. Superintendent A.T. Hanretta told him that the old building was "unsanitary, ill-adapted, and a dangerous fire trap." Porter also noted that "overcrowded" was the word that described the entire hospital. With an "official capacity" set 25 years earlier in 1925 at 1,700, the "capacity had increased to 2,810 with "practically no expansion," and in 1949, there were more than 3,000 patients housed there.[125] Porter also described "the world for fifty-six sick men at San Antonio State Hospital." It consisted of "straw mattresses soaked in human filth; a bare cement floor sticky with saliva; three wooden park benches; steel barred windows and grated doors." The men had epilepsy, and with frequent convulsions, they lost control of their "bodily functions." "The straw [could] be destroyed when soiled, like that in a chicken coop. The stench resembles that of a barnyard, but low-paid attendants soon get used to the smell."[126]

[124] Porter, March 20, 1949: 4.
[125] Porter, March 22, 1949.
[126] J.P. Porter, "San Antonio Patients Sleep in Human Filth," *Dallas Morning News*, March 23, 1949: 18.

At Terrell, he found a hospital built on the land given to the state that had had problems from its first years.[127] Porter noted that there was "A constant shifting of the earth beneath the hospital buildings. The entire plant is plagued by cracked walls, split floors, tilted stairways, jammed windows, broken water mains, and jig-sawed pavements."[128]

In visiting the hospital at Rusk, Porter looked back to its previous life as a prison and stated, "After thirty years of playing tag with decency, it [had] slipped back into much of its former penal atmosphere."[129] At Wichita Falls, he found that "overcrowding" of the new hospital built in 1922 had "turned the airy wards into something little better than teeming cages." Porter learned that the most significant problem for Wichita Falls was finding staff. Its location six miles from town made hiring attendants with low salaries so difficult that it actually "[had] fewer attendants per number of patients than any other state institution."[130]

Beyond the overcrowding, the state of the facilities, and problems of obtaining attendants, the biggest problem was finding qualified physicians to provide the care and treatment for the patients. Porter's summary column noted that the national average income for a private physician in the United States in 1949 was $17,476. Still, the top salary for a general physician in the Texas state hospitals was $3,444. He stated that in Texas, "nobody expects a state doctor's salary to be $17,000, but it obviously should be

[127] "New Lunatic Asylum," *Dallas Morning News*, November 28, 1891, 1.

[128] J.P. Porter, "Terrell Mental Hospital in Tumble-Down Shape," *Dallas Morning News*, March 24, 1949: 9.

[129] J.P. Porter, "Former Prison Building Houses Mental Patients," *Dallas Morning News*, March 26, 1949: 11.

[130] Ibid.

more than $4,000—even with free room and board."[131] He noted that San Antonio had the best ratio of doctors to patients at one for every 300 patients, but that was less than half required to meet the standards of the American Psychiatric Association.[132] At the time of Porter's visit, Austin had seven doctors for the more than 3,000 patients, three of whom worked part-time and were over 70 years old.[133] Terrell had seven doctors in addition to the superintendent for its 2,400 patients. Those seven had an average age of 69, the oldest being 84, and only four of the seven worked full-time.[134] At Rusk, the budget called for 14 doctors for its 2,750 patients and the state's "only extensive insulin program." The superintendent noted, "I couldn't properly use that number if we had them. If it were possible to combine some appropriations to pay eight to ten decent salaries we could solve our personnel problem."[135] The superintendent at Wichita Falls was 78, and he had a staff of six doctors for the 2,582 patients; three of them were over 70.[136]

[131] J. P. Porter, "Cash No Cure-All at State Hospitals: But it would Help," *Dallas Morning News*, March 27, 1949: 7.

[132] Porter, March 23, 1949: 18.

[133] Porter, March 22, 1949: 17

[134] Porter, March 24, 1949: 9.

[135] Porter, March 26, 1949: 11.

[136] Ibid.

Figure 3 John (J.P.) Porter

John (J.P.) Porter following a presentation in Houston. J.P. Porter was a native of Mt. Pleasant, Texas, who enlisted in the Army in 1942 while a student at UT in Austin. He received the Purple Heart, Bronze Star, and Silver Star while in service. His articles on Mental Health in Texas received a nomination for the Pulitzer Prize later when he was a student at the Pulitzer School of Journalism at Columbia University. His first position after leaving UT was with the St. Louis Post Dispatch as a reporter. He later worked for LIFE magazine as a reporter in San Francisco. He then transferred to New York City in the early 1960s to become part of the startup of Time/Life Books. He was a writer and editor there. When he retired, he was the European editor of the books division of Time-Life International Ltd, London. [137]

[137] Picture from *Houston Press*, February 19, 1949. "John Paul Porter," *The Post Star*, accessed October 9, 2019, https://poststar.com/lifestyles/announcements/obituaries/john-paul-porter/article_fbb573e6-4208-11e4-b2dd-c71c4c132757.html.

The Attendants, Not the Physicians, Controlled the Lives of the Patients

Given Porter's report on the situation of physicians in the Texas state mental hospitals in 1949, the findings of Ivan Belknap in his examination of the mental institutions and his three-year observation of the Austin State Hospital in the early 1950s are entirely believable. Belknap stated that Texas had created "a centralized and hardly more humane form of the older county and city poor farms" in its less than 100 years of operation.[138] He described the meager salaries, extensive levels of responsibilities, and constant turnover of physicians. His intensive study found that in Austin, each ward's lead attendants, not the physicians, actually led the informal organization of the hospital. Their role was critical to the operations of each ward, maintaining order and control of potentially unruly patients. With limited staffing, the attendants used the cooperative patients as staff by rewarding them with better job assignments and special privileges in exchange for helping the attendants. These patients assisted by doing manual work on the ward, caring for other patients, providing surveillance and informing on other patients, and providing protection as the attendants needed it. Neutral patients—those who were not as cooperative but did not go against the system—received some privileges to keep them compliant, but non-cooperative patients received no privileges.[139] Instead of assigning patients to different wards based upon illness or functioning level, every ward at Austin had a mixture of patients. This mix was because no attendant wanted a ward

[138] Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: Blakiston Division, McGraw-Hill Book Company, 1956): 34.

[139] Ibid: 163.

where no cooperative patients were available to perform the necessary work of caring for the patients and maintaining the ward.[140] Since the physicians had limited time, they depended on the attendants to tell them what was going on, and whom they should visit. In general, the non-cooperative patients had limited access to the doctor. Patients who caused excessive trouble and refused to cooperate over time received a request from the attendants that the physician transfer him/her to another ward. "Good" doctors, in the attendants' eyes, honored their requests.[141]

Creation of a New Board and an Infusion of Funds to Improve Facilities

Figure 4 Robert Sutherland with Ima Hogg [142]

[140] Ibid: 129-131.

[141] Ibid: 165-171.

[142] Associated Press. Houston Public Media, Accessed July 21, 2019, https://www.houstonpublicmedia.org/articles/news/2018/07/23/296840/stolen-historic-ima-hogg-brooch-has-been-recovered-2-arrested/attachment/ima-hogg-robert-sutherland/

Thanks to J.P. Porter's newspaper articles, the impact of the lack of maintenance of the facilities during the war, and the change in the nation's view toward the treatment of mental illness, there was a movement to change the miserable conditions in the state psychiatric hospitals. From 1948 through 1950, working under the auspices of the Texas Society for Mental Hygiene, several individuals provided leadership for changing mental health care in Texas. Hamilton Ford M.D., a practicing psychiatrist, professor of psychiatry at the University of Texas Medical Branch in Galveston, who was an active member of the Texas Society for Mental Hygiene, chaired the Texas Medical Association's new standing committee on mental health. In his dual capacity, he was actively involved in seeking legislation to change public mental health in Texas. Joining him in the leadership of this effort was Robert Sutherland Ph.D., a sociologist and the Executive Director of the Hogg Foundation for Mental Health, an endowed organization affiliated with the University of Texas.[143] Following a national search, Sutherland had come from Ohio to Texas in the early 1940s to serve as the first leader of the newly created foundation.[144] The Foundation and its endowment were the creations of the children of the former Governor of Texas, Jim Hogg.[145] Three others played significant leadership roles in the late 1940s in working to change mental health in Texas. Percy Williams, an attorney and associate professor of law at the University of Texas, was

[143] Letter from Hamilton Ford M.D. to Robert Sutherland with an attached amended copy of the proposed act to establish a State Hospital Board, February 24, 1948, Box MAI 9/U27, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

[144] Wayne H. Holtzman, "Sutherland, Robert Lee," *Handbook of Texas Online* (http://www.tshaonline.org/handbook/online/articles/fsu15), accessed November 26, 2013. Published by the Texas State Historical Association.

[145] Wayne H. Holtzman, "Hogg Foundation for Mental Health," *Handbook of Texas Online* (http://www.tshaonline.org/handbook/online/articles/vrh01), accessed November 26, 2013. Published by the Texas State Historical Association.

critical in planning legislative strategy.[146] James S. Mahon, a nonprofessional, chaired the Committee on Mental Health as a civic project for the Texas chapter of the Junior Chamber of Commerce. The Junior Chamber of Commerce**,** a national organization of young men between the ages of 21 and 39**,** had local and state chapters in each of the states. The Texas state chapter adopted the cause of improving the treatment of mental illness in Texas as a civic project, and Mahon served as chair of the statewide effort working with local chapters across the state.[147] Ozro T**.** Woods M.D, a surgeon and associate professor at the Southwestern Medical School in Dallas**,** served as chair of the Citizens Committee on Mental Health that formed in 1949. Governor Alan Shivers looked to this committee to help pass legislation and to advise him on the improvements needed for mental health in Texas.[148]

HB 1 of the 51st Texas Legislature meeting in 1949 created a new board, the Board for Texas State Hospitals and Special Schools (BTSH&SS) to focus on the specific needs of the populations served in the state hospitals for mental health and tuberculosis and the special schools for the intellectually disabled from the former SBOC in 1949.[149]

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[146] Percy Williams, "Memorandum Regarding the Organization of a Legislative Action Program of the Texas Society for Mental Hygiene," September 10, 1948, Box MAI 9/U27, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

[147] Letter from Jim Mahon to Robert Sutherland, October 11, 1949, Box MAI 9/U27, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

[148] Letter from Ozro T. Woods M.D. to those who had responded that they would join the Citizens Committee on Mental Health at the invitation of Governor Shivers, November 2, 1949, Box MAI 9/U27, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

[149] HB 1, 51st Regular Session (1949), Bill Files, Texas Legislature, Archives and Information Services Texas State Library. The Texas Medical Association had lobbied hard for the new board and sought to have a strong medical presence on it. The legislation did not specifically require physicians on the board, but it did limit the number of medical doctors to three at any one time. Throughout its history, at least two board members were physicians. One of the most notable was Raleigh R. White MD from Temple, Texas of the Scott and White Hospital, and another was George A. Constant of Victoria, Texas, a psychiatrist who brought Devereux School, a private nationally based behavioral health facility, to Victoria, Texas. Another notable was Mrs. Howard E. Butts, wife of the founder of the H-E-B

In addition, the Legislature in a special session in 1950 passed a special tax on cigarettes to raise $35 million for new construction and renovation of facilities over seven years.[150] That $35 million repaired and replaced worn out buildings, but it did not create new facilities.[151] The board added programs for senile patients at Kerrville in a former state tuberculosis sanitarium and the Mexia State Home. These joined the Confederate Home for Men in offering care to the geriatric population, freeing space for younger patients who were more recently ill.[152]

Conclusion

In looking at the first 100 years of the Texas programs to serve the mentally ill, it is clear the state never adequately funded care. It used federal funds to begin, depended upon the generosity of the superintendent during the Civil War, and delayed expansion of the facilities that could empty the jail cells of the mentally ill. It built new asylums and expanded them. Still, they were always overcrowded and funded at levels to keep them going, but never with the opportunity to develop more than custodial care for the patients served. For 30 years, the asylums operated at the whim of each superintendent while the Board of Control sought to save money each year from appropriated resources. In 1949 and 1950, when its services hit bottom, the state did fund significant capital improvements for its old and hard-worn structures. Its new board began to develop actual

supermarkets and a philanthropist who served on this board and its successor longer than any other person did.

[150] HB 2, 51st 1st Called Session (1950), Bill Files, Texas Legislature, Archives and Information Services Texas State Library.

[151] *BTSH&SS Report September 1, 1953 – August 31, 1955:* 2-3.

[152] Ibid: 25.

mental health treatment programs, but the facilities remained overcrowded and the tangible resources low.

VI. THE MEDICAL COMMUNITY'S FOCUS ON CHANGING THE TEXAS PUBLIC MENTAL HEALTH SYSTEM LED TO FUTURE PROBLEMS

Just as the Medical Community played a crucial role on the national level in changing the treatment of serious mental illness beginning in the 1950s, it also advocated for change in Texas. Its focus on bringing the state health care system under medical control, ultimately allowed the Legislature to use its advocacy for that body's purposes, and in the end to create a system with limited leadership capacity.

Introduction

Texas has never supported the treatment of mental illness at the level needed. In 1949 and 1950, the state created a new department focused only on the states' public hospitals and special schools, and passed a cigarette tax to raise money to improve the facilities under its control. The medical profession played a significant role in pushing for these changes. It continued that role as it advocated for improved treatment of those with an SMI in Texas in the 1950s and 1960s. However, its focus was on creating a state department led by a psychiatrist rather than passing a bill to secure the funding for the future programs it envisioned. The medical profession's actions did create a new combined hospital and community mental health center department with the board led by a psychiatrist. However, the Texas Legislature did not approve the strong physician presence on the board that the medical profession wanted, and Governor John Connally chose to re-nominate the two physicians from the former board (BSH&SS), but no

additional ones. The combination of a psychiatrist leading the agency with a non-medical board would lead to future leadership issues.

The new board, the Texas Department of Mental Health and Retardation (TDMHMR), had the challenge of supporting the creation of community mental health centers for both the mentally ill and the intellectually disabled in the communities that chose to create them. At the same time, the board's biggest challenge was to lead two massive institutional programs of state hospitals for those with SMI and state schools for the intellectually disabled. In both of these actions, the Legislature limited and directed the funding of TDMHMR. As Chapter VII will show, this organization and the Legislature would find themselves at the mercy of legal action and federal court directives for over a quarter of a century due to poor leadership by its board and executive.

The Medical Community Leads Efforts to Improve the Treatment of Mental Illness in Texas, but is Used by the Legislature Budget Board to Scuttle a Hospital for Houston

In 1949, the Texas Medical Association (TMA) began a drive to gain control of the hospitals treating mental illness and tuberculosis in Texas. It saw political interference driving that the three-person lay Board of Control and the hospitals under its leadership. TMA wanted to create a merit system that would allow appointments and promotions of worthy physicians within the state hospitals.[1] It drafted legislation to change to a new Board of State Hospitals and Special Schools (BSH&SS). TMA's proposed legislation left no doubt that it wanted a strong leadership role on the new

[1] "Report of Committee on Mental Health," *Texas State Journal of Medicine* 46, no. 6, (June 1950): 417.

board, for it sought a board of nine members, four of whom would be physicians.[2] Fearing loss of control if it gave political power to physicians, the Legislature did not accept the recommendation that required physicians to be on the board;[3] however, over the life of the new board, at least two physicians were on the board at all times.[4]

The TMA continued its efforts to improve the treatment of mental illness in Texas throughout the 1950s. In 1953, the American Medical Association (AMA) added a committee on mental health that suggested a 13-point program to encourage state and county medical societies to promote mental hygiene within their communities.[5] In 1954, the TMA's Committee on Mental Health noted that it had met with the budget officer of the Legislative Budget Board (LBB) regarding training within the hospitals and ways to increase appropriations for improved treatment. That same year, the committee reported that some of its members were part of the advisory committee to the BSH&SS that met with that board every other month.[6] Also, in 1954, the Women's Auxiliary of the TMA made up of the wives of the physician members, accepted the challenge from AMA and began an extensive effort to educate themselves and their communities about the

[2] Draft of proposed legislation for the State Hospital Board from Hamilton Ford, M.D., to Dr. Robert Sutherland, February 24, 1948. Box MAI 9/U35, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

[3] HB 1, 51st Regular Session (1949), Bill Files, Texas Legislature, Archives and Information Services Texas State Library. The TMA was disappointed with the new structure, and that the Legislature had not followed its recommendation that superintendents had to have ten years' experience in psychiatry. Hamilton Ford, "Report of Committee on Mental Health," *Texas State Journal of Medicine*, June 1950: 417. However, the new board did have one physician serve as Executive Director from 1952 to 1957. At other times when laypersons filled that position, the medical director and later the director of mental health and hospitals were physicians. Richard Morehead, "Tenure Short in Mental Health Post," *Dallas Morning News*, March 19, 1970: 23.

[4] BSH&SS Annual Reports 1949 to 1963.

[5] "American Medical Association: AMA Mental Health Program," *Texas State Journal of Medicine*, December 1953: 901-902.

[6] Hamilton Ford, "Report of Committee on Mental Health, *Texas State Journal of Medicine* 50 no 6, (June 1954): 384.

"overcrowded and understaffed" mental hospitals of Texas.[7] The BSH&SS advisory committee, with the encouragement of TMA's Committee on Mental Health, created a public health information subcommittee to educate the public about the needs of the state hospitals and schools and those it served.[8]

TMA enjoyed its standing with the new board and the Legislature, but the LBB used that relationship to ask for help against the BSH&SS. In 1956, the BSH&SS budget request for the 55th Texas Legislature meeting the next spring went to the LBB first. It contained a request to build a large state psychiatric hospital in Houston, the state's largest city. The LBB saw the request as "too much emphasis on bricks and not enough on treatment and restoration." Lt. Governor Ben Ramsey (1903-1985), the chair of the LBB, advised the board to approach the TMA "hat in hand" and ask the association to sponsor an "objective study of state mental health services." TMA agreed to do so, and they obtained a donation from Howard E. Butt Sr. (1895-1991) to fund the study.[9] Butt was a South Texas grocer who founded the HEB grocery stores and whose wife was a member of the board of BSH&SS. Francis J. Gerty MD (1893-1994), Chair of the Department of Psychiatry at the University of Illinois – Chicago, was engaged to complete a three-month consultation. His charge was to recommend "short term, specific

[7] "Auxiliary Section—Mental Health, a New Project, *Texas State Journal of Medicine* 49 no. 12, (December 1953): 907. Mrs. A. B. Pumphrey, "Report of the Mental Health Committee of the Auxiliary, *Texas State Journal of Medicine* 50 no. 7, (July 1954): 534.

[8] Hamilton Ford, "Report of Committee on Mental Health, *Texas State Journal of Medicine" Francis* 51 no. 6, (June 1955): 354.

[9] Clifton McCleskey, "Houston," in *The Politics of Mental Health: Organizing Community Mental Health in Metropolitan Areas,* ed. Robert H. Connery (New York: Columbia University Press, 1968): 144. Mary Elizabeth Holdsworth Butt (1903-1993), would continue serving on that board and its successor for 18 years. Mrs. Butt became a strong supporter of community mental health when it began.

steps that should be taken administratively and legislatively to develop an optimum program of modern care and treatment for the Texas mentally ill."[10]

Gerty's 1957 report recommended that the state develop a model program in a region of the state large enough to serve a significant portion of the population, and ideally one without an existing state psychiatric hospital. The model should include all of the elements needed for the prevention and treatment of mental illness, including research and training, and should contain a small community-centered psychiatric hospital.[11] The study recommended a 500-bed hospital for this model program in addition to the research and training program, instead of the larger state hospital envisioned by the BSH&SS leadership. Though the Legislature approved the concept of the 500-bed hospital, the opposition of the LBB successfully blocked the funding for it. However, twenty-five years later, this approval from 1957 became the vehicle, when funded by the Legislature, to build the Harris County Psychiatric Center (HCPC).[12]

The LBB, under Lt. Governor Ben Ramsay's leadership, did not want to build the hospital, and just as the legislature opened, it flew 'key figures in the legislature to Michigan for a week to study … work being done at a clinic there." While the work there was expensive, the LBB sought to convince the leadership of the Legislature that the "high daily cost of patient care could be good economy in the long run." Despite a

[10] "Francis J. Gerty Named Mental Health Consultant, *Texas State Journal Medicine* 52 no. 11, (November 1956): 829..

[11] "Dr. Gerty Reports on Mental Health," *Texas State Medical Journal* 53 no. 3, (March 1957): 179-180. Gerty also endorsed outpatient clinics as well as a small community hospital with the capacity of no more than 500 beds. He suggested Houston-Galveston as the area for the demonstration project, for there were two medical schools in the region, it had an active medical society, and there was no state hospital within 200 miles.

[12] Spencer Bayles, M.D., Video Interview by Dan Creson on August 20, 1988, AVV.MS108.005. Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

"knock-down, drag-out battle" with BSH&SS, which pushed to build the needed hospital for the largest city in Texas, the visit to Michigan and the TMA sponsored study was successful in defeating the effort to build it.[13] The Legislature approved Gerty's plan for a research institute in Houston and the establishment of two outpatient clinics, one in Dallas and the other in San Antonio.[14] The LBB's focus was on saving money, not on building the quality care the legislators had seen in Michigan. Instead of spending the millions of dollars it would have cost to build and staff a large state hospital, and the continued ongoing expense, the legislature spent just over $1 million the first two years for operations of the new research center and outpatient clinics.[15] It would face additional costs in the construction and operation of the research center, but not the cost of a large state hospital.

TMA, having supported the action of the LBB and Gerty's 1957 report created under its auspices, applauded this action. Like the AMA on the national level, TMA opposed new mental hospitals seeing them only as vintages of the past given the negative image of the hospitals since World War II and the new medications helping people to leave the hospitals. In the *Texas State Medical Journal*, the TMA Committee on Mental Health stated, "The Texas State Legislature has made itself, psychiatrically, the best-informed legislative body in the United States." In other states, the citizens are putting pressure on their legislatures to build more psychiatric hospitals. However, in Texas, the Legislature is pushing "not for more buildings, but more psychiatrists, clinical psychologists, social workers, and psychiatrically oriented nurses and psychiatric

[13] McCleskey, 145.

[14] HB 133, 55th Legislature, Regular Session (1955), Bill Files, Texas Legislature, Archives and Information Services Texas State Library, 906-907.

[15] Ibid.

aides."[16] For TMA, the creation of the Houston State Psychiatric Institute for Research and Training (HSPI) gave psychiatry and medicine a new role of in the treatment of mental illness that better fit their image. It opened in a temporary facility in 1958 and moved into its newly constructed permanent home in 1961 within the Texas Medical Center. In 1968, the Legislature renamed HSPI the Texas Research Institute of Mental Sciences (TRIMS), provided funds to lease space for a sixty-bed hospital in Houston, and added outpatient services.[17] This small hospital and outpatient services, however, would not meet the needs of those suffering from an SMI in Houston. It would be another eighteen years before the construction of a public psychiatric hospital in Houston, and it would prove to be too small and not created to serve the longer-term needs of this overwhelmed population.

The Medical Community Takes the Lead in Planning for Community Mental Health

In the fall of 1962, the United States Department of Health, Education, and Welfare (HEW) received $4.2 million to award to the states to plan for community-based mental health programs. AMA's Mental Health Congress in October 1962 asked the TMA, the Texas Neurological Association (TNA), and the Texas Association of Mental Health "each to get five of their best people together on the subject of mental health planning … to begin making preparations for a plan for community mental health services in Texas." At the same time, staff from the Division of Mental Health within the Texas Health Department started the grant application for funding the planning effort for

[16] Perry Tarkington, "Psychiatry in Texas," *Texas State Journal of Medicine* 54 no. 11, (November 1958): 758.

[17] HB 5, 60th Legislature, 1st Called Session (1968), Bill Files, Texas Legislature, Archives and Information Services Texas State Library

Texas even before Congress had given its final approval to the authorization.[18] While the Health Department applied for the funding and would provide the staffing for the planning effort, in reality, mental health was not the focus of the department. The three advocacy groups had a better knowledge of mental health, and TMA and TNA had a strong bias for the medical leadership of the work. However, the planning effort was not without controversy within TMA; many of the physicians opposed it out of fear that acceptance of federal funding could lead to socialized medicine. The planning committee ultimately presented the grant proposal, which included the acceptance of federal funding to TMA, for consideration "where it was approved only after vigorous discussion."[19] The prominent role played by TMA ultimately made this a medical proposal, without significant input from other groups.

Three planning committees—Executive, Steering, and General—completed the planning task over a year, holding six multiple-day meetings from December of 1963 to October of 1964. The committees were long on knowledge of mental health but quite

[18] McCleskey, 145-146.

[19] Ibid: 146. The TMA's Committee on Mental Health had previously endorsed the use of the federal grant for planning purposes. However, at the first meeting of the planning steering committee, Perry Talkington, M.D. (1909-1996), chair of that committee, sent word that TMA's committee opposed "accepting federal money for planning." The planning committee determined that the funding would aid the state in doing their planning and did not involve "imposing some type of federal control on the operation of the program." After significant debate, TMA accepted the planning committee's proposal and its submission to the National Institute of Mental Health (NIMH) for funding. "Panel to Help Chart Mental Health Setup," press release of the Mental Health Educational Materials, Division of Mental Health, Texas State Department of Health, 1.29.63, Box MAI 9/U35, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin. "First Meeting of the Steering Committee for Statewide Mental Health Planning—Austin, March 1963—Minutes," March 15, 1963, first and second page, Box MAI 9/U35, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

short on individuals with experience in politics and finance. Of the 127 members, almost 60 percent were mental health professionals, and 30 percent were physicians.[20]

Three members of the Executive Committee for the current statewide and community mental health planning program conferred with Dr. Moody C. Bettis (right), psychiatrist-coordinator for the work, at an August planning session. They are (from left) Dr. James E. Peavy, Texas State Commissioner of Health, chairman; Dr. Cyril J. Ruilmann, Director of Mental Health and Hospitals for the Board for Texas State Hospitals and Special Schools, co-chairman; and County Judge C. L. Abernethy of Hale County and Plainview, chairman of the 112-member General Planning Committee. Fourth member of the Executive Committee, not pictured, is Robert L. Sutherland, Ph.D., director of the Hogg Foundation for Mental Health at the University of Texas and vice chairman of the General Planning Committee.

Figure 5 Leadership of the Community Mental Health Planning Committee 1964 [21]

"Several conservative political and community leaders who could have helped the committee a great deal" chose not to do so.[22] Among those invited, but who declined to serve were Lt. Governor Preston Smith (1912-2003) and Speaker of the Texas House of Representatives Byron Tunnell (1925-2000), who by their positions were two of the most

[20] McCleskey: 146-147. The program for planning called for an executive committee of four. They were James E. Peavy, M.D. (1911-1980), Commissioner of the Texas Department of Health; C. J. Ruilmann, M.D. (d. 1981), Director of Mental Health and Hospitals of BSH&SS; Robert L. Sutherland, Ph.D. (1937-1973), director of the Hogg Foundation for Mental Health; and the County Judge-Executive of Hale County in west Texas, Judge C. L. Abernethy (1907-1996). Beyond that group was a seventeen-member steering committee that included the executive committee. Lastly, there was a general committee of 110 people assigned to twelve task forces. "Highlights and Recommendations from the Texas Plan for Mental Health Services," The Statewide Citizens Committee for Mental Health, December 1, 1964, 37-40.

[21] *Texas State Journal of Medicine* 60, no. 9, (September 1964): 777.

[22] McCleskey: 147.

influential leaders in the state. Others who declined were Ed Kilman (1896–1969), editor emeritus of the *Houston Post*, and Mrs. Amon Carter, widow of the publisher of the *Fort Worth Star Telegram*, who represented two key media resources in the state. Miss Ima Hogg (1882-1975) of Houston and benefactor of the Hogg Foundation and Ben Taub (1889–1982), a medical benefactor from Houston, were prominent philanthropists with interest in health care. Richard Kleberg (1917-1979) of the mammoth King Ranch in South Texas and Boone Powell (1912-1996), administrator of Baylor Hospital in Dallas, were active leaders in their respective areas. These individuals were all influential in their communities and the state, who could have offered valuable political insight to the committee.[23] If Governor John Connally (1917-1993), had asked these individuals personally to participate in the planning, some of their responses would have likely been different; however, the form letter that the Governor reluctantly signed did not convey his support of the planning. That reluctance of the Governor led the planning leadership not to ask the governor to appoint the committee formally. The governor did not express opposition to the planning; however, he was not a strong supporter. He noted specifically that funding for new programs would need to come from the local communities and not the state.[24]

[23] "General Planning Committee: Preliminary Proposals for Task Force Composition, Steering Committee for Statewide Mental Health Planning—Friday, August 16, 1963," Box MAI 9/U34, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

[24] In a speech made two months before the opening planning session, the governor made clear his strong support for the improvement of state hospitals and the research work of the HSPI. While he noted the work of the mental health planners, he specifically stated that funding for it should come from the local communities, for the "state government [would] continue to perform only those necessary functions which are beyond the reach of local units of government and private resources." "Remarks of Governor John Connally, Texas Assn for Mental Health, October 18, 1963—Dallas," p. 6. Box MAI 9/U35, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin. McCleskey: 146-147.

Why did Governor Connally not support the state's funding of community mental health? In 1965, Democrats controlled both the national government and the government of Texas. However, while the liberal side of the Democratic Party dominated the national government, Texas Democratic leadership came primarily from the conservative wing. Texas Democrats were willing to take federal funding if the local communities wanted to fund new programs. However, they did not want a federal mandate forcing the Legislature to spend Texas' money in a specific way. The Governor expressed firm support for mental health in Texas as it existed at that time, but he was not willing to champion new funding against other state priorities.

The Planning Committees Fails to Plan for the Financing of New Programs

Though the planning committees had a finance task force, it did not develop any cost projections for the many new community-based ideas created in the plan, and it suggested no viable plan for financing them. The plan assumed that funding for new mental health services was the responsibility of private citizens and that treatment would continue to be the responsibility of "the private sector of medicine." It noted that the private sector had not been responsible for preventive and rehabilitative services in the past, so it would be up to the new board to determine how to fund those.[25]

This idea of funding came from the physician's opposition to any funding not controlled by the patient. They wanted no interference in the doctor-patient relationship that the government might impose if it paid for the service. The TMA, AMA, and other physicians' groups wanted patients or their families to pay physicians directly for the services received. These were long-standing views of physicians in America that grew

[25] *The Texas Plan for Mental Health Services: Highlights and Recommendations*, 1964: 36.

more resilient as medicine changed in England, Europe, and other places where countries created government-funded single-payer health care systems. In those systems, a physician's payment for services was not under the doctor's direct control. Though the planners were planning for services that they would theoretically provide for those with an SMI then receiving services free from the state, they failed to identify any public funding stream for the thousands of those patients who had no money to pay for the services in the community. The physicians' focus was not on funding but on ensuring that the leadership would come from the medical community. In the end, this would almost prevent the passage of the implementing legislation, and it did specifically decrease the funding available for community mental health for the first two years after it passed.

The formal plan of community services was not a part of the legislation needed to implement it. The planned legislation created a new mental health board. It charged that board with implementing community mental health centers in those communities creating them, without identifying any specific funding mechanisms and assuming that the new board would know how to create the centers. The plan itself was a watershed of possible programs to implement without any prioritization or implementation schedule. The planners failed to educate the Legislature about the plan, believing they had completed their task with the plan's completion. The new board would have no real instruction on what community centers were or how to establish and work with them.[26] In reality, it was not a real plan, but a means by which state government would implement a mechanism to bring federal funds into the state that could eventually lead to less need for

[26] Ward Burke Speech, "Texas Community Mental Health Centers: 'Their Future,'" July 17, 1992. AVV.MS108.111, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

state funding of the state hospitals in the future. Fiscal conservatives and community mental health advocates both saw the opportunity to gain their goals, while physicians saw themselves increasing their leadership role on the new board.

A Political Deal is Cut Bringing the State Mental Hospitals, Special Schools, and Community Centers under One Board

James E. Peavy, M.D. (1911-1980), commissioner of the Texas Department of Health and chair of the Executive Committee, and co-chair Cyril J. Ruilmann, M.D. (1909-1981), Director of Mental Health and Hospitals for the BSH&SS, provided limited leadership for the planning effort, and the psychiatric-consultant staff leadership of the effort was only part-time.[27] However, as planning neared an end in September of 1964, Peavy and Ruilmann reached an agreement to move the mental health aspects of the Health Department to a new Department of Mental Health that would include the state mental hospitals and the special schools for the intellectually disabled (ID). The state tuberculosis hospitals would transfer to the Health Department.[28] The planners included the special schools in the new department without any input or discussion with advocates for that group. This action would prove to be a significant issue in the subsequent legislative process.

As its work neared completion, the planning committee sought support for the final product from the TMA. Because the committee's leadership believed the Legislature

[27] McCleskey: 148.

[28] Ibid: 149-150. The Governor gave his informal support for this arrangement in a written comment by Bill B. Cobb, who was an ex-officio member of the Steering Committee representing the Governor's office. This support allowed the changes to be part of the proposals from the planning committee and allowed the new board to have all of the mental health services in the state under its control. "Comments Regarding Administration and Coordination of the Texas Plan," September 15, 1964, Box MAI 9/ U34, Hogg Foundation for Mental Health Papers, Briscoe Center for American History, University of Texas, Austin.

would oppose a medically dominated board, they recommended that there be no designation of membership categories on the new board. They did recommend that the Legislature require the new commissioner of the department to be a psychiatrist and that there be a "strong professional advisory board" that "would not be limited to the medical profession alone." The TMA mental health committee refused to endorse the plan specifically because they did want a medically dominated board. After much negotiation, the TMA committee endorsed a change in the planned legislation to require three of the new board members to be physicians, with one of those being a psychiatrist. They also required a separate medical committee made up of six psychiatrists, two general practitioners, and a pediatrician. One duty of the medical committee would be to name three psychiatrists from which the board could choose one to be the commissioner.[29]

TMA Failed to Gain the Leadership Role and Created a Troubled Leadership for the Future Agency

The bills carrying TMA's new board and committee structure in the Legislature met a quick demise. The leadership of the planning committee was correct in stating that the Legislature would oppose a medically dominated board. When presented with bills containing language creating such a board, both the Senate and House committees dropped all aspects of the medical committee and the requirement that physicians be on the board. As the legislation moved forward, it became apparent that there was strong opposition even to retaining the requirement that the commissioner of the new department had to be a psychiatrist. The bill encountered opposition from advocates for the ID who feared that psychiatric leadership would place all the emphasis on the

[29] Ibid: 151.

mentally ill, leaving the care and treatment of the ID a "step-child."[30] The advocates for the ID had strong support in the Legislature. They wanted to continue with the arrangement that existed within BSH&SS and called for the criteria for selection of the commissioner to be one with "proven administrative experience and ability."[31] Following extensive debate in both houses and a win by only one vote with all senators present and voting in the Senate, the Legislature passed House Bill 3 that included the requirement the commissioner be a psychiatrist.[32]

The result of the legislation was the creation in 1965 of the Texas Department of Mental Health and Mental Retardation (TDMHMR) with an independent board of nine appointed by the governor and confirmed by the Senate.[33] This new board had only $600,000 to devote to establishing community mental health centers because the chair of the House Appropriations Committee, W.S. "Bill" Heatly (1912-1984), opposed the requirement of the commissioner being a psychiatrist, and he led the Appropriations committee to limit the appropriation.[34] The focus by the medical community on psychiatric leadership and the lack of understanding and focus on funding meant an inauspicious beginning of the new department related to the start of community mental health in Texas. The new board had the challenge of hiring a commissioner who was a psychiatrist, creating new rules for its role and that of the commissioner, and working with new independent community mental health centers as sponsoring entities created

[30] Carl Freund, "Compromise Mental Health Plan Faces 1st Test," *Dallas Morning News*, February 21, 1965: 9.

[31] "Mental Health Bill Gets Major Change," *Dallas Morning News*, March 5, 1965: 4.

[32] McCleskey: 153-154.

[33] House Bill 3, 59th Legislature 3, Regular Session (1965), Bill Files, Texas Legislature, Archives and Information Services Texas State Library.

[34] McCleskey: 154.

them. The ongoing relationship between the board and commissioner would prove a difficult one. Some board members wanted more significant efforts in creating the new community mental health centers. Others argued for the growing needs of the state hospitals and special schools. The new psychiatrist-commissioner immediately faced pressures from a board with conflicting ideas and a belief that it was in charge.[35]

The happy ceremony on April 5, 1965, when Governor John Connally signed into law House Bill 3 -- the Mental Health and Mental Retardation Act. Assisting the Governor, left to right: James Dinsmore, executive director of the Texas Social Welfare Association; Mrs. Chester Snyder, TAMH Legislative Chairman; The Honorable W. H. Miller, Houston, sponsor of the Bill; Reverend Robert S. Tate, Jr., TAMH Legislative Consultant; Don Wooten, TAMH president; Senator Bruce Reagan, Senate sponsor of the Bill; and Mrs. Merle Huston, TARC Legislative Chairman.

Figure 6 Governor John Connally Signing HB 3 on April 5, 1965 [36]

[35] Ward Burke Speech.

[36] From the Special Legislative Issue of *TAMH TOPICS,* the newsletter of the Texas Association for Mental Health in Austin, Texas. Harris County Mental Health Association, 031/015, 1458-31 1965, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

The Challenges of the New Department

Forging a new department out of the old BSH&SS was a challenge for the new board, which, in reality, was the old board with three new members.[37] The first task of the board was to hire a psychiatrist-commissioner. They found that few psychiatrists with the skills to manage a large state organization were interested in the position paying $22,500 annually.[38] The board turned to Baylor University College of Medicine (BUCM)[39] in Houston, with which it already had an ongoing relationship through the Houston State Psychiatric Institute (HSPI). They asked Shervert Frazier M.D. (1921-2015), the chair of psychiatry at BUCM, to become commissioner in the fall of 1965. He was a strong advocate for community mental health and had served on the Mental Health Planning Steering Committee. He was willing to serve if he could retain his role and salary from Baylor, and the board agreed. Unfortunately, after nine months on the job, he resigned when Baylor required him to return to the School of Medicine full-time.[40]

[37] Richard M. Morehead, "9 Named to Board on Mental Health," *Dallas Morning News*, August 28, 1965.

[38] Ward Burke Speech. "State Commissioner of Mental Health Resigns," *Dallas Morning News*, August 11, 1966: 4.

[39] Baylor University College of Medicine would become independent from Baylor University in 1969 and dropped university from its name. Today it is known as Baylor College of Medicine.

[40] "State Commissioner of Mental Health Resigns." Shervert Frazier, M.D., interview by Dan Creson October 6, 1988. AVV.MS108.038, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

Figure 7 Shervert Frazier M.D., First Commissioner of TDMHMR [41]

During his brief tenure, Frazier oversaw the completion of a survey of the 15,000 patients housed in the state mental hospitals in the summer of 1966. That survey found that while 99 percent of the residents had a "diagnosable psychiatric disorder," only 44 percent needed to remain in the hospital if appropriate alternative resources were available. It also revealed that a significant number of patients had physical health problems in addition to their mental disorders. Sixty-two percent needed dental work, 45

[41] "Shervert Frazier," *Research Ethics*, Haklak.com, February 17, 2017, accessed on October 10, 2019, https://haklak.com/page_Shervert_Frazier.html. [Google translation website below] https://translate.google.com/translate?hl=en&sl=ja&u=https://haklak.com/page_Shervert_Frazier.html&prev=search.

percent had other physical diseases, and 25 percent had a tentative diagnosis of neurological disorders. The latter was likely from tertiary syphilis, however, the report did not identify it as such.[42] The survey provided the knowledge of the need for improvements across the system within the hospitals and especially for the significant development of appropriate alternative resources for discharged patients.

Who Would Lead the New Department: Board or Commissioner?

The next commissioner, Vernon John Kinross-Wright M.D. (d. 1999), also from HSPI and BUCM, accepted the position full-time because he was concerned about the patients he had seen in the state's hospitals. He knew the job would involve bringing the system into the twentieth century and, at the same time, building a new community mental health program for which the Legislature had not appropriated the funds necessary for all of the communities wishing to establish one.[43] In Houston, he had assumed responsibility for leading the HSPI while Frazier was splitting his time between being chair of the department at Baylor and commissioner for the TDMHMR. Kinross-Wright had worked with severely mentally ill patients in his research. In 1954, he had published the first clinical study of the treatment of psychiatric patients with chlorpromazine in the United States.[44]

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[42] Alex D. Pokorny, Shervert H. Frazier, *Report of the Administrative Survey of Texas State Mental Hospitals 1966*, Mental Health Project Grant Number 09235-01 of the National Institute of Mental Health, sponsored by the Texas Foundation for Mental Health Research in collaboration with the Texas Department of Mental Hospitals and Mental Retardation, Austin, Texas, 1967, 86. The report did not identify specific neurological disorders but found a "tentative or presumptive diagnosis of neurological disorder" that would have been secondary to the psychiatric diagnosis. Pokorny and Shervert: 29

[43] V.J. Kinross-Wright, M.D., interview by Dan Creson October 15, 1992. AVV.MS108.154, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[44] Vernon Kinross-Wright, "Chlorpromazine—A Major Advance in Psychiatric Treatment," *Postgraduate Medicine* 16, no. 4 (October 1954).

When Kinross-Wright moved into his new position, he argued that the hospitals did not have enough trained staff to even plan for the discharges of "half the patients in the system [that] do not belong here." He hoped that with better staff pay and more money to train them, he could improve that situation. He also pointed to the need to centralize several functions. Each of the state hospitals had operated under separate policies and procedures unique to that institution in the past. He noted that this action would require a more substantial central administration in Austin. He also stated that he would "follow an open-door policy toward the public and news media."[45] This openness to the press led to coverage that reflected positive dynamic changes under his leadership.[46] Within his first year, he also brought in a data processing system to help administer the department and to better track patients.[47]

[45] Stewart Avis, "New Chief Speaks: Mental Hospital Changes in Store," *Dallas Morning News*, July 12, 1967.

[46] Kinross-Wright's openness to the press led at least two newspapers to feature the agency under his leadership in their coverage. The *Dallas Morning News* ran several positive articles highlighting the changes in the state hospitals under his leadership and published positive articles about him in the conflict with the board at the end of his tenure. According to Gary Miller, who was Assistant Commissioner for Mental Health at the time, the *Houston Chronicle* was also supportive of Kinross-Wright. Gary Miller Follow-up Phone Interview on November 2, 1992, by Suzanne Gallo, AVA.MS.108.155, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[47] Marquita Moss, "Not Giving Up on 'Hopeless Cases,'" *Dallas Morning News,* July 24, 1969: 1AA.

Figure 8 Vernon John Kinross-Wright M.D., Second Commissioner of TDMHMR [48]

Kinross-Wright initiated the "unit system" whereby the hospitals reorganized by placing patients from the same geographic area within the same wards. Patients in each ward saw the same doctors, nurses, counselors, and attendants during their entire stay. Caseworkers could visit patients regularly from their home area and maintain communication with the patients' families. After discharge, if a patient needed to return, he or she would come back to the same unit with the same staff. This change was Kinross-Wright's first significant one within the hospitals, and he labeled it a "gimmick that opened up the way for all kinds of other changes." These additional changes included having both sexes in the same building, eliminating locked facilities, and creating governing systems that allowed patients a voice in the governance of their unit. These changes brought a reduction in the average length of stay in the hospitals.[49]

[48] Undated picture from the McGovern Collection 15 TRIMS Series 1 box 1.
[49] Moss, July 24, 1969.

Under Kinross-Wright, state funding of community mental health centers began. The 60th regular session of the Texas Legislature in 1967 and its special session in 1968 included appropriations for state grant-in-aid funding for community mental health centers created under House Bill 3 that had passed in 1965.[50] The board of TDMHMR approved the guidelines for state funding of the centers and authorized the first such funding for three centers in August 1967. The local community centers were encouraged to apply for federal funding for staffing the facilities since this would provide additional resources that would make the centers viable. The state had no control over the federal funding, but most of the centers were successful in qualifying for federal funds. As other centers qualified under the new rules, which required a local match to receive state funding, the board approved additional grants.[51] When Kinross-Wright left office in 1970, 24 community centers were receiving funding from the state.[52] Though the ranking would not last long, a report from the National Association of State Mental Health [Program Directors] ranked Texas sixth in the nation in state spending for community mental health in 1969 and 11th overall in mental health spending. The fact that many states had not yet begun their state community mental health funding no doubt helped with these rankings.[53] During his tenure as commissioner, the population of the state

[50] $3 million was budgeted for Contract Services and State Grants-in-Aid for the year ending August 31, 1968, and $3.5 million was budgeted for the same purpose for the year ending August 31, 1969. Senate Bill 15, 60th Legislature, Regular Session (1967), Article 2: 11-12, HB 5, 60th Legislature Regular Session (1967) Bill Files, Texas Legislature, Archives and Information Services Texas State Library. House Bill 5, 60th Legislature, Special Session (1968) Article 2: 11-11, Texas Legislature, Archives and Information Services Texas State Library.

[51] Minutes of the TDMHMR Board of Directors, August 12, 1967: 57-68, Texas State Library and Archives Commission, Austin, TX.

[52] Minutes of the Board of TDMHMR August 23, 1974: 4.

[53] "Meteoric Improvement Shown: Texas Sixth in Mental Health," *Dallas Morning News*, June 15, 1969. The article states the organization as the National Association of State Mental Health; likely, it left off the last two words Program Directors.

hospitals dropped from 15,000 to 12,990, though admissions were continuing to rise.[54] Other innovations during his leadership included the expansion of halfway houses and rehabilitation services and the incorporation of alcohol and drug treatment programs within the state hospitals.[55]

Based on the circumstances of the time, Kinross-Wright's leadership seemingly built a stronger mental health system that included a focus on the institutions, community mental health, and aftercare services. However, his efforts encountered resistance in the boardroom of TDMHMR and from others not accustomed to change or others who wanted even more change. In January 1969, the board adopted its first formal administrative policies for the board and commissioner, which focused on restricting the commissioner's authority to take any actions without the board's explicit approval.[56] Two board members, Rev. Robert Tate and Mrs. Howard Butts (1903-1993), expressed opposition to the purchase of computers, believing there was not enough emphasis on the creation of community mental health programs and the patients. They were leaders of the

[54] Stewart Davis, "Board of Mental Health Receiving Poor Marks," *Dallas Morning News*, June 3, 1970:1.

[55] *Marquita Moss,* "'Work Village' Helps Many: Mental Health Workers Find Ways to Fill Gaps," *Dallas Morning News,* July 25, 1969: 1AA. The Texas Department of Mental Health and Mental Retardation 1969 Annual Report, Austin: Texas Board of Mental Health and Mental Retardation, 1969: 35-37. Texas Department of Mental Health and Retardation Annual Report 1970, Austin: Texas Board of Mental Health and Mental Retardation, 1970: 37-38.

[56] Some of the specific requirements included: they were to "be apprized and consulted by the Commissioner before the implementation of any new plans, programs or procedures affecting the Department and its institutions." All procedural manuals used within the department required submission to the board for approval, and the board was to approve the appointment of Deputy Commissioners, Assistants to the Commissioners, Director of Regional Programs, and the heads of all facilities within the department. The board would work with the Commissioner on all departmental policies, and they were to have "complete freedom to make inquiry of departmental employees concerning implementation of policies." Minutes of the Board of TDMHMR, January 25, 1969: 45-49.

opposition to the commissioner. Both of these members had strong convictions that undergirded their support for community mental health.[57]

In the spring of 1970, circumstances reached a critical point when Kinross-Wright attempted to fire Assistant Commissioner for Mental Health Gary Miller M.D., whom he saw as operating independently with Rev. Tate and Mrs. Butts. Miller appealed to those two board members about his dismissal and refused to leave his position, claiming that the board had to approve it before it was official.[58] A secret meeting of the board in Houston to fire Kinross-Wright ended before it began when State Representative Ray Lemmon, a supporter of the commissioner, showed up and reminded the board that the open meetings law required proper notice.[59] Because of the increasing hostility, at the next board meeting, Kinross-Wright asked for a special meeting of the board to discuss the situation.[60] Before that meeting occurred, however, six members of the board wrote to Kinross-Wright, advising him that they no longer had confidence in him.[61] The

[57] Minutes of the Board of TDMHMR December 6, 1969: 5. Gary Miller Follow-up Phone Interview. Mrs. Butts began her service on the board while it was the BSH&SS. She served the longest tenure of anyone on the two boards. She visited the hospitals, but she became an avid supporter of the community mental health centers. One center director stated, "If it had not been for her, the community centers would have gone by the wayside. … She fought a real battle the first 3 to 4 years." Marion Shirah, Executive Director of the Tropical MHMR Center in Edinburg, Texas, by Suzanne Gallo, January 11, 1993, AVA.MS.108.175. Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX. Mrs. Butts and her family were very active Christians and created Laity Lodge in Texas as a non-denominational retreat center. Tate was the pastor of First Methodist Church in Austin, where Governor Connally was a member. Tate's wife had a mental illness, and he became an active leader of the state Mental Health Association. He led his church to have a strong role in supporting programs for the mentally ill. Notes from an unrecorded phone conversation with Kathleen Jones of Austin, Texas, who was the Director of Youth Ministry at First Methodist under Tate's leadership, August 30, 2016.

[58] Kinross-Wright Interview. Gary Miller indicated that several board members were antagonistic toward Wright and wanted his (Kinross-Wright's) removal. He did note that the two leaders against Wright were Rev. Robert S. Tate and Mrs. Howard E. Butts. Gary Miller Follow-up Phone Interview. Minutes of the TDMHMR Board, April 28, 1970.

[59] "Board Kills Meeting to Study Firing," *Dallas Morning News,* March 16, 1970: 22.

[60] Minutes of the Board of TDMHMR March 21, 1970: 8.

[61] Stewart Davis, "Only a Superman Can Run Mental Health System," *Dallas Morning News,* April 8, 1970: 18.

commissioner submitted his resignation at the next board meeting. He stated that he believed it was best to resign rather than have an open hearing before the board because the controversy had now involved all the staff of the department and that an open hearing could destroy its programs.[62]

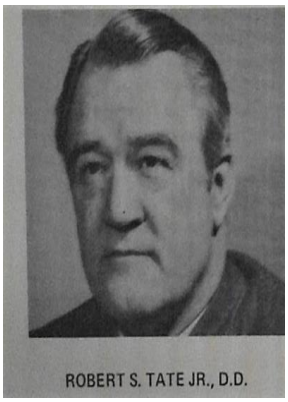

Figure 9 Mary Elizabeth Holdsworth Butts and Rev. Robert S. Tate [63]

Kinross-Wright had accomplishments, but his possible marriage and alcohol problems,[64] his lack of experience in running a large organization, lack of political experience, and the massive number of changes he made in a short time all led to his downfall. He worked for a board in which at least five members in 1970 had family members in the care of the institutions of the department, which undoubtedly influenced their objectivity as board members. The board members were also politically connected individuals who were accustomed to getting their way, and as Kinross-Wright asserted his role, there was conflict.[65] The active board gave notice that they were in charge of the department even though the commissioner had to be a psychiatrist.

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[62] Minutes of the TDMHMR Board, April 28, 1970.

[63] Mrs. Butt picture from *Dallas Morning News* February 2, 2017. Rev. Tate from the TDMHMR Report 1, no. 6 June 1969.

[64] Gary Miller noted that Kinross-Wright had problems with his marriage, as well as, alcohol problems and that he was in and out of the office a lot. Gary Miller Follow-up Phone Interview.

[65] Davis, June 3, 1970.

It was not until 1987 that the Legislature dropped the requirement that the commissioner must be a psychiatrist. The board still hired the commissioner, and he or she served at its pleasure. However, the legislation spelled out the specific responsibilities of the commissioner. It also identified specific conflicts of interest to avoid appointing members to the board and in their service on the board.[66] The board-controlled system ultimately changed in 2003 to one utilizing advisory boards with no real power over administration. This change gave the governor much greater control over what had been independent boards.

A Peaceful Interlude Leads to Long-term Problems

Following the resignation of Kinross-Wright, the board of TDMHMR hired David Wade M.D. to become commissioner in 1970. Wade was serving on Gov. Preston Smith's (1912-2003) staff as Director of Comprehensive Health Planning at the time of his hiring. He had owned and led a private psychiatric hospital in Austin from 1947 to 1966. Wade had also served as president of the TMA and as a lobbyist to the Legislature on medical issues. Governor John Connally, and then Smith, had asked him to work within their administrations after he sold the hospital.

Kinross-Wright had received favorable press coverage, and his departure had created a concern by Governor Smith that the problems at TDMHMR in the spring of 1970 could cost him politically. Wade stated that Smith asked him "to straighten MHMR out because it would cost him the next election." Smith met with the board of TDMHMR

[66] SB 257, 70th Legislature, Regular Session (1987) Bill Files, Texas Legislature, Archives and Information Services Texas State Library.

and told the board to hire Wade.[67] Wade enjoyed the political support of the governor, had friends on the board, and had excellent political skills. He received a substantial increase in funding for programs from the Legislature and never "had a negative vote on any subject with the board." In reality, he provided TDMHMR "a peaceful shop" after Kinross-Wright's transformative days.

The next two leaders of the department were psychiatrists as required by law, but neither were strong commissioners. Kenneth D. Gaver M.D., who came from a similar position in Ohio on September 1, 1974, left his position on February 28, 1978, "for other personal pursuits."[68] His departure came after a petition drive by a former board member to have him removed from office because of suspected abuse at the Mexia State School in 1977 and his failure to take action.[69] In October of 1977, Gaver fired the administrator at Rusk State Hospital after the report of patient abuse.[70] Seemingly, these two highly public actions led to his departure with no specific job at hand. His successor, John D. Kavanagh M.D., was a retired U.S. Air Force who had served as a hospital commander at several bases. Upon retirement from the Air Force, he worked at the San Antonio State Hospital from 1974 to 1978 then transferred to the Department's Central Office as Deputy Commissioner. He served in that position only a short time before Commissioner

[67] Wade stated that Smith told the board to hire him; however, the minutes of the board meeting indicated that the board told the governor whom they wanted to hire, and he approved. Technically the decision was the boards, but it is highly likely that the governor made the selection. A rumor at the time suggested that the initial approach to Wade came while Kinross-Wright was still employed, though the board chair denied this. David Wade, M.D. Interview on October 6, 1992, AVA.MS.108.152, Daniel L. Creson, M.D., Ph.D. Papers MS 108, the John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX. Minutes of the Board of TDMHMR August 29, 1970: 5-6. "Dr. Wade Appointed MH-MR Commissioner," *Dallas Morning News*, August 30, 1970: 12.

[68] Minutes of the Board of TDMHMR, February 17, 1978: 3.

[69] "Group for Retarded Citizens Says Mexia School Reforms 'Inadequate," Dallas Morning News, March 31, 1977: 14. "Group's Audit Held for Public Release," Dallas Morning News, April 22, 1977: 6. "U.S. called on to help schools for retarded," *Dallas Morning News*, August 28, 1977: 37.

[70] "Hospital Head at Rusk Fired," Dallas Morning News, October 20, 1977: 45.

Gaver resigned, and the Board elevated him to the Commissioner's position where he remained until 1981.[71] On June 24, 1981, several individuals came to the board meeting to protest Kavanagh's dismissal of the Superintendent of the Richmond State School. Though he had the support of the board chair, in the closed executive session at the end of the meeting, Kavanagh tendered his resignation effective October 1, 1981.

The combination of weak leadership and a board exerting its control was not the combination needed as the TDMHMR faced the two federal lawsuits that would require enormous amounts of time, energy, and money to fight and settle over the next 24 years. They have shaped Texas's work with the mentally ill and the intellectually disabled to this day.

Conclusion

The work of the medical community in Texas was crucial to the positive changes in the state hospitals in the 1950s. However, that community's desire to provide even stronger leadership led it to overplay its hand in the passage of legislation to create the new department of TDMHMR. The result of its overreach was the development of a department that needed both a strong leader and an active board to deal with the development of the new community mental health centers, and the strengthening and maintaining the institutions, it oversaw. Unfortunately, the fight for who actually would be in charge, commissioner or board, created a situation where the department was not

[71] John Kavanagh Interview with Susan Gallo on November 19, 1993, AVV.MS108.040, Daniel L. Creson MD, Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at The TMC Library, Houston, TX.

prepared to deal with the two federal lawsuits that would reshape the state's work with the severely mentally ill and the intellectually for years to come.

VII. TEXAS STRUGGLES TO COPE WITH FEDERAL COURT ACTIONS, RISE OF MANAGED CARE, POLITICAL CHANGES IN THE STATE, AND NEW FEDERAL FUNDING

Introduction

As noted in Chapter IV, federal court decisions played a significant role in changing the treatment of severe mental illness in the nation. Most states became involved in one or more cases within the federal or state courts. Arturo Perez in *Major Litigation against the States: Policy Recommendations on Dealing with the Issues* noted that in 1994, forty states were involved in federal courts over issues of inadequate funding of schools. That same year, forty-six were in federal or state courts related to their adult and juvenile corrections programs, and twenty-seven were in litigation regarding their schools for the intellectually disabled and their state mental hospitals.[1] In Texas and other states, many of these cases were ones that had begun years earlier. Local legal aid societies—funded in part by the federal government—and the American Civil Liberties Union (ACLU) filed the cases and generally provided the legal representation in these cases as they did in Texas. Ultimately, the courts required the public agency defendants to fund both sides of the litigation if they ruled in favor of the plaintiffs.

The cases involving the states mental hospitals forced legislatures to fund significant and often expensive changes to their institutions. At the same time, the states were also trying to build and fund new community mental health centers. In Texas and

[1] David Pharis, "Politics and Costs," in *State Hospital Reform: Why Was It So Hard to Accomplish?* ed. David B. Pharis (Durham: Carolina Academic Press, 1998): 204.

other states, the legislatures refused to fund the massive funds required to do both. This refusal resulted in the transfer of more individuals from the hospitals and a reduction in available beds. Also, there was a corresponding increase in numbers of persons served through community mental health centers, with limited or more often, no housing arrangements. In Texas, there was an ongoing battle between the federal court and the Texas Department of Mental Health and Mental Retardation (TDMHMR) over what the department had agreed to do in its mental hospitals in a case filed in 1974 and first settled in 1981. This battle lasted for many years. It increased funding for the hospitals and improved care, but at a cost to other services and the severely mentally ill.

The rise of Behavioral Managed Care Organizations (BMCOs) and significant political changes in the Legislature and executive leadership in 2002 brought a further reduction in funding and services provided to the mentally ill. With little funding and Texas' exponential growth, services continued to decline until 2012. Two circumstances brought improvements. First, a federal Medicaid waiver allowed the temporary use of previously unmatched local and state funding to draw down more Medicaid funding to prepare for the expansion of Medicaid under the federal Affordable Care Act. Second, the Legislature's preference to increase funding for mental health rather than address gun control after the horrible school shooting in Connecticut increased state funding and brought at least a temporary hope for improvement for the treatment of mental illness in Texas.

Federal Class Action Lawsuits Reshape Texas Institutions

One case in which TDMHMR was the defendant was *Lelsz v. Kavanaugh*, filed in November 1974, regarding the state schools housing the intellectually disabled.[2] The other case was *Jenkins v. Cowley*, which was later, renamed *R.A.J. v.* whoever was Commissioner at the time of the court's rulings. This latter case, also filed in 1974, focused on the treatment of those with an SMI in Texas's state psychiatric hospitals.[3] TDMHMR would deal with these two significant lawsuits for over 20 years, and they would drive its funding from the Legislature. The *R.A.J.* case would eliminate public services for those who were not suffering from an SMI, and it would ultimately reduce the number of services for those with an SMI in Texas. These two suits and one against the Texas Youth Council and another against the Texas Department of Corrections shaped Texas' health and human services and correctional institutions and policies perhaps more than any other factor in the last quarter of the twentieth century.[4]

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[2] In the lawsuit, the plaintiffs accused the defendants of failing "to provide less restrictive community alternatives for residents, thereby effectively forcing them into large institutions." This failure exposed them to "diseases, neglect, excessive medication, unnecessary restraint, unsafe building, inadequate medical and dental care, and physical abuse from other residents and staff in violation of their constitutional rights." The case became a class action one in 1981 and was settled three different times because of continuing issues of TDMHMR's noncompliance with the agreement. There was extensive monitoring of the agreement by an expert consultant. The case finally closed in 1995, following the closing of the Fort Worth State School and the placement of those students into community settings. *Lelsz v. Kavanaugh*, 85-2462 (N.D. Texas), University Civil Rights Litigation Clearinghouse of the University of Michigan Law School. Accessed on April 23, 2018, https://www.clearinghouse.net/detail.php?id=503&search=source%7Cgeneral%3BcaseName%7CLelsz%20v.%20Kavanaugh%3Borderby%7CfilingYear%3B.

[3] *Jenkins v. Cowley*, United States District Court, N.D. Texas, Dallas Division, 384. Suff. 441, No. CA 3-74-394-C, September 17, 1974. Accessed April 26, 2018, https://www.clearinghouse.net/chDocs/not_public/MH-TX-0001-0001.pdf. The case became *R.A.J. v*. whoever was Commissioner at the time the court published a decision. These new case titles included *R.A.J. v. Miller*, *R.A.J. v. Jones,* and *R.A.J. v. Gilbert*.

[4] The other two cases were *Ruiz v. Estelle* in 1972 for the corrections and *Morales v. Turman* in 1971 for the Texas Youth Council. Unrecorded Interview (notes taken) with William Schnapp, by Curtis Mooney on January 27, 2016. Schnapp was the Mental Health Policy Advisor to Harris County Judge-Executive. Before that, he was on the faculty of the Department of Psychiatry and Behavioral Sciences at the University of Texas Health Science Center at Houston.

R.A.J. Forces Texas to Improve Inpatient Treatment for Mental Illness

Robert A. Jenkins was an adult patient at Terrell State Hospital, and Luis M. Cowley, M.D. (d. 2007), was the superintendent there. Jenkins had a dual diagnosis of mental illness and intellectual disability. Because he was "aggressive and dangerous," the hospital staff kept him in a seclusion room, and anytime he was out of that room, the staff and other patients "were met with vicious attacks."[5] Jenkins, the staff, and the other patients were okay with what became a permanent situation of Jenkins staying in the seclusion room, but Jenkins' parents, understandably, were not. They saw their son receiving neither attention nor treatment and, working with the North Texas Legal Services in Dallas, sued TDMHMR on September 17, 1974. Other patients in similar situations at Terrell and all the other state hospitals eventually joined the lawsuit, and it became a class-action lawsuit against all of the state psychiatric hospitals.[6]

Discovery did not begin in the case until 1978 when the U.S Department of Justice joined the suit and began to press for a settlement. The parties reached the first of several settlements in 1981.[7] In 1977 the state Legislature had increased funding for the state hospitals, and "the fervor [for the case] behind the plaintiffs began to wane." The

[5] David Bell, Patsy Cheyney, Mary Dees, Susan Medlin, and Anonymous, "Reminiscences," in *State Hospital Reform: Why Was It So Hard to Accomplish?* ed. David B. Pharis (Durham: Carolina Academic Press, 1998): 5.

[6] Don Gilbert Interview by Susanne Gallo on November 15, 1993, AVA.MS.108.197, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX. The basis of the case was federal district ruling in 1972 in *Wyatt v. Stickney* that any person with a mental condition committed against his/her will had a constitutional right to treatment. Later in *O'Conner v Donaldson* the Fifth District Court of Appeals reaffirmed this right, but the Supreme Court in 1975 vacated that ruling and sent it back to the Court of Appeals but did not address the right of treatment in its decision.

[7] Genevieve Tarlton Hearon, "May Our Tears be Turned into Dancing," Pharis, in *State Hospital Reform: Why Was It So Hard to Accomplish*? ed. David B. Pharis (Durham: Carolina Academic Press, 1998): 49.

plaintiffs offered to settle the case if the board of TDMHMR would "admit that the state had not done all that was needed, but was doing better." The board "refused to admit any wrongdoing and continued to oppose the lawsuit."[8] After TDMHMR refused the settlement offer, and the Federal Justice Department entered the case, the state hospitals underwent reviews by the Civil Rights Division of the United States Department of Justice. When the Civil Rights Division's findings concurred that problems did indeed exist, TDMHMR was willing to settle, and in April 1981, TDMHMR agreed to make several improvements in the inpatient care of those with an SMI.[9] Judge Harold Barefoot Sanders, Jr. (1925-2008) appointed a panel of three monitors to visit the state hospitals and ensure compliance, but unfortunately, what at first seemed like a clearly defined settlement agreement became anything but that.

In the *R.A.J.* settlement agreement in April 1981, TDMHMR agreed to several improvements. It agreed to improve patient rights safeguards, provide individualized treatment, ensure sufficient staffing to give each patient 30 hours of suitable programming, and to make building repairs. It also agreed to provide guidelines for psychotropic medications, create policies that allowed patients placed involuntarily to decline medications, and to have each hospital obtain accreditation by the Joint Commission on Accreditation of Hospitals.[10] Also, it agreed to create specialized geriatric programming, to develop plans for patients after discharge that utilized community programs for support, and to seek funds for the Legislature to put these new

[8] Don Gilbert Interview.

[9] David Pharis, "The History of the R.A.J. Lawsuit in Texas," in *State Hospital Reform: Why Was It So Hard to Accomplish?* ed. David B. Pharis (Durham: Carolina Academic Press, 1998): 65.

[10] Accreditation of the state psychiatric hospitals by the Joint Commission did not occur until the 1990s as each hospital exited the R.A.J. settlement process. They have remained accredited by JCHAO since that time.

program aspects in place.[11] These agreements would bring significant changes to care in Texas' state hospitals and would require the expenditure of substantial resources to put in place. However, they were broad statements lacking specificity and allowing wide latitude in understanding and misunderstanding of the agreement. This lack of specification would lead to years of conflict, subsequent court battles, and more agreements that also had some of the same flaws.

Figure 10 Federal North Texas District Judge Harold Barefoot Sanders, Jr. [12]

TDMHMR hired Gary Miller, M.D., the former Deputy Commissioner for Mental Health Services under Kinross-Wright, as commissioner in 1982. After leaving Texas in the wake of the Kinross-Wright firing, Miller had served as Assistant Commissioner for Mental Hygiene in New York State, head of Georgia's Mental Health and Mental Retardation Program, and Director of Mental Health and Mental Retardation Services in New Hampshire. He saw himself as a reformer and believed that he could work well with those who had just reached the settlement agreement since both he and they focused on

[11] David Pharis, "The History of the R.A.J. Lawsuit in Texas": 65.

[12] Picture by Yoichi Okamoto. Property of the LBJ Presidential Library. Published on Wikipedia. Accessed January 20, 2019, https://en.wikipedia.org/wiki/Barefoot_Sanders#/media/File:Barefoot_Sanders.jpg.

"improving treatment and conditions in the state hospitals, assuring patient rights, and shifting resources and patient care from the state hospitals to the community."[13] However, the parties soon found that the settlement agreement was far from specific. TDMHMR believed they were meeting the requirements, but the monitoring panel found several areas of non-compliance. Judge Sanders, the federal district court judge for both TDMHMR cases, generally agreed with his panel. As the disagreements persisted, Sanders changed the panel of three to a single court monitor who brought in expert consultants as needed. Over the next several years, TDMHMR and the plaintiffs came to several new settlement agreements. However, the state's concept of their implementation and the court monitor's concept remained at odds. For years, the leadership of TDMHMR and the court monitors fought over what constituted compliance with the agreements. It was not until 1991, after a change in the plaintiff attorney by Judge Sanders and leadership changes at TDMHMR that the two parties ultimately came to an understanding that the problem was the "lack of specific agreement over what constituted compliance," and moved toward a final means of settling the case.[14]

[13] Gary Miller, "Reform through Litigation: A Commissioner's Perspective," in David B. Pharis in *State Hospital Reform: Why Was It So Hard to Accomplish?* (Durham: Carolina Academic Press, 1998): 99-100.

[14] Pharis, "The History of the R.A.J. Lawsuit in Texas": 72.

Figure 11 TDMHMR Commissioner Gary Miller M.D. [15]

One significant change at TDMHMR grew out of the federal court's establishment of a 1-to-5 staffing ratio in the hospitals based on its understanding of the state's existing staffing requirements. In reality, TDMHMR had no specific staffing requirements. However, the court monitor had heard an Assistant Deputy Commissioner of Mental Health address the TDMHMR board about inadequate staffing. In doing so, the individual described a staffing schedule that equated to a 5 to 1 staff ratio during awake hours and 10 to 1 during sleep. TDMHMR disputed this finding stating that there was no formal written policy requiring this ratio, but the court ordered its application.[16] This increase in staffing would have required a considerable investment in more personnel in the hospitals at the time the state was trying to build the community mental health system. Instead of adding staff, Commissioner Miller created a program to reduce the

[15] *Houston Post*, May 31, 1985.

[16] Pharis, "The History of the R.A. J. Lawsuit in Texas": 78. Don Gilbert, "The Positive Impact of R.A.J.," in *State Hospital Reform: Why was it so Hard to Accomplish?* ed. David B. Pharis (Durham: Carolina Academic Press, 1998): 126.

number of inpatients. He developed the "3550 program" whereby TDMHMR determined a "baseline utilization rate" for each of the community mental health authorities (CMHAs) in the state.[17] For each day the number of patients from an authority reduced to below its previous baseline, that CMHA received $35.50 per patient. The state calculated the payments each quarter and based the reduction on the previous quarter's population. These payments provided the CMHA's $38 million additional funding for community mental health centers from 1984 through 1988 when the program ended.[18] This funding was an incentive for the authorities to accept individuals from the state hospitals and to create programs to keep them out of the hospitals. Miller also pushed for the community centers to create a case management program whereby there was a tracking system for patients in the community and a person responsible for working with individuals identified as needing additional services.[19]

The "3550 program" led to a significant reduction in the state hospital census, but it also led to concern by the court monitor regarding the quality of placements for individuals in the community, which were most often in nursing homes or boarding homes. Three different studies revealed that approximately 20 percent of those discharged did not seek aftercare services, and "the court concluded that many clients discharged from the hospitals were receiving services which were minimally adequate" and did not meet the court order that required "adequately staffed facilities sufficient to

[17] House bill 3 created the local community mental health centers as authorities with responsibility for a given area. The term CMHA refers to the Texas CMHCs.

[18] Pharis, "The History of the R.A.J. Lawsuit in Texas": 70-71. The 3550 plan used a baseline of the state hospital daily census per 100,000 population from catchment areas to determine the starting point for 1984. For each reduction, the center received $35.50 per reduced day, which was the amount it cost the hospital for each patient in residence. Gary Miller, M.D., Video Interview by Susanne Gallo, October 6, 1992, AVV.MS108.070, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX

[19] Gary Miller, M.D., Video Interview by Susanne Gallo, October 6, 1992.

provide appropriate treatment." The state had failed to provide adequate funding to the CMHCs, the nursing homes, and the boarding homes to make sure enough resources were available to provide for the needs of those leaving the state hospitals and had failed to coordinate the services to ensure the patients received the proper care in the community.[20]

Though TDMHMR initially agreed that "adequate discharge plans" should be included in the settlement agreement, it later questioned the legitimacy of the court's involvement in the aftercare issue since there were "no constitutional requirements to provide community services." The U.S. Justice Department accepted the state's view presumably since the original case questioned the constitutional violation of patient's rights within the state hospitals. While the plaintiffs continued to argue that appropriate discharge planning should be part of the agreement, "the legal issues were never thoroughly explored through court hearings."[21] The final settlement plan failed to provide for agreement on what constituted appropriate discharge planning.

Though there was progress between 1984 and 1991, the court monitors submitted eleven monitoring reports to the court of problems with the "provision of individualized treatment" by TDMHMR. The department "usually attempted to deny or discredit the findings in these reports." To the department, the goals and requirements of the settlement agreement kept changing.[22] David Pharis (1941-2008), the court monitor

[20] David Pharis, "The Excursion into the Community," in David B. Pharis, *State Hospital Reform: Why Was It So Hard to Accomplish?* (Durham: Carolina Academic Press, 1998):162-165. Howard H. Goldman and Anne Mathews Younes, "Evaluating Compliance with Aftercare Standards," in David B. Pharis, *State Hospital Reform: Why Was It So Hard to Accomplish?* (Durham: Carolina Academic Press, 1998): 181-191.

[21] Pharis, "Excursion into the Community": 178-179.

[22] Pharis, "The History of the R.A.J. Lawsuit in Texas": 73.

appointed by Judge Sanders, served in that role throughout the case. He argued that the main issues were over politics and costs. The state agency and other state officials pushed back against federal interference in what they saw as the state's prerogative. Also, the legislators, the state agency, and other state officials were concerned about the costs, which were virtually out of their control as they responded to the mandates of a single federal judge. The budget was the Legislature's sole prerogative, yet with R.A.J. and other federal cases, they were losing at least a portion of their role to a federal judge.[23]

TDMHMR Commissioner Miller struggled with R.A.J. until he left the department in 1988. His replacement was the first non-physician to hold the commissioner position, Dennis R. Jones, MSW, MBA. Jones came from Indiana, where he was serving as Commissioner of Mental Health.[24] Instead of continuing to battle the court, Jones, similar to Miller when he arrived, saw the goals of the court as his goals, and he focused on resolving the case. The plaintiffs' lead attorney at the time, Randy Chapman, stated, "Having a person heading the agency that is not allied with psychiatry was one of Jones' important strengths." When Jones took the job, he visited each of the agency's facilities and surprised the direct care staff and patients by "literally staying overnight in one of the beds." Jones "had a better understanding of how to implement institutional change beyond issuing edicts."[25]

[23] Pharis, "Politics and Costs": 193-198..

[24] He had previously served as the director of a community mental health center and was the first Executive Director of the Indiana Council of Community Mental Health Centers, Inc. Joseph D. Stephens, "Brief History of Community Mental Health Centers in Indiana," accessed September 8, 2018, http://www.iccmhc.org/sites/default/files/History%20of%20Community%20Mental%20Health%20in%20Indiana.pdf.

[25] Randy Chapman Legal Services Attorney Plaintiff Interview by Suzanne Gallo on January 4, 1994, AVA.MS108.213, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

In 1990, Judge Sanders, in frustration at the impasse of the case, appointed Ed Cloutman, a Dallas attorney, to replace Chapman as the plaintiffs' lead attorney.[26] Cloutman had a "reputation of being very tough, but also very reasonable." That "reasonableness" helped the parties move beyond the impasse that had existed for several years.[27] A second change was the addition of Don Gilbert to the TDMHMR central office staff at the time when the critical issue was to resolve R.A.J. because the Legislature had lost patience with the case and wanted relief from having to deal with it each session.[28] Because the court monitor had worked with Gilbert when he was superintendent of Terrell State Hospital and acting superintendent at Vernon State Hospital, the court monitor did not view him as a member of the "Central Office," which as acting Deputy Commissioner for Mental Health, he was. Instead, the court monitor saw him as a person whose work he had seen firsthand, and he accepted his competency.[29]

Gilbert presented the idea that the department should develop a continuous quality improvement (CQI) process. With this, the court monitors, consultants, and TDMHMR would first agree on a level of standards for the hospital to achieve in each area of concern raised by the lawsuit. The department would then put in place a CQI process that would work toward each hospital reaching those standards and sustaining them. The timing and situations would vary for each hospital but ultimately result in reaching the final settlement of the agreement. The hospitals would create their own CQI monitoring

[26] Ed Cloutman ESQ Interview, November 30, 1993 by Suzanne Gallo, AVA. MS108.199, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[27] Don Gilbert, "The Positive Impact of R.A.J.," in David B. Pharis in *State Hospital Reform: Why Was It So Hard to Accomplish?* (Durham: Carolina Academic Press, 1998): 131.

[28] Don Gilbert Interview.

[29] Don Gilbert, 1998: 131.

teams that would guide their work, and the monitor and the consultants would have teams doing the same thing to verify the results. The final agreement reached in 1992 accepted standards gleaned from visits to several nationally known hospitals as the end goal of the program. Over the next five years, each hospital was able to gain release from the lawsuit as it achieved the standards.[30] The case formally closed in 1996.[31]

Figure 12 Don Gilbert, Deputy Commissioner for Mental Health [32]

The R.A.J. Lawsuit Provides More Funding for TDMHMR

One significant result of the *R.A.J.* lawsuit was a dramatic increase in mental health funding by the Legislature from 1977 through 1993, with appropriations increasing from just over $100 million in 1977 to $475 million 16 years later in 1993.[33] Those increased appropriations and the court monitoring over the years led to "real

[30] Don Gilbert Interview. Don Gilbert, 1998: 131-140.

[31] *R.A.J. v. Gilbert*, Case 3:74-CV-00394-H, United States District Court for the Northern District of Texas Dallas Division, Document 3. Filed 07/08/96. Accessed May 1, 2018, https://www.clearinghouse.net/chDocs/not_public/MH-TX-0001-0003.pdf.

[32] Photo by Brian Blalock, University Photographer, Sam Houston State University, https://www.shsu.edu/campaign/don.html. Gilbert would later serve as Commissioner of TDMHMR and the Texas Health and Human Services Commission.

[33] Don Gilbert, 1998: 123.

improvement in the quality of care … [as] evidenced throughout the state hospitals in Texas."[34] As measured in funding increase alone and improvement in care for hospitalized patients, the lawsuit brought significant results. Dennis Garza, the Assistant Attorney General for the State Defense from 1988 to 1991, stated in 1993 when both *R.A.J.* and *Lelsz* cases were ongoing, "the entire formula for the department funding [was] driven" by the two lawsuits. He noted that Texas was behind in education, welfare, and anything in the human services, but TDMHMR "actually got better funding and more attention from the Legislature than other services." Garza stated, however, that he expected that when the lawsuit ended, the increased funding for mental health would likely end as well.[35] Commissioner Dennis Jones noted in 1993 that while both lawsuits did bring new funding for TDMHMR, the state remained "48th in the nation in per capita spending for mental health." "At best," he stated, the department is "able to serve one-half of the priority population, the most severely disabled." To him, the job of commissioner came down to "setting priorities, and putting one's energy in the vital few versus the significant many." He noted that with the "strong anti-tax sentiment in the public that it [would] be hard for the state to raise the level of funding" for mental health.[36]

Indeed, if one looks only at the years of the lawsuits, the growth in funding for mental health was phenomenal; however, when examined in constant dollars and

[34] Ibid: 124.

[35] Dennis Garza ESQ Interview by Suzanne Gallo on November 29, 1993, AVA.MS108.207, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[36] Dennis R. Jones interview by Suzanne Gallo on December 6, 1993, AVA.MS108-182, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

dramatic population growth, one sees that it was not that remarkable. Table 2 below presents the total appropriations by the Legislature for mental health at five-year intervals from the beginning of TDMHMR in 1966 through 2018, in constant 2018 dollars to control for inflation. It also shows the results of dividing those appropriations by the state's population for the year, to obtain the per capita spending for each selected year. As shown, the highest per capita spending came in the first year of the lawsuit before any monitoring had begun and six years before the parties reached the first settlement. That year's per capita spending of $49.74 per member of the population is the highest of any succeeding year. The funding remained in the low $40s until near the end of the lawsuit in 1995, when it reached $47.64. Since then, with the rapidly increasing population, the state's highest level of appropriation per capita surpassed 1995 only in 2015 after a 27.1 percent increase in funding over 2010.[37]

[37] According to Democratic State Representative Garnett Coleman of Houston, who is a strong advocate for the mentally ill, that jump in funding occurred because of the school shootings at the Sandy Hook primary school in Connecticut. The Legislature argued that mental illness rather than gun availability caused the mass shootings. By increasing funding for mental illness, they could claim that they had done something to solve the problem. State Representative Garnett Coleman interview with Curtis Mooney on February 25, 2016. Interview available at the John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

Table 2 Texas Legislature Appropriations for Mental Health for Selected Years Divided by the Texas Population for that Year to yield Per Capita Spending in 2018 Dollars [38]

FY Year	Actual Appropriation	Appropriation in 2018 Dollars	Percent Change	Texas Population	Per Capita Spending for MH in 2018 Dollars
1966	30,603,148	237,245,612	--	10,490,000	$22.61
1970	57,959,012	378,999,668	59.7 %	11,200,000	$33.84
1975	131,633,779	625,257,914	64.9 %	12,570,000	$49.74
1980	193,979,744	623,476,694	-.2 %	14,230,000	$43.81
1985	280,785,495	657,363,375	5.4 %	16,270,000	$40.40
1990	379,580,153	742,074,684	12.8 %	17,060,000	$43.48
1995	548,532,808	903,316,646	21.7 %	18.960,000	$47.64
2000	613,765,708	899,037,299	-.47 %	20,940,000	$42.93
2005	755,262,254	978,403,951	8.8 %	22,780,000	$42.95
2010	906,462,574	1,034,803,493	5.7 %	25,260,000	$40.97
2015	1,252,942,044	1,315,436,538	27.1 %	27,450,000	$47.92
2018	1,326,278,364	1,326,298,364	.8 %	28,704,330	$46.21

The Lawsuit Improves Quality but Dramatically Reduces Quantity of Services in a Fast-growing State

By allocating resources in the state budget to respond to the court's directives instead of increasing the total resources available, the Legislature and TDMHMR eliminated public services for those who were not suffering from an SMI, and dramatically reduced the services available for those with an SMI in Texas. The number of state psychiatric hospital beds in Texas decreased from 15,284 in 1966 to an average patient population of 5,599 for the year 1978. It remained near that level until the state responded to the lawsuit's requirement to set a staff-to-patient ratio of 1 to 5 by creating

[38] Actual appropriations for each fiscal year come from Article II of the Legislature Appropriations bill for the year ending on August 31 of the listed year. Accessed May 4, 2018, http://www.lrl.state.tx.us/legis/approBills.cfm. The appropriations include program expenditures, capital or construction appropriations, and central office overhead. In instances where more than one program shares an expense, such as Mental Health and Mental Retardation, that number is divided in half to capture only the mental health appropriation. Estimations were made at other times when the funding between the two departments was not clearly divided. The appropriation in 2018 dollars was calculated using the inflation calculator accessed on May 4, 2018, https://www.dollartimes.com/calculators/inflation.htm. The Texas population for selected years was accessed on May 4, 2018, using http://worldpopulationreview.com/states/texas-population/.

the "3550 program" to incentivize the community centers to take more state hospital patients in 1985. By 1995, the average patient population had dropped to 2,738, and by the year 2000, it reached 2,456. The Legislature has appropriated funding for an average daily inpatient population of only 2,237 to 2,477 since that time.[39] While the number of available public beds for the SMI declined by 85 percent from 1966 to 2018, the population of the state grew by 173 percent. TDMHMR's annual report in 1995 noted that of the state's total population of 18.6 million, an estimated 2.7 million persons had a mental illness, but because of the lack of funding they could provide services to only a "small subset" of that number, which was those "most severely impaired." TDMHMR labeled the subset the priority population, and by its estimate, 500,000 persons were the most severely impaired, making them eligible to receive services. In reality, the state admitted that 2.2 million people in Texas with a mental illness were not able to receive any services from the state. Of the 500,000-priority population, TDMHMR could only provide services to 131,002 of them, with 13,084 receiving inpatient treatment and 117,542 receiving treatment through the community mental health centers supported by the state. They estimated that another 192,000 persons of the priority population "received services from private sources, primarily general medical sources." The remaining "175,000 severely impaired persons with mental illness did not receive needed services."[40] These individuals and their families had to suffer the ravages of an SMI without any help. Many of them would live on the streets, as their family could not

[39] Alex D. Pokorny and Shervert H. Frazier, "Texas Surveys its Mental Population," *Hospital and Community Psychiatry* 19 no. 3, (March 1968): 88. "More Than Meets the Eye—A report from the Texas Department of Mental Health and Mental Retardation: 1978, 10. "Setting the Stage for Change: FY 1995 Annual Report," Texas Department of Mental Health and Mental Retardation: 54. Actual State Appropriation bills from FY 2000 through 2018, https://lrl.texas.gov/legis/approBills.cfm.

[40] "Setting the Stage for Change": 17, 50.

provide the support needed nor tolerate the behaviors brought on by the illness. Others would find themselves arrested and placed in jail as they committed crimes caused by their illness and the lack of treatment.

The year before the 1995 report, Randy Chapman, the Legal Services Plaintiff Attorney until 1990 in the *R.A.J.* case, noted, "In Texas, we fund things on a shoestring," and getting into a state hospital has become much more difficult. Voluntary admissions to a state hospital are rare, for "you have to do something violent to get mental health care in Texas. If you threaten the governor, you are going to be seen." Chapman went on to state that admitted patients stayed on average three weeks with follow-up in the community, where there was not enough funding to provide adequate care.[41] Today the state's population has grown by over 10 million since 1994, but the number of state Legislature budgeted psychiatric hospital beds has dropped from was 3,210 in 1994 to 2,400.[42] In contrast to 1994, today, more than half of the state's psychiatric beds exist to restore the competency of mentally ill patients to stand trial.[43] Today there are less than 1,200 public state hospital beds available in Texas for patients who have not committed a crime in a state with a total population of 28.7 million citizens. A report in 2005 stated that Texas had a total of 223,195 persons in prison and jails in the state. Studies at that time revealed that approximately 16 percent of prisoners were seriously mentally ill,

[41] Randy Chapman Interview.

[42] SB 5, 73rd Regular Session, Bill Files, 1993: II-56SB 1, 85th Regular Session, Bill Files, (2017): II-46. . Texas Legislature, Archives and Information Services Texas State Library.

[43] "The Growing Crisis in Inpatient Psychiatric Care: Forensic Crowd-out and Other Access Barriers." Texas Council of Community Centers, December 2016: 1. Accessed May 16, 2018. https://txcouncil.com/wp-content/uploads/2016/12/Inpatient-Psychiatric-Care-Issue-Brief-121616-Updated-12417.pdf. Legislative Budget Board Staff, "State Hospitals: Mental Health Facilities in Texas Legislative Primer," *Legislative Budget Board,* April 2016: 8-9. Accessed May 16, 2018, www.lbb.state.tx.us/Documents/Publications/Primer/3144_State_Hospitals-Mental_Health_Facilities_in_Texas_Diehl.pdf.

which was up from 6.4 percent that studies in 1983 had found. Based upon 16 percent, Texas had 35,711 seriously mentally ill individuals in its prisons and jails on June 30, 2005. In 2004, Texas had only 4,579 patients in state and private psychiatric hospitals and psychiatric units in general hospitals in the state. The odds of a seriously mentally ill person being in prison versus a hospital were 7.8 to 1 in 2005.[44] In a report released in 2018, the number of persons incarcerated in Texas prisons and jails has declined to 218,500, which mirrors the overall trend in the United States.[45] The percentage of seriously mentally ill in prisons has declined to 15 percent; however, the percentage of that population in jails has increased to 20 percent.[46]

Clearly, in Texas and the nation, the criminalization of mental illness is a fact. We are far more likely to incarcerate a seriously mentally ill person in jail or prison than we are to place them in a state mental hospital.

Texas Private Psychiatric Hospitals Grow until Managed Care Significantly Alters Care

Problems for those with an SMI in Texas are not just in the public sector. In 1983, Texas dropped its requirement that all health care organizations obtain a certificate of need before building and opening a medical facility, joining six other states that also did

[44] E. Fuller Torrey M.D., Sheriff Aaron D. Kennard, Sheriff Don Eslinger, Richard Lamb M.D., and James Pavle "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States," *Mental Illness Policy.Org.,* May 2010, accessed October 10, 2019, https://mentalillnesspolicy.org/ngri/jails-vs-hospitals.html.

[45] U. S. Department of Justice, *Correctional Populations in the United States, 2016,* Danielle Kaeble and Mary Cowhig, April 2018, NCJ251211: 2, accessed October 10, 2019, https://www.bjs.gov/content/pub/pdf/cpus16.pdf.

[46] "Serious Mental Illness (SMI) Prevalence in Jails and Prisons," Treatment Advocacy Center Office of Research & Public Affairs, September 2016, accessed October 10, 2019, https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf.

so between 1982 and 1985.[47] With the declining number of public psychiatric hospital beds in Texas, the private market rushed in and eventually created an oversupply.[48] With the Reagan administration's focus on less regulation and health insurance policies "offering generous psychiatric benefits," the business environment created a lucrative market that saw the "number of private, for-profit psychiatric hospitals [go] from 220 in 1984 to 444 in 1988" across the country.[49] Funding for these hospitals came from private insurance companies, families, the patients themselves, and up to 190 days over a lifetime from Medicare. These new psychiatric hospitals and other medical expenses led to rising health insurance costs for employers, causing insurance plans with mental health coverage to limit hospital "stays to weeks rather than months."[50]

As the number of private psychiatric hospitals increased, there was competition for patients. Some hospitals worked to retain patients for as long as the funds flowed from the insurance companies before discharging them. Other abuses included "kidnapping" or "luring" patients "with promotional claims, then providing unnecessary treatments or simply holding them to tap their insurance benefits."[51] Regenia Hicks, a Ph.D. psychologist who worked at a private psychiatric hospital in San Antonio in the 1980s, stated that patients were "cured …based on when their insurance ran out." Patients often remained longer than they needed to be in the hospital because they had insurance

[47] S.B. 818, 68th Regular Session, Bill Files, (1983), Texas Legislature, Archives and Information Services Texas State Library. *James B. Simpson, "State Certificate-of-Need Programs: The Current Status," American Journal of Public Health 75, no. 10 (October 1985).*: 1226.

[48] Missy Turner, "Hospital Market in Texas is Displaying Strong Vital Signs," *San Antonio Business Journal*, July 21, 1998, accessed May 9, 2018, https://www.bizjournals.com/sanantonio/stories/1998/06/22/story6.html.

[49] Geoffrey Cowley, "Money Madness," *Newsweek* on November 3, 1991. Accessed May 9, 2018, http://www.newsweek.com/money-madness-201718.

[50] Ibid.

[51] Ibid.

funding available. Dr. Hicks remembered hearing the Commissioner for TDMHMR, Gary Miller M.D., state that many of the patients in the private hospitals were the "worried well" and not the seriously mentally ill treated by the state's mental health system.[52] Other abuses included paying "bounties to teachers, probation officers and psychiatrists [to] refer people for treatment." In 1991, ABC's *Prime Time Live* program featured Colonial Hills Psychiatric Hospital in San Antonio and other Psychiatric Institutes of America (PIA) hospitals in Texas and around the country to illustrate some of these abuses.[53] In Houston in 1997, therapists at Spring Shadows Glen, a private psychiatric hospital, lost a judgment awarding $5.8 million to a patient in federal district court for implanting false memories in his mind.[54] In 1991, Alan A. Stone, M.D. professor of law and medicine at Harvard University and a former president of the American Psychiatric Association identified the potential harm to the welfare of patients by the various means used to find and retain patients in these hospitals. He stated, "It is the major issue in psychiatric care today. Psychiatric standards are on a slippery slope as hospitals try to survive."[55]

To provide more cost control, health insurance companies turned to managed care. By 1995, over half of Americans were part of a managed health care plan. The treatment of mental illness underwent a rapid transition to managed care in both the private sector and the public sector as Behavioral Managed Care Organizations (BMCOs)

[52] Interview of the Director of the Harris County Mental Health Jail Diversion Program Regenia Hicks, a Ph.D. social and clinical psychologist by Curtis Mooney on January 27, 2016. Interview available at the John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[53] Cowley, "Money Madness."

[54] Mark Smith, "5.8 Million awarded in lawsuit, claims therapists implanted false memories of satanic ritual abuse." *Houston Chronicle*, August 16, 1997: 1.

[55] Cowley, "Money Madness."

proliferated. These organizations moved the field away from more expensive inpatient care by limiting the number of providers from whom patients could receive treatment, regularly reviewing "treatment decisions," and "closely monitoring high-cost cases."[56] Referrals by BMCOs are usually to practitioners who are willing to accept less money for the promise of more patients. In Texas, these practitioners, who accept behavioral health insurance, are primarily licensed professional counselors, social workers, and psychologists with psychiatry limited to medication management, but also under managed care.

Texas Turns to a Public Mental Health Managed Care Pilot in North Texas

In 1997, the 75th Texas Legislature authorized the Texas Health and Human Services Commission (THHSC) to administer and operate Medicaid-managed care programs within the state.[57] Joining with TDMHMR and the Texas Commission of Alcohol and Drug Abuse (TCADA), THHSC developed a request for proposals from BMCOs to manage the mental health and substance abuse services in Dallas and six neighboring counties in North Texas. In a move toward the privatization of public services, state funds previously available to the CMHCs in the area were part of the contract with the BMCO. Local CMHCs went out of business or continued as a subcontractor under the BMCO. Value Options, a BMCO now called Beacon Health Options after a merger with Beacon Health Strategies in 2014, won the bid and created a program named NorthSTAR. The new program became responsible for all mental health

[56] Institute of Medicine Staff. *Managing Managed Care: Quality Improvement in Behavioral Health*. Washington: National Academies Press, 1997. Accessed May 9, 2018. ProQuest Ebook Central: 15-16.

[57] HB 2913, 75th Regular Session, Bill Files, (1997), Texas Legislature, Archives and Information Services Texas State Library.

and substance abuse assessment and treatment for Medicaid and indigent clients in those counties, beginning in 1999. It created a network of 300 clinicians, agencies, and hospitals to provide services. Value Options agreed to accept the authorized payment from the state and to manage and pay for all services. Individuals could select a provider from their approved providers. Value Options committed to serve all patients or clients quickly, so there would be no waiting lists. This program served many more persons annually than their counterparts in the other CMHCs who were not involved in managed care, but the other CMHCs argued that Northstar's services were far less robust than they provided. A study in 2012 by an outside consultant recommended that the state move the entire state to the managed care model citing its improved outreach, better care coordination, broader provider network, and the separation of service authorization from service provision,[58]

Initially, this program was a pilot project intended to expand to the rest of the state if successful. Despite the outside consultant recommendation from 2012, and while Medicaid managed-care proliferated in Texas, the combination of TTHSC with mental health and substance abuse never expanded beyond the one region, and NorthSTAR ended on December 31, 2016, with that region returning to the traditional community mental health and substance abuse agencies.[59] There was always strong opposition to the

[58] Public Consulting Group from Boston, Massachusetts, "Analysis of the Texas Public Behavioral Health System: Recommendations for System Redesign," State of Texas Health and Human Services Commission Department of State Health Services, June 2012: 3. Accessed May 10, 2018, https://www.dmahealth.com/pdf/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System_Recommendations%20for%20System%20Redesign.pdf.

[59] Market Intelligence Team, "ValueOptions and Magellan Finalists in Texas NorthSTAR Program," *Open Minds,* November 2, 1998. Accessed May 10, 2018, https://www.openminds.com/market-intelligence/editorials/110198f/. Matthew Watkins, "After 15 years, Dallas area's mental health experiment may be ending," *Dallas Morning News*, December 20, 2014. Accessed on May 10, 2018, https://www.dallasnews.com/news/news/2014/12/20/after-15-years-dallas-areas-mental-health-experiment-may-be-ending.

NorthSTAR program by the CMHCs in the state. While NorthSTAR had support in the six counties served, because of the way it was structured, it was "ineligible for many state and federal funding sources" and when the Legislature increased funding for mental health by $330 million statewide in 2013, NorthSTAR received very little of the increase.[60] In reality, Medicaid funding in Texas is so low that the private sector cannot provide mental health services without taking a loss. Neither the managed care system nor the traditional system had enough resources to provide for both the quality and quantity needed by those with an SMI in Texas.

Political Change Brings Major Change to Health and Human Services in Texas

In November 2002, for the first time since Reconstruction in 1877, the Republicans gained control of the Texas House of Representatives, the Senate, the Lt. Governorship, and the Governorship.[61] The 78th Legislature regular session of 2003 passed HB 2292, which abolished ten of the eleven health and human services agencies in Texas. The Legislature then consolidated the ten into three new agencies. Those three and the single agency not abolished, the Department of Family and Protective Services (DFPS), moved under the control of an executive commissioner appointed by the governor with the advice and consent of the Senate. Mental health and intellectual disability, which had been together since 1965, were now a part of two different agencies. Mental health became part of the Department of State Health Services (DSHS), and intellectual disability moved to the Department of Aging and Disability Services

[60] Watkins, 2014.

[61] Garnet Coleman Interview. "Overview and history of the Republican Party of Texas," accessed May 11, 2018, https://www.texasgop.org/overview-and-history/.

(DADS). The third new agency became the Department of Assistive and Rehabilitative Services (DARS). The existing boards of the agencies ceased to exist, and the governor named new advisory councils for the four agencies. These councils could advise the executive commissioner, but they had no power to make decisions. The executive commissioner now hired the commissioners of the subordinate agencies who serve at his/her pleasure.

These changes give the governor much greater control over the agencies than any Texas governor had had since Reconstruction.[62] This change is positive on the one hand, for it places the responsibility for mental health under the direct control of the governor and his appointed staff rather than volunteer boards with staggered appointments over six years by different governors. However, in a state dominated by one party, there are limited voices raised for the needs of the people served and advocating for expanded services.

The Republican-led legislation also attempted to require CMHCs to diversify the delivery of services to other providers in the community. HB 2292 required CMHCs to serve as the "provider of last resort" and to demonstrate to the state department that there was not already a "willing provider" of relevant services in the area or county if it delivered the services. [63] While the CMHCs are an arm of the state, they do operate under boards appointed by local county commissioners or other authorities. A review of 39 community centers reveals that each is unique, and that they provide most of the direct

[62] House Bill 2292, 78th Regular Session, Bill Files, (2003), Chapter 198: 612, 619. Texas Legislature, Archives and Information Services Texas State Library. The current executive commissioner, appointed by Governor Abbott in 2018, is Courtney N. Phillips, an African-American woman who previously served in similar roles in Nebraska and Louisiana.

[63] "Local Mental Health Authorities (LMHAs)," Texas Department of State Health Services, accessed on May 11, 2018, https://dshs.texas.gov/mhsa/lmha-list/. House Bill 2292, Chapter 198:676.

services through their staff.[64] Though the Legislature tried to increase the provider base, they provided no additional funds to do so. The CMHCs developed solicitations for more providers, but there were few providers interested in providing services at the rate the CMHCs were willing to pay. In 2019, CMHCs in Texas receive the bulk of their funding from the state mental health budget, but they also receive funding from Medicaid, Medicare, health insurance companies, local county funding, federal grants, as well as private funds raised locally. In addition to these several funding streams, the CMHC in Harris County also receives in-kind medications from pharmaceutical companies.

Another requirement that had a pronounced impact on the use of state resources to provide services to the mentally ill through CMHCs was the requirement that state funds were only available for "disease management practices and jail diversion measures." The state required the CMHCs to treat only adults diagnosed with bipolar disorder, schizophrenia, or severe clinical depression.[65] While this limitation did provide more funding for those with the specified SMIs, there were significant problems. One, these specified illnesses are chronic illnesses for which many do not recover as they do in physical medicine. Most patients will always require some level of care—at a minimum, medication management. Two, by limiting treatment only to specific diagnoses, others with equally debilitating conditions such as Post Traumatic Stress Disorder or Borderline Personality Disorder received only crisis care through the CMHCs.[66] Third, and the most critical, the state did not budget enough resources to provide the level of service required

[64] Ibid. "Local Mental Health Authorities," An examination of each of the 39 LMHA's websites, reveals that they primarily provide services through their staff.

[65] House Bill 2292, Chapter 198:676.

[66] Garnet Coleman Interview.

for the number of individuals who met the qualifications for treatment.[67] There were always waiting lists for some levels of care, and unfortunately, a growing number of mentally ill who did not receive treatment.

Medicaid Section 1115 Waiver Provides Increased Funding for Mental Health in Texas

With the passage of the Affordable Care Act by Congress in 2009, the four largest states—Florida, New York, California, and Texas—were given the opportunity to begin the transformation to the mandatory expansion of Medicaid to 138 percent of the Federal Poverty Level. The funding for this action came by using a Medicaid Section 1115 waiver,[68] whereby increased funds were available under the Upper Payment Level (UPL) program.[69] The waiver continued federal funding to hospitals for uncompensated care and created a second funding stream to serve as an incentive for the states to experiment with

[67] The FY 2004 and FY 2005 appropriations called for 60,771 adults and 11,322 children to receive treatment each month. By FY 2006 and FY 2007, the monthly numbers dropped to 46,143 adults and 9,994 children. By FY 2017, the monthly numbers were back to 60,995 adults and 12,561 children. These individuals required months, if not years of treatment. The total population of the state grew by 6 million during that period, but FY 2017 was appropriating resources to treat the same number as in 2004.

[68] Section 1115 Medicaid waivers are demonstration waivers that "provide states an avenue to test new approaches in Medicaid that differ from what is required by federal statute. Waivers can provide states considerable flexibility in how they operate their programs. … Waivers generally reflect priorities identified by states and the Centers for Medicare and Medicaid Services." Elizabeth Hinton, Mary Beth Musumeci, Robin Rudowitz, Larisa Antonisse, and Cornelia Hall, "Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers," Henry J. Kaiser Family Foundation, February 12, 2019, accessed June 25, 2019, https://www.kff.org/medicaid/issue-brief/section-1115-medicad-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/.

[69] The UPL is the limit of federal funding to reimburse fee-for-service Medicaid providers. It originated in 1983 when Medicare moved to a prospective payment system, and states could set their rates to reimburse hospitals and nursing homes. A prospective payment system is one where reimbursement is made for services rendered based upon a previously agreed upon fixed sum. The upper limit is a determination of what "Medicare would have paid facilities for the same services. Kip Piper, "Medicaid Upper Payment Limit: Understanding Federal Limits on Medicaid Fee-For-Service Reimbursement of Hospitals and Nursing Homes," *Piper Report: Kip Piper's Health Care Blog Medicare, Medicaid, Health Reform,* April 25, 2012. Accessed May 14, 2018, http://piperreport.com/blog/2012/04/25/medicaid-upper-payment-limits-understanding-federal-limits-medicaid-fee-for-service-reimbursement-hospitals-nursing-homes/.

new health care delivery systems.[70] The two funding streams provided $17.6 billion for the Uncompensated Care (UC) Pool and $11.4 billion for the Delivery System Reform Incentive Payment (DSRIP) pool from 2011 to 2016 in Texas.[71] A 15-month extension allowed the program to continue through October 2017, and another five-year waiver extended the program through September 2022.[72] The latest extension, however, phases out the DISRIP funding in 2022.[73] Uncompensated Care provides funding to hospitals to support their provision of care to the indigent and others without insurance. The DISRP program is "designed to incentivize innovations to increase access, improve quality and better manage costs of healthcare for low income Texans."[74] Through DISRIP, local, and state healthcare funding that was previously not part of the state match for Medicaid became eligible through Intergovernmental Transfers (IGT) from the local governments to the state. These transfers serve as matching funds for additional federal Medicaid funding.[75] In essence, without the state or local governments providing any additional

[70] Kristin Allen, "Texas Receives 1115 Waiver Renewal," *Health Management Associates,* January 25, 2018. Accessed May 14, 2018, https://www.healthmanagement.com/blog/texas-receives-1115-waiver-renewal/.

[71] Health Management Associates, "Texas Health and Human Services Commission: Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and he Role of Texas' Uncompensated Care Pool," August 26, 2016: 1. Accessed May 14, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-uncomp-care-eval-rpt-08312016.pdf.

[72] Kristin Allen.

[73] "1115 Medicaid Transformation Waiver," *Texas Hospital Association*, Accessed May 15, 2018, https://www.tha.org/waiver.

[74] "Community Centers and the Texas 1115 Medicaid Transformation Waiver," *Texas Council of Community Centers,* accessed May 15, 2018, https://txcouncil.com/userfiles/files/1115%20Waiver%20Overview_Legislative%20FINAL.pdf.

[75] IGTs are funds transferred from one governmental entity to the State Medicaid Agency that is matched at the Federal Medical Assistance Percentage (FMAP) of 58.19%. Kris Mastrangelo, "Intergovernmental Transfers: Funding State Medicaid, July 14, 2015, *Harmony Healthcare International*, accessed May 15, 2018, http://www.harmony-healthcare.com/blog/intergovernmental-transfers-funding-state-medicaid-programs.

funds, increased federal funds became available for the Medicaid eligible and indigent population.

These two pools of funding allowed the creation of temporary programs to help the four largest states move toward the expansion of Medicaid under the Affordable Care Act. Texas applied for this funding in July of 2011 and received approval for the waiver in December of that year, six months before the Supreme Court ruling that Medicaid expansion was optional for the states. Since that ruling, however, the Texas Legislature has refused to expand Medicaid under the Federal Affordable Care Act of 2009. Even though Texas has not expanded Medicaid, the federal government has allowed the state to continue to receive this funding temporarily. In reality, if Texas had or were now to expand Medicaid, there would be no need for the funding under the waiver, and those served through this program would be receiving care through Medicaid. The waiver has allowed the state to expand services temporarily to provide services to the children and adults through innovative new programs. Texas is losing $65.6 billion in federal funding over ten years by not expanding Medicaid, and Texans are paying $36.2 billion in federal taxes so other states can expand Medicaid.[76] Governor Abbott and the Republican-led Legislature claim expansion is wrong for Texas, claiming it would be "a massive expansion of an already broken and bloated Medicaid program."[77] More likely, the reason

[76] "Texans Want to Expand Medicaid. Politicians Don't. [Editorial]." *Houston Chronicle*, September 14, 2018, accessed September 19, 2019, https://www.houstonchronicle.com/opinion/editorials/article/Texans-want-to-expand-Medicaid-Politicians-13228093.php.

[77] Edgar Walters, "With Hospital Funds in Question, Abbott Holds Firm on Medicaid," *The Texas Tribune*, April 20, 2015, accessed September 19, 2019, https://www.texastribune.org/2015/04/20/hospital-funds-question-abbott-holds-firm-against-/

for not expanding Medicaid is political, based upon conservative Republican's opposition to the Affordable Care Act.

DISRIP works through regional healthcare partnerships (RHP) under an anchor institution, which can be "public hospitals, hospital districts, a hospital authority, a county, or a State University with a health science center or medical school." The regional partnership develops program plans in partnership with other local public and private providers and submits them for approval to the federal Medicaid program. Once approved, those providers deliver the services authorized through the plan. The services must produce results at the levels set in the plans before payment from the DSRIP funds is available. While the Section 1115 Medicaid waiver is primarily a demonstration project to test new ideas, in Texas, it continues to provide much-needed resources for the indigent and particularly the mentally ill. Under its flexibility, it has allowed enhanced methods of delivery of services to those in need.

Houston Representative Garnet Coleman of the Texas State House points out that the funding, through its flexibility, has allowed the co-location of mental health services with physical health providers, and it has enabled several community mental health agencies to eliminate their waiting lists. Given these new resources, in 2015, the Legislature lifted the requirement that community mental health centers could only treat those with major mental illnesses. Coleman also noted that the funding is "off the budget," meaning it uses matching funds that are not part of the state budget, which has allowed for much greater flexibility in delivering mental health services.[78] There remains, of course, the critical question of whether the state will revert to care for only those with

[78]Garnet Coleman Interview.

major mental illnesses when the temporary funding ends in 2022 and whether the state will fund the now federal portion of the Medicaid that is matched by local funds when the program ends.

Representative Coleman also notes that Texas, under Republican control, began to increase funding for mental health after the Sandy Hook primary school shootings in Connecticut in 2012, right before the legislative session opened. There was such a focus on the need to do something about the shootings, and the "pro-gun lobby could not say that guns had nothing to do with the killings," so the Legislature focused on mental health by putting more money into it. In 2015, the Legislature continued to add money for mental health thanks to Representatives Cindy Burkett from the Dallas area and Sarah Davis from Houston and Senator Jane Nelson from North Texas who are "champions for mental health."[79] While the Legislature in 2017 increased funding again with a significant commitment for capital improvements, one suggests that with the politics of a conservative state and its self-imposed limited taxing structure, this commitment is heavily dependent upon the boom-to-bust cycles of the Texas oil-based economy. Though it has these champions, with the history of inadequate funding for mental health and health care in general in the state, one has to question whether future legislatures will fund the new levels of care.

The Future of Care for the Mentally Ill in Texas

Given the history of Texas, it is easy to be cynical about the future; however, there are recent signs of improvement. In 2018, the two highest courts in Texas, the Supreme Court and the Texas Court of Appeals, created the Judicial Commission on

[79] Ibid.

Mental Health. They appointed 31 commissioners, including judges and other key public officials to serve on it, and they asked the governor, lieutenant governor, and speaker of the house to send a representative to serve as ex-officio members of the commission. Its purpose is to "examine best practices in the administration of civil and criminal justice for persons with mental illness."[80] The Legislature provides funding for the Commission to hire staff to support its work. The Commission and the supporting Collaborative Council that it has appointed seek input at their meetings that includes a wide variety of mental health experts and persons or families of persons experiencing mental illness. The Commission focuses on specific projects that fit its strategic planning model. That model stresses that the mission of the Commission is to "engage and empower court systems through collaboration, education, and leadership."[81] The membership of the Commission and Collaborative Council represents vital public and private experts in the field of mental health. Its work is long-term in nature and designed to bring about meaningful change in the state's laws, services, and policies on the treatment of mental illness. With so many severely mentally ill persons in jail or prison, the courts already have some concept of the need for improvement.

In another positive note in 2015, the Texas Legislature directed the 18 state agencies receiving general revenue funds for behavioral health to work together to develop a "collaborative five-year behavioral health strategic plan and coordinated

[80] Adam Faderewski, "Members appointed to Judicial Commission on Mental Health, April 23, 2018," *Texas Bar Blog: News on the Lawyers and Legal Professionals of Texas -- State Bar of Texas.* Accessed May 15, 2018, https://blog.texasbar.com/2018/04/articles/news/members-appointed-to-judicial-commission-on-mental-health/.

[81] "Strategic Plan," Texas Judicial Commission on Mental Health, 2019, accessed June 25, 2019, "Strategic Plan," Texas Judicial Commission on Mental Health, accessed June 25, 2019. https://texasjcm.gov/media/1587/jcmh-strategic-plan-209.pdf..

expenditures proposal." These agencies were spending collectively $6.7 billion from state general revenue, Medicaid, and local and federal resources on behavioral health services. That developed plan stated that

> Texas has come to recognize the unique needs of individuals with complex behavioral health issues. These individuals experience a range of other risk factors, including unemployment, homelessness, and co-occurring health issues. Texas also appreciates the need for specialized services for individuals with intellectual disabilities, new mothers with depression, and military trauma affected veterans and their families. [82]

That statement represents more of a hope or goal, for it certainly does not represent the history nor the present situation for the treatment of individuals with mental illness in Texas, and much will have to happen to make it the reality in the future. The Substance Abuse and Mental Health Services Administration (SAMSHA) found that in 2016, there were 677,000 adults age 18 and over in Texas suffering from an SMI and 191,000 youth ages 12 to 17 who suffered from major depression during the previous year.[83] The state Legislature appropriated resources to provide services in the state psychiatric hospitals to treat 12,231 persons, but less than half of that number is for individuals not accused of a crime. They also appropriated resources to serve 60,995 adults and 12,561 children per month in the state-supported community mental health centers, but individuals receive treatment over several months, so there is a limitation to the number they can serve. They also appropriated resources to provide 30,915 residential crisis days of care and 72,200 crisis outpatient services for the year.[84] The report to the

[82] "Texas Statewide Behavioral Health Strategic Plan: Fiscal Years 2017-2021." *Statewide Behavioral Health Coordinating Council,* May 2016: 1. Accessed May 16, 2018, https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf.

[83] Legislative Budget Board: 1.

[84] HB 1, 84th Regular Session, Bill Files, (2015): II-52, Texas Legislature, Archives and Information Services Texas State Library. I derived the number 12,231 by multiplying the budgeted number of days of 2463 for all state hospitals, including the Waco Center for Youth, by 365 to get the total possible days of

Legislature citing SAMSHA numbers noted that mental illness was one of the five most costly illnesses to treat and that it required "the highest out-of-pocket payments" from those receiving treatment.[85] These numbers show that the state of Texas provides only a small portion of the care needed by those with a severe mental illness in Texas. Individuals not treated by the state must either have personal or family funding to pay for the high cost of care. Without treatment, they are likely to commit a chargeable offense leading to their incarceration. In jail or prison, they will perhaps receive some care, but not in a place designed to provide them the help and services they need to function in society to which they hope to return. When they leave jail, they will have lost their Medicaid benefits because of their placement in jail. They will have to reapply for them, but in the meantime, they will not have access to a physician or medications. They will also now have a criminal record added to their mental illness, both major stigmas in society.

In 2017, the Legislature removed the state's mental health system of state hospitals and community mental health centers from DSHS and placed it directly under the Health and Human Services Commission (HHSC).[86] Working directly under HHSC rather than DSHS, mental health in Texas has a much higher profile within the state. It sets the stage for potential changes in the system. Recognizing the woeful shape of the state hospitals described in a review by an outside consultant that rated all except one of

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care. I then divided that number by 73.5 days, which was the average length of stays in those hospitals, as noted in the Legislative Budget Board Report on page 6.

[85] Legislative Budget Board: 1.

[86] Senate Bill 200, 84th Regular Session, Bill Files, 2015), Texas Legislature, Archives and Information Services Texas State Library.

its facilities in poor condition,[87] the Legislature included within the appropriations bill $66.3 million for existing mental hospitals to make repairs necessitated by neglected maintenance. They also added $300 million for the upcoming biennium (2017-2019) to begin replacing worn-out facilities and adding new ones.[88] These sums are a good start on the repairs and new construction, but it will require future legislatures to make similar appropriations to accomplish the identified plan. State funding of schools, road construction, and many other needs in one of the fastest-growing states in the nation will force mental health to compete with other critical wants in a state where the Legislature refuses to increase taxes to fund essential services.

While the initial focus on improving mental health funding in Texas came from the need to do something instead of talking about gun control, the state's efforts to improve the treatment of serious mental illness seems to have moved beyond that motivation to a real desire to improve the system. The Legislature has directed HHSC to put together a master plan to redesign the state hospital system in Texas to meet the needs of the mentally ill. This plan establishes three principles to guide their planning--unparalleled care, easy access, and a systems-based continuum of care. It calls for additions to existing campuses and new campuses beginning in FY18 and going through FY24. These changes include a new hospital in Houston, a new psychiatric hospital in the Dallas-Fort Worth area, replacement of the Austin and San Antonio State Hospitals,

[87] Cannon Design CBRE, The Innova Group, Pacheco Koch, Pape-Dawson Engineers, rh2, Twogether Consulting, VAI Architects, and WestEast Design, *Analysis for the Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals (SPHs): Consulting Services Regarding DSHS Rider 83 RFP Final Report*, November 2014: 126. Accessed May 16, 2018, https://www.dshs.texas.gov/mhsa/reports/SPH-Report-2014.pdf.

[88] Senate Bill 1, 85th Regular Session, Bill Files, (2017), Texas Legislature, Archives and Information Services Texas State Library.

converting an existing hospital in Waco to serve psychiatric patients, a possible new hospital in the Panhandle, and new maximum-security units at Rusk and Kerrville State Hospitals.[89] In January of 2018, the Texas Health and Human Services Commission authorized the initial funds for the construction of a new 300-bed psychiatric hospital in Houston that along, with the existing 274 acute care beds in HCPC, "will create the most extensive academic behavioral health hospital in the country.[90] In a positive move for the treatment of mental illness in Texas, the Legislature in 2019 appropriated the funding for construction of the new Houston hospital, and it appropriated initial funding to create a new psychiatric hospital in the Dallas Fort Worth area.

A Skeptical Hope

The Medicaid 1115 waiver expansion of funding has created new services for those with an SMI in Texas as well as those with less debilitating mental illnesses. The state has spent more money, much of it federal funds, and some of its own spurred by the need to do something short of discussing gun control in response to school shootings. The courts are exploring their role concerning the mentally ill. The Legislature has begun to spend funds on replacing woefully outdated and inadequate state hospitals, and it is locating new ones in the major population centers of Houston and Dallas-Fort Worth. It is

[89]"A Comprehensive Plan for State-Funded Inpatient Mental Health Services: As Required by S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 221)," *Texas Health and Human Services,* August 2017, accessed May 16, 2018, https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/comprehensive-inpatient-mental-health-plan-8-23-17.pdf.

[90] Deborah Mann Lake, "Plan for UTHealth Continuum of Care Campus for Behavioral Health announced with State's approval of Initial Funds," UTHealth-The University of Texas Health Science Center at Houston Media Relations, January 8, 2018. Accessed September 11, 2018, https://www.uth.edu/media/story.htm?id=51ed5739-acc0-4a4f-8576-143be9a14b9c.

committing itself to work with the state's public medical schools to train more staff and to upgrade care in the hospitals.

All of these changes give hope for the future. One must ask, however, from where will the funds for this hope come? Texas has a history of funding the care of its mentally ill citizens near the bottom in a ranking of the states. It has not expanded Medicaid even though the federal government under the Affordable Care Act would pay for 90 percent of the cost of this expansion. When the 1115 waiver expires in 2022, will the state provide significant resources to maintain the status quo and increase funds to meet the rapidly expanding needs of its growing citizenship? Will future legislatures approve the funds necessary to meet the aggressive planning for new facilities? Will the Legislature provide the operating funds to pay for programming needed at both the community level and in the state hospitals? In a conservatively political state where the Legislature maintains a limited taxing structure based primarily upon sales taxes, how will mental health fare in competition with other expanding needs at both the state and local levels? One would like to hope it will fare well, but history suggests skepticism may prove to be the wiser view.

Conclusion

TDMHMR's commissioner and board lacked understanding of the challenge of the two lawsuits that hit them in 1974. They spent years ignoring the problem and refusing a settlement offer that would have required no significant changes before the next commissioner agreed to a settlement that he did not understand right before he resigned. Commissioner Miller spent years battling the federal courts on the terms of the agreement. He created a program to move patients out of the hospitals rather than

increase staffing to meet what a staff member had incautiously noted was its staffing plan. The first non-psychiatrist commissioner, Dennis Jones, continued to struggle until changes in his office and the legal counsel for the plaintiffs allowed the final settlement of the case nearly twenty-five years after it began. Unfortunately, for the severely mentally ill, the result was a dramatic loss in the number of beds available for them in the state hospitals that has only decreased since that time. Additionally, the state turned to managed care to control Medicaid costs, and new political leadership in Austin brought further reductions in spending and a limitation on individuals served through the community mental health system. New funding from a federal Medicaid waiver and the state legislature have brought increased services, and a skeptical hope for the future as the state faces a rapidly increasing population, but with limited taxing ability.

VIII. THE BEGINNINGS OF COMMUNITY MENTAL HEALTH CENTERS IN HOUSTON AND HARRIS COUNTY, TEXAS SHOW THE FATAL FLAW OF FEDERAL FUNDING AND THE INADEQUACY OF STATE AND LOCAL FUNDING

Introduction

This chapter is the first of two that focuses on the treatment of the severely mentally ill in the local community of Harris County and Houston, the states' largest county and city. While Houston and Harris County are the largest city and county in Texas today, that was not always the situation. The founding of the city and county in 1836 and its service as the state capital for 1837 to 1839 held great promise for the area, but it was many years before it became what it is today. Thanks to the Galveston Hurricane in 1900 that significantly changed the fortunes of that city, the rise of the oil boom after the Spindle Top oil gusher in nearby Beaumont in 1901, and the opening of the 50 mile Houston Ship Channel from the Gulf of Mexico to downtown Houston in 1914 the city and county's fortunes began to change. It became the largest city and county in Texas in 1930 and has continued that to today. Houston had a population of 292,352 in 1930, and Harris County had 359,928. Harris County passed one million in population in 1960 with 1,243,158. Houston passed a million in 1970 with 1,232,802. In 2018, Houston was the fourth-largest city in the United States, with 2,464,124 citizens, and Harris County was the third-largest county in the nation in population with 4,698,619. The Houston, Sugarland, Woodlands Metropolitan area has a population of just under 7 million, which makes it the fifth-largest metro area in the nation by population. Houston and Harris County have the most culturally diverse population in

America. Beyond its being the headquarters for the nation's and the world's energy business, Houston has the world's largest medical complex, the Texas Medical Center, and is home to NASA and America's space headquarters. The diversity, rapid and exponential growth, along with its susceptibility to hurricanes and flooding, means the community faces many ongoing challenges. One of those challenges is in providing for its most vulnerable citizens—those who suffer from severe mental illness (SMI).

Before the passage of federal and state laws creating funding for community mental health centers (CMHCs) in 1963 and 1965, Harris County and Houston's work with the SMI consisted of the county's Psychiatric Diagnostic Center that provided diagnoses for patients and a holding facility in the county-owned hospital for persons awaiting placement in the state hospital in Austin. There were also 25 emergency and acute inpatient psychiatric beds at the Ben Taub County Hospital, and two private psychiatric hospitals providing 40 inpatient beds each. Four private, general hospitals had approximately 125 inpatient psychiatric beds in total in 1964. The state's Houston State Psychiatric Institute for Research and Training (HSPI) had 43 inpatient psychiatric beds along with a follow-up clinic for patients leaving the state hospitals. In partnership with Baylor University College of Medicine, HSPI also offered one adult and one child outpatient clinic.[1]

Following the passage of House Bill 3 by the Texas Legislature, which provided a mechanism for communities to begin CMHCs, several organizations worked with Harris County Commissions Court to create a local board for a Harris County CMHC. Before

[1] Clifton McCleskey, "Houston," in *The Politics of Mental Health: Organizing Community Mental Health in Metropolitan Areas,* ed. Robert H. Connery (New York: Columbia University Press, 1968): 105-109.

that organization became operational, a local hospital took the opportunity to apply for federal funding to begin the area's first CMHC. St. Joseph Hospital obtained both a federal CMHC construction grant and a federal CMHC staffing grant in 1966. It gained early recognition as the first community mental health center in Texas and the southwest. A national study identified it as one of the most successful CMHCs in the nation in 1969.[2] With federal funding diminishing over five years and no state or local funding to support the quality services it provided, the hospital worked with the Harris County Community Mental Health and Mental Retardation Authority (MHMRA), the county-and state-supported CMHC, to take over the program in 1972. The beginnings of MHMRA with the many problems it endured in getting started stands in sharp contrast to the success of the St. Joseph CMHC. MHMRA, a creation of the Harris County Commissioners Court in 1965, began with no funding from the state and little from the county. It struggled for the first three years to pay its bills and begin programming. It went through significant board and executive leadership issues for many years and labored to serve such a large county with the limited resources available. For many years, scandals and local politics provided far more headlines than the services provided by the agency.

While Harris County has the largest population in the state and has grown exponentially over the last 50 years, most patients needing the services of a state hospital still must travel three hours by car to receive treatment at a state hospital. In 1958, the Texas Legislature had created HSPI, as a unique research and training program that

[2] Raymond M. Glasscote, James N. Sussex, Elain Cumming and Lauren H. Smith, *The Community Mental Health Center: An Interim Appraisal* (Washington DC: The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1969): 129.

served a selected population as part of its research and training. It, however, was not capable of serving all those with an SMI needing treatment in a state psychiatric hospital. It was renamed the Texas Research Institute for Mental Sciences (TRIMS) in 1967. The region lobbied the state Legislature from the 1950s onward for a local state psychiatric hospital.

The Mid-Houston CMHC—the First in Texas and the Southwest

In the spring of 1966, Sister Mary Amelia Shannon (Sister Amelia) (1919-1987) and her order, the Sisters of Charity of the Incarnate Word, were exploring ways they could expand their new psychiatric service at St. Joseph Hospital, the oldest general hospital in Houston. They had opened the new service in 1964 in space that needed renovation, and they were providing inpatient treatment, 24-hour emergency care, and limited outpatient services through the hospital to the general population of the city. Sister Amelia had come to the hospital with years of experience in psychiatric nursing, and following the completion of a master's degree in that field from Catholic University in Washington, D.C. While in Washington, she had become "very much involved in community 'action for mental health programs.'"[3] Sister Amelia was also part of the Harris County Action Committee for Mental Health and had worked to establish the new community mental health board in Harris County.[4]

[3] News Release from the National Institute of Mental Health News Feature Service in Washington, D.C., an undated five-page release about the Mid-Houston Community Mental Health Center. Archives of the Congregation of the Sisters of Charity of the Incarnate Word, Houston, TX: 2.

[4] "Minutes of Houston-Harris County Committee for Mental Health Action Community Workshop on Mental Health-Mental Retardation, October 11, 1965. Harris County Judge William M. (Bill) Elliott Papers, Mental Health Action Committee 1453-12, Archives of Harris County, Houston, TX.

In the search for funding, St. Joseph's Hospital found that federal funding was available for new CMHC programs. The board of the hospital applied for both a matching construction grant under the original 1963 CMHC law and a staffing grant under the 1965 amendment to that law.[5] The latter provided reducing funding for staffing costs for new CMHC programs over five years to qualifying public entities or private non-profit organizations. Those receiving the funding agreed to provide five essential services—inpatient treatment, outpatient services, 24-hour emergency care, partial hospitalization treatment, and education and consultation services—to a defined catchment area of between 75,000 and 200,000 persons with a "reasonable volume" of services provided below-cost or free for those who could not afford them.[6] The board of the hospital received a federal construction grant of $342,363 to fund 56 percent of the cost of remodeling the building[7] and a staffing grant of $719,000 for the first year. The latter grant provided 75 percent of the personnel costs for the new center the first year, but it reduced each year until it reached zero at the end of in five years. While the hospital's inpatient psychiatric facility served persons from all over the metropolitan area, the CMHC's catchment area (designated number 10 by the county) served a much smaller area. It included the hospital's location on the east side of downtown and the

[5] Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. Public Law 88-164, October 31, 1963. Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965. Public Law 89-105, August 4, 1965.

[6] Memorandum from Mother Mary Fidelis, president, to Mr. Hugh Rafferty, Dr. Harris Hauser, and Sister Mary Amelia, May 29, 1967. Archives of the Congregation of the Sisters of Charity of the Incarnate Word, Houston, TX: 2. "A Minute for the Facts -- Texas State Plan for Construction of Community Mental Health Centers – 1966, Texas Department of Mental Health and Mental Retardation, 1966: 9.

[7] Letter from J. Eugene McKee, TDMHMR Supervisor of Community Facilities Construction, to Mother Mary Cecilia of the Sisters of Charity of the Incarnate Word, July 1, 1966: 1, St. Joseph Hospital Mental Health Services Advisory Board, 031/015 1453-11 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

adjacent lower socio-economic area of the city, with a population of approximately 170,000 and with a large Hispanic and African American population.[8]

Despite Internal Opposition, Mid-Houston Expands Beyond the Hospital to Serve Its Catchment Area

The newly created Mid-Houston CMHC began operations in September 1966 and from the beginning, offered the five essential services through the hospital. However, by the summer of 1967, Sister Amelia and the staff of the CMHC began to question whether they were providing the community services needed in their "over-centralized, hospital-bound setting." They determined that they needed to move services out into the community. They began working with the Neighborhood Centers Association, a United Fund organization that administered "a social settlement and community recreation program for persons of all ages," which served the same general area in some different locations. Through working with that organization, the local schools, and other organizations, they created a decentralized outpatient service through three district offices and some other outposts. This change enabled the center to broaden its outreach to the mentally ill and their families across the catchment area.[9] However, this action led to the resignation of the center's medical director, Harris M. Hauser M.D., a prominent local psychiatrist, who saw the move outside of the hospital as changing his role dramatically. He opposed Sister Amelia's expanded role as administrative director, believing that the overall leadership must be under a psychiatrist, and likely from a man.[10] Other staff who

[8] Glasscote et al.: 129-130.

[9] Sister Mary Amelia, "Decentralized Outpatient Services in an Urban Setting," in *The Community Mental Health Center: Strategies and Programs, ed. Allan Beigel and Alan I. Levenson* (New York: Basic Books, Inc., Publishers, 1972): 211-216.

[10] Letter from Harris M. Hauser, M.D., to Mr. Hugh Rafferty, September 6, 1967. Archives of the Congregation of the Sisters of Charity of the Incarnate Word, Houston, TX.

opposed the more open community base also left, but the center hired a new clinical director, Harold Rockaway M.D., who was "more sympathetic" to the broader community approach, and he and Sister Amelia replaced the other departing staff.[11]

Figure 13 Sister Mary Shannon (Sister Amelia) [12]

Mid-Houston Recognized Nationally for Its Leadership in Community Mental Health

In November 1967, fourteen months after the Mid-Houston Community Center began its operations and just two months after the departure of the medical director and other staff, the CMHC received a visit by a national survey team from the National Institute of Mental Health (NIMH). The NIMH team was completing an interim study on the development of new CMHCs. Mid-Houston CMHC was one of only eight centers selected from the approximately 50 federally funded community mental health centers

[11] Robert J. Rao, "The Effect of a Change in Philosophy on the Delivery of Services at the Mid-Houston Community Mental Health Center," (master's thesis, Trinity University, 1969): 54. Glasscote et al: 134.

[12] *Teletopics St. Joseph Hospital* 13 no. 1, (December 1966-January 1967): 1. Archives of the Congregation of the Sisters of Charity of the Incarnate Word, Houston TX.

with six months of operational experience at the time. The survey team intended to write a detailed description of each of the eight centers, but after the conclusion of the visits, the team determined that only two sites, the one in Denver and Mid-Houston CMHC, were far enough along to provide insight to others. The report regarding Mid-Houston described it as having "moved swiftly and well toward providing services according to the federal concept of the community mental health center." It identified four significant accomplishments of the Center:

1. Through a formal arrangement with the local psychiatric receiving center, the mental health center has intercepted a substantial number of patients who would otherwise have gone to the state hospital.
2. By collaborating with a network of settlement houses in its catchment, the center has intricately involved and influenced the community.
3. Even though at high cost per unit of service, the center has involved psychiatrists in private practice to a greater extent than any other program we know of.
4. Private and public patients have been successfully integrated in a single treatment program.[13]

Areas of success included no waiting list for treatment for individuals from the center's catchment area, and the center never refused service to anyone from the catchment area.[14] Of the 175 persons from the catchment area who were candidates for admission to the state hospital from January of 1967 to November of 1967, 92 were admitted and successfully treated by the CMHC and did not require admission to the state hospital. The CMHC admitted eleven other patients, who subsequently required admission to the state hospital. Seventy-two patients entered the state hospital without receiving services from the CMHC. "Of all the persons who were already candidates for admission to the

[13] Glasscote et al.: 129.
[14] Ibid: 130.

state hospital, 59 percent were intercepted, and of these, 89 percent were successfully treated in the mental health program."[15]

Mid-Houston had an agreement with the state that provided funding of $15 per day for up to six months for any patients they were able to divert from the state hospital, up to a maximum billing of $100,000 per year. Though this would not fund the costs to provide the service, it served as an incentive to create programs and services locally to serve those previously served only by the state hospital. The CMHC also had a second formal agreement with Austin State Hospital, the state facility for Harris County. By that agreement, the two entities kept each other informed about patients from Mid-Houston's catchment area, agreed to accept patients from that area upon the request of the other, and the CMHC worked with the families of the patients from their area to keep them informed about their hospitalized family member.[16]

In 1972, the last year of its operation under the Sisters of Charity, Mid-Houston provided 146,666 hours of service through 25 different programs to an unduplicated 1,014 clients from the catchment area. These services included intake, diagnosis and evaluation, individual, group, and family therapy; medications; vocational and social rehabilitation and counseling; a sheltered workshop which provided a protected work opportunity for patients; a halfway house; case consultation; partial hospitalization; and home visits.[17] Sister Amelia and the program gained national recognition for creating the

[15] Ibid: 148

[16] Ibid: 148.

[17] "Narrative Program Information," "Service Data Fiscal Year 1971-1972 Mid-Houston MHMR," Application for Continuation Staffing Grant to the National Institute of Mental Health Project, Identification Number 858-15-1572, Mental Health and Mental Retardation Authority of Harris County, May 17, 1973. Harris Commissioner Court Files for MHMRA December 9, 1965 to December 1973, Harris County Archives, Houston, TX.

CMHC envisioned by the law passed in 1963 and for going far beyond its requirements. In 1969, the NIMH issued a five-page press release highlighting Sister Amelia and the Mid-Houston Center's work. The release noted that over 5,000 persons had received treatment since it opened and that many of those would not have received help if not for the center. They noted as well, "many would have been sent to the State hospital, for varying periods of confinement."[18] President Richard Nixon (1969-1974) wrote Sister Amelia a personal letter after reading a newspaper account based on the news release. He stated in his letter, "As a woman, as a nun, as a pioneer in the field of mental health, you deserve the gratitude of all Americans."[19] Sister Amelia also received recognition in Houston. She received the 1968 Houston Citizen of the Year Award by Goodwill Industries of Houston, and the YWCA of Houston named her the Woman of the Year in 1975.[20] In 1988, the year following her death, Vice President George Bush led the dedication of her picture in the lobby of the mental health building built under her leadership to honor her work with the mentally ill, alcoholics, and drug abusers.[21]

[18] News Release from the National Institute of Mental Health News Feature Service: 4.

[19] Letter from Richard Nixon to Sister Mary Amelia, July 7, 1969. Archives of the Sisters of Charity of the Incarnate Word, Houston, TX.

[20] "Wake for Sister Amelia set for St. Joseph Hospital," *The Houston Post*, October 12, 1987

[21] "Vice President Unveils Portrait of Sister Amelia," *Texas Catholic Herald*, June 24, 1988.

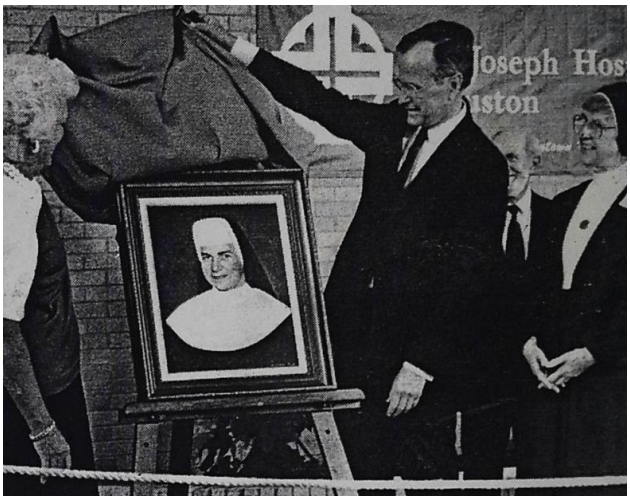

Figure 14 Vice President George Bush Unveiling a Picture of Sister Amelia [22]

The Fatal Flaw of the Design for Federal Funding

While Mid-Houston and Sister Amelia received recognition, in reality, the program illustrated the fatal flaw of federal funding. Congress had anticipated that other funds would fill the gap to sustain the programs; however, programs such as Mid-Houston, which served an impoverished area primarily, found that there were few other funds except their own to sustain the work. Though the Sisters of Charity set up the Mid-Houston CMHC with a separate board, the parent organization provided supplemental funding from the earnings of the private psychiatric patients and its reserves as the federal grant decreased each year.[23] After five years, with federal funds ending, the Sisters of Charity recognized that without other substantial funding sources, they could no longer maintain the program. They also recognized that only MHMRA had access to state and local funding that could support it. Mid-Houston's board spent six months negotiating with MHMRA to take over the program. While the Sisters of Charity could have simply

[22] Ibid. Photo by Curtis Dowell.
[23] Memorandum from Mother Mary Fidelis: 1-5.

closed the program when the federal funding ended, they worked with MHMRA to take over the program, seeing that course of action as the best thing they could do for "the long-term interests of the Mental Health patients in the geographical area of Catchment X [10]."[24] In reality, MHMRA took over the program, but they could not provide the same level of care as the patients treated under the Sisters of Charity. The last year's expenses under Sister Amelia for Mid-Houston was $1,345,884.[25] The first full year under MHMRA, the expenditure for the same area was $674,704.[26] After the first year under MHMRA, the ten catchment areas of Harris County merged into three districts, and MHMRA ended the relationship with Neighborhood Centers and greatly expanded the former coverage area, thus significantly reducing the services provided to the former Mid-Houston catchment area patients. Only two other catchment areas in Harris County had developed CMHCs, and seven areas had no CMHCs, so MHMRA was serving more people but providing fewer services.

How had Mid-Houston Created a Program Seen as an Early Success on the National Level?

The recognition of early success was no accident. Sister Amelia was a strong leader who was committed to building a center based on the ideals espoused by the leadership of the community mental health movement. Hugh Rafferty, board chair of Mid-Houston CMHC, described her as "a powerful woman, a big woman, soft-spoken,

[24] Memorandum to Sister Mary Bernice from Hugh J. Rafferty, chair, St. Joseph Mid-Houston Community Mental Health Center Board, Archives of the Sisters of Charity of the Incarnate Word, Houston, TX.

[25] Jim Craig, "County Mental Health Budget Plea Nearly Doubled," *The Houston Post,* January 7, 1972. Harris County Everett Squatty Lyons Scrapbook, *Harris* County Archives, Houston, TX.

[26] "FY 73 Audit for MHMRA," LaFrance, Walker, Jackley & Saville, Certified Public Accountants, November 26, 1973, Exhibit 1. Harris County Commissioner Court Files on MHMRA 1974-1, Harris County Archives, Houston, TX.

but when she spoke, people listened. She had an aura of authority, you did not cross her."[27] Louis Faillace, M.D., the founding chair of the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical School in Houston (UT-Houston) noted that Sister Amelia was "a great advocate for mental health who ran a great operation. … She was a dominant person who, if she wanted to do something, it would get done."[28] At the dawn of a new movement, she expanded the program from its hospital base to serve the community and battled one of the leading psychiatrists in the city to make the change. She successfully recruited other organizations to join her in building a supportive community base for mental health. She worked with the state hospital to create a new funding stream for patients served in the community instead of the state hospital and negotiated trailblazing agreements with the state hospital where patients from her area received treatment. She persuaded the Sisters of Charity to apply for the federal grants and to sustain the program for the life of those grants by using its funds to support it. Finally, she persuaded MHMRA to take over the program when federal grants ended.

While much of the reasons for the program's success came from its leadership, some fundamental principles emerge as significant. One, the program had quality staff. The study group from the NIMH noted that Mid-Houston paid the equivalent of twice the national salary for the psychiatrists who provided care; there were no salaried

[27] Hugh Rafferty Interview by Curtis Mooney, July 14, 2015. Interview notes available at the John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[28] Louis Faillace, M.D., recorded interview by Curtis Mooney, January 13, 2016. Interview available at the McGovern Center at the TMC Library, Houston, TX.

psychiatrists at Mid-Houston, as each one billed individually for the patients they saw.[29] Also, when Dr. Hauser left the program, he noted the high quality of the entire team assembled by Sister Amelia.[30] St. Joseph was an accredited hospital, whose leadership recognized the importance of the people serving the clients. Second, the program focused on one area and continually expanded the services and support for the mentally ill in that area. Mid-Houston was an area of great need, and throughout the grant period, the CMHC built relationships in the community to support the needs of those served and added programs to provide more care. Third, and undoubtedly most crucial, they had the resources, thanks to the generosity of the Sisters of Charity and other organizations working with them to provide the necessary programming. The Mid-Houston CMHC shows that if the federal, state, or local governments had provided the resources to meet the needs of the mentally ill in each community long-term, instead of just startup funds, the severely mentally ill would have fared much better.

In reviewing the success of this early pioneer in community mental health, one must question why her name and work have faded into history. She was a person who did not seek out glory for herself, yet the community of Houston and the mental health field itself could have done much more to recognize her accomplishments. Did the lack of recognition occur because Sister Amelia was a woman trained as a psychiatric nurse at a time when men trained as psychiatrists dominated the field? She was not afraid to disagree with a leading male psychiatrist in the community and move the program into uncharted territory. Sister Amelia pushed the male-dominated county MHMRA to take

[29] Glasscote et al.: 134. The Harris County Medical Society opposed salaried physicians, so the only recourse of Mid-Houston was to pay the psychiatrist per client served.

[30] Hauser to Rafferty letter.

over a very successful program. Was the new male leadership at MHMRA uncomfortable with the success she had brought to the community? Did he downplay her role, or was he not aware of her accomplishments? Whatever the cause, one must salute her as a true innovator and developer of community mental health.

The Inauspicious Beginnings of Public Community Mental Health in Harris County

Following the passage of House Bill 3 (HB 3) by the Texas Legislature in the spring of 1965,[31] more than sixty entities in Harris County, led by the Houston-Harris County Mental Health Association, lobbied the Harris County Commissioners Court to name a board of directors to start the development of a public community mental health authority under HB 3.[32] Commissioners Court formally appointed the Board of Trustees for the Harris County Mental Health and Mental Retardation Authority (MHMRA) on December 9, 1965, with an effective date of November 19, 1965.[33] The new board had nine members; three were doctors, two of whom, Spencer Bayles M.D. and Moody Bettis M.D., had served as the psychiatric consultants for the state's mental health planning

[31] HB 3, 59th Regular Session (1965), Bill Files, Texas Legislature, Archives and Information Services Texas State Library.

[32] Letter to County Judge Bill Elliott from John Rathmell, Chairman of the Community Planning Committee of the Mental Health Association of Houston and Harris County, July 21, 1965, Harris County Mental Health Association 031/015 1458-31 1965, Harris County Judge William M. (Bill) Elliott Papers. "Mental Health Association Community Planning Committee Meeting, July 27, 1965, Terrace Room, River Oaks Country Club," Houston-Harris County Committee for Mental Health Action, 031/015, 1459-01, 1965, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX. Letter from John Rathmell to Judge Bill Elliott, October 15, 1965, Houston-Harris County Committee for Mental Health Action, 031/015, 1459-01, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[33] The Court had appointed them on the earlier date but had failed to record the action officially in the minutes, and the new board had already met three times by December 9. "Minutes of the November 23, December 2, and December 8, 1965 meetings of the Harris County Board of Trustees Mental Health-Mental Retardation Centers," Mental Health Action Committee, 031/015 1453-12 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

committee in 1963-64.[34] The latter two knew the state's plan better than anyone in the state did, and they should have been in a position to provide clear direction for this new county board. Their lack of leadership and the struggles the new board encountered point to the difficulty these new organizations faced in becoming organized and funded. The other members held active roles in local or state advocacy groups for mentally ill and intellectual disabled persons, and hence had a commitment to the project and an understanding of the local resources that could assist with the work.

Though the advocates and agencies pushing for the new board were expecting results immediately, they soon began to realize that the new board was not going to be able to deliver what they wanted.[35] Though unknown at the time, the new board had no money. In the first month of its creation, the board met with the Harris County Hospital District Board at the urging of Commissioners Court, the governing body of the county, to determine whether they could have space in Jefferson Davis Hospital, of which the

[34] The initial board members were: Dr. Samuel M. Nabrit, president of Texas Southern University; John Flanagan, VP (retired) of United Gas Corporation; George Alexander, M.D., physician; Mrs. William J. Salman, president of the Auxiliary for the Houston Council for Retarded Children; Rev. Harold Bomhoff, pastor, St. Paul's Lutheran Church and President of the Baytown Mental Health Association; Mrs. I. H. Kempner, member of the Houston Mental Health Foundation; Mr. Robert U. Parish, senior VP, Houston National Bank and member of the Governor's Council on Mental Retardation; Dr. Moody C. Bettis, former psychiatric consultant for the State Mental Health Planning Committee in 1964 and chief of sociological research at HSPI; and Spencer Bayles, M.D., Chairman of the Medical Society Committee on Mental Health and former psychiatric consultant for the Texas State Mental Health Planning Committee before Bettis. "Mental Health and Mental Retardation Board," November 12, 1965, Mental Health Board, 031/015 1453-09, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX. Two members of the Board, Nabrit and Flanagan, were active for only a short time, and when the Commissioner's Court reauthorized the board in 1968, Dr. Ernest C. Kershaw, a professor at TSU, was listed in place of Nabrit, and John Castillo replaced Flanagan. Kershaw is noted in the board minutes as early as August 1966. The action of the Commissioner's Court of Harris County February 8, 1968, vol. 66, p. 149. Harris County Commissioner Court Files for MHMRA Dec. 9, 1965 to Dec. 1973, Harris County Archives, Houston, TX.

[35] "Letter to Steering Committee of Mental Health & Mental Retardation from John Rathmell, Chairman," received by Bill Elliott's office on February 28, 1966, "Meeting Notice Mental Health-Mental Retardation Action Committee for Houston and Harris County, September 6, 1966," Mental Health Action Committee 031/015 1453-12, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

District had just gained control. The Hospital District was a new entity as well, having just won approval from the voters of Harris County that same month. There were crucial differences, however, between the two new organizations. The hospital district was following other successful districts already in existence in the state, so they had a blueprint to follow going forward. Most crucially, they were a taxing authority that would have resources to fund operations and remodel the hospital.

With no clear direction nor money to fund any action, the MHMRA board decided that it was "not ready to make any decisions."[36] In reality, it was the only decision it could make. Incredibly, Commissioners Court had appropriated no resources for MHMRA, and the board would learn over the next years that getting funds from Commissioners Court would be difficult. Presumably, the commissioners assumed that the Legislature would appropriate funding for the board and saw their role as just appointing the board. Unfortunately, the state Legislature had appropriated only $600,000 for all CMHCs for 1966 and 1967; thus, the state board had little money to fund services either.

The state used its limited funding to provide program developers for local groups that had created new mental health authorities under HB 3. In April 1966, the TDMHMR announced that it would hire and fund a program developer for Harris County for one year, contingent on MHMRA providing a secretary and office. MHMRA agreed to do so, believing it would receive funding from Commissioners Court to pay for those necessary expenses. The board, however, noted that for a period, it was continuing to meet weekly

[36] "Harris County Board of Trustees—Mental Health Mental Retardation Centers Minutes, November 23, 1965," Mental Health Action Committee, 031/015, 1453-12 1966, Harris County Judge William M. (Bill) Elliott Papers, Houston, TX.

"to resolve certain legal questions about its functions."[37] The legal issue the board was not talking about in public was an attorney general's opinion released on April 6, 1966, stating that the constitution of Texas did not permit any entity except a hospital district to fund mental health and intellectually disabled services in those counties with hospital districts.[38] Since the voters of Harris County had created a hospital district to tax themselves to fund public health care services, no other tax-supported resources could legally fund public health in the area.[39] Though mental health would later become a part of the Harris County Hospital District services, at the beginning of the District, state psychiatric hospitals were responsible for mental health services for the indigent and MHMRA, though with no money, had just received the responsibility for local mental health services. The courts would agree with the attorney general's opinion, and it would take the passage of a constitutional amendment in November 1967 to allow other public entities to fund mental health and intellectually disabled services in those counties with hospital districts.[40]

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[37] "Mental Health-Mental Retardation Board of Trustees Conduct Hearing," *Mental Notes: News Letter of the Mental Health Assoc. of Houston and Harris County,* May 1966: 2, 031/015 1452-34 1964, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[38] "Opinion No. C-646, Re: Authority of Wilbarger County to pay for land on which is to be established a facility to be operated by the Texas Department of Mental Health and Mental Retardation, and related questions," Texas Attorney General's Office, April 6, 1966: 6.

[39] The Harris County Hospital District today provides extensive mental health services through Ben Taub Hospital and its outpatient clinics. When the district formed in 1966, they could have legally provided such services as well, but the state hospitals were essentially the system that served the indigent mentally ill, and MHMRA and other CMHCs were created to provide local mental health services to the public and the indigent.

[40] HJR 37, 60th Legislature, Regular Session (1967) Bill Files, Texas Legislature, Archives and Information Services Division, Texas State Library and Archives Commission. The Texas constitution of 1876 reflects the small conservative government ideas held by the people of Texas in the year of its adoption. It has been amended 235 times since its adoption, and it is the longest constitution by far in the United States. To amend the constitution, both houses of the Legislature must approve the amendment by a two-thirds vote, and a majority of those voting in a public election set by the Legislature must approve it. The courts ultimately decide if a provision of a law passed by the Legislature is constitutional, and if it is not, the Legislature must set in motion the amendment process, which has failed on several occasions. Joe E. Ericson and Ernest Wallace, "Constitution of 1876," *The Handbook of Texas Online*, Texas

In hindsight, keeping quiet was a mistake by the board, for the time to raise the issue of lack of funding was when the momentum for new community services for the mentally ill and the intellectually disabled was at its highest. At this point, over 60 agencies and professional groups in the community were working to make these new services a reality, and St. Joseph Hospital had just received two federal grants to begin the first CMHC in Texas. The Harris County Hospital District had won the election over stiff opposition from the Harris County Medical Society after four failed elections between 1954 and 1965.[41] Both entities were under Commissioners Court, which had encouraged MHMRA to work with the Hospital District. With political pressure from the advocates and lobbying by the board of MHMRA to the commissioners who had appointed them, the issue at least would have surfaced raising the possibility of MHMRA becoming part of the Hospital District or funded by them. The new board members of

State Historical Association, (2010), accessed on June 25, 2019, http://www.tshaonline.org/handbook/online/articles/mhc07.

[41] The medical society saw the hospital district as "unfair competition with other non-profit hospitals in the county …, [and believed] it was not good policy to allow district hospitals to contract with the federal government for patient care and treatment." Minard Heston Gildon, "Hospital Districts in Texas" (master's thesis, Texas Technological College, 1966): 42-43, accessed September 23, 2016, https://ttu-ir.tdl.org/ttu-ir/bitstream/handle/2346/10537/31295004051511.pdf?sequence=1. 43. Though the medical society opposed the hospital district, there was a town-gown split with physicians in private practice opposed while those associated with Baylor University College of Medicine in favor because the medical school had contracts with the existing city-county hospital that with the formation of the hospital district would provide for their continued work and its expansion. William T. Butler, *Arming for Battle Against Disease Through Education, Research and Patient Care at Baylor College of Medicine, Book II—Independence* (Houston: Baylor College of Medicine, 2011): 337-349. In contrast, MHMRA had the support of both the medical society and the Houston Psychiatric Society. There were three members of the latter group serving on the Houston-Harris County Committee for Mental Health Action, which petitioned the Commissioners Court to form MHMRA, and that group nominated nine psychiatrists to the Court for consideration for membership on MHMRA's board. Two, Bayles and Bettis served on the board. Sam Keeper, "Mental Health Association Community Planning Meeting-Previously Confirmed Attendance," July 27, 1965, "Recommended Nominations for Harris County Mental Health and Mental Retardation Board of Trustees," Attachment to letter from John Rathmell, Chair of Houston-Harris County Commission for Mental Health Action, to Judge Bill Elliott, October 15, 1965, Houston-Harris County Committee for Mental Health Action, 031-/015, 1459-01 1965, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, Texas.

MHMRA did not raise the issue. Perhaps the new board members feared that mental illness and intellectual disability would be the poor relation in a hospital district focused on physical health. However, these board members were in their positions because they knew about mental illness and intellectual disability and presumably had political connections at multiple levels. Why they chose to remain silent is a mystery, but it certainly handicapped the early development of the new organization.

By not voicing the problem of lack of funding, the board of MHMRA spent the last six months of 1966 begging Commissioners Court to pay the expenses of Merton J. Trast (1907-2004), the program developer funded by the state, for whom MHMRA had committed to providing an office and secretary. Trast, a very experienced social worker and administrator, began working in the summer of 1966 to help local agencies interested in creating community mental health services.[42] He assisted St. Joseph Hospital in working with Austin State Hospital and helped two other groups interested in applying for federal funding.[43] MHMRA asked the Commissioners Court, led by Judge Bill Elliott, for $17,850 to pay for one year of expenses in April 1966.[44] Judge Elliott, had served on the State Planning Committee for Mental Health and had presumably encouraged the Commissioners to approve the funding. However, when there was no response from

[42] Merton Trast received his Master's Degree from the University of Chicago School of Social Service Administration in 1934 and worked for the next 30 years in social work in Kansas. He had served as chief social worker at the 1,000 bed Winfield (Kansas) State Hospital and Training Center before being hired by TDMHMR to serve as Community Program Developer for Harris County's MHMRA program. "New Community Planning Director," Mental Notes—Mental Health Association of Houston and Harris County, Texas, (September 1966): 1. 031/015 Mental Health Board 1452-34 1964, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX

[43] Harris County Board of Trustees Mental Health-Mental Retardation Centers, minutes of the meeting of August 4, 1966: 2-3. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[44] Letter from Robert Parish to Judge Elliott and Commissioners, April 8, 1966. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

Commissioners Court and Trast was due to arrive at work in July—MHMRA secured the donation of furnished office space for thirty days.[45] In September, the board met with the Commissioners Court to ask for the funding but received no action by the court.[46] In October, the board advised the court it had "a bank over-draft, [had] not paid the office rent that month, and [had] several other unpaid bills," but again received no response.[47] Robert Parish, the MHMRA board chair who was senior vice president of Houston National Bank, arranged an emergency loan from the bank,[48] which was probably the only way the board, without any other means of support, could have obtained a loan.

Figure 15 Merton J. Trast [49]

[45] Letter from Robert Parish to Judge Elliott and County Commissioners, July 13, 1966, 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[46] Merton Trast, "Minutes of Meeting of September 15, 1966," Harris County Board of Trustees Mental Health-Mental Retardation, 031/015 Mental Health Board 1453-09 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archive, Houston, TX.

[47] Letter from Robert Parish to the Honorable Commissioners of Harris County, October 12, 1966. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archive, Houston, TX.

[48] Harris County Board of Trustees Mental Health-Mental Retardation Centers, Minutes of Meeting October 13, 1966, p. 2. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[49] *Mental Notes-Newsletter of the Harris County Mental Health Association, 1966.*

Robert Parrish, who served on the Governor's Counsel for Mental Retardation, would presumably have access to the Governor's office to ask for assistance, but there is no record that he did so. Interestingly, the board members did not donate to the organization from their resources or seek to raise private donations from others. Perhaps they believed that if Commissioners Court did not provide funding in the beginning, they never would. More likely, they saw their role as giving their time and talent but not their resources to make this public entity a reality. Since its beginning, the MHMRA board has had only a limited fundraising role on behalf of the agency.

Ultimately, the court passed a resolution transferring $5,000 from the county's general fund to the MHMRA board on November 7, 1966.[50] However, County Auditor S. B. Bruce refused to transfer the money, citing the attorney general's opinion that precluded the county from funding mental health because of the presence of the hospital district.[51] Much to the relief of everyone on the MHMRA board, Chairman Parish notified them that the county commissioners under the leadership of County Judge Elliott had appropriated $5,000 to cover the expenses of the board through the end of the year.[52] Funding would come through Harris County's Psychiatric Diagnostic Unit at Jeff Davis

[50] Harris County Commissioner Court Motion by Chapman, seconded by Lyons, November 7, 1966. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[51] Letter from Harris County Auditor S. B. Bruce to Judge Elliott, November 9, 1966. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[52] Harris County Board of Trustees Mental Health-Mental Retardation Centers, Minutes of Meeting November 10, 1966, p. 4. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Houston, TX.

Hospital.[53] The Commissioners Court had funneled support of the program developer's expenses through their County Psychiatric Diagnostic Unit as a consulting cost.[54]

The ultimate problem was the attorney general's opinion, but why did the county commissioners ignore for so long the pleas of the board they created? Harris County Judge Executive Bill Elliot (1926-2016), the chair of the court, had served on the state mental health planning committee and had shared his ideas about local funding to support it. However, he had noted the reluctance of public entities "to support new programs that could lead to new taxes."[55] Texans have a strong reluctance to raising taxes, and, likely, the rest of the commissioners were not supportive of the program because it required spending the county's money and possibly raising taxes. Until 1972, when the commissioners dissolved the original board and became the board themselves, the court mostly ignored MHMRA. They paid a limited number of bills before the state grant-in-aid funding began in 1968, but provided little attention or support beyond that.

MHMRA Receives State Funding and Begins to Provide Services

Following the Texas voters' approval of the constitutional amendment allowing public support of mental health and intellectual disability services within hospital districts in November of 1967, MHMRA received its first grant-in-aid of $334,799 from TDMHMR in February of 1968 to fund services for six months.[56] In August of that year,

[53] Harris County Board of Trustees Mental Health-Mental Retardation Centers, Minutes of Meeting November 17, 1966, p. 1. 031/015 Mental Health Board 1453-08 1966, Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[54] Letter from County Judge Bill Elliott to Commissioners Court, November 13, 1967. Harris County Commissioners Court Files for MHMRA December 9, 1965 to December 1973. Harris County Judge William M. (Bill) Elliott Papers, Harris County Archives, Houston, TX.

[55] "How are Centers to be financed? Judge William Elliott – Local Funds," in *Design for Community Care—From Concept to Reality* (Austin: Texas Association for Mental Health, 1967): 23.

[56] Minutes – TDMHMR, February 9-10, 1968: 5.

TDMHMR approved the second grant-in-aid to MHMRA of $550,000, this time for FY 1969. MHMRA had requested $1,452,417, but the Legislature had appropriated only $2,769,617 for all nine existing CMHCs, and that group together had requested a total of $4,892,031.[57] Harris County, as the largest county in the state, received the most substantial amount of funding, but its funding was not proportional to that received by smaller counties.[58] This situation would remain the fate of MHMRA to this day, as the state funding for Harris County per person is smaller than that provided to other CMHCs.

To receive the state funds, MHMRA had to provide inpatient services, outpatient services, partial care services that could be either day care, night care or weekend care, 24-hour emergency services through either inpatient, outpatient or partial services, and consultation and education services. They were required to charge those who were not indigent a reasonable fee to cover the cost of the service; however, MHMRA could not refuse services because of an individual's "inability to pay."[59] This was a critical point for the middle of a mental health crisis is no time to have to look for funding. In FY 1969, MHMRA served 3,644 patients through these five programs. By FY 1971, the number of patients served had increased to 7,460.[60]

In FY 1971, state support reached $845,256 and required a local match of $312,745.[61] The local matching funds came through MHMRA, but it was not its money.

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[57] Minutes—TDMHMR, August 10, 1968: 10.

[58] Ibid: Appendix D: 25.

[59] "Rules of the Texas Department of Mental Health and Mental Retardation Governing State Grants-in-aid to Community Centers," Minutes—TDMHMR, August 12, 1967: 58, 63.

[60] "In Support of an Intensive Treatment Facility in Harris County," Texas Department of Mental Health and Mental Retardation Program Analysis and Statistical Research Planning Support Services, April 1972:10. McGovern Institutional Collection, No. 15, TRIMS Series 1, Box 11a, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[61] Minutes—TDMHMR, June 15, 1970: 54. Harris County MHMR Financial Statements and Audit, August 31, 1972: Note 3.

MHMRA was using the value of facilities and services provided by agencies with which they subcontracted in the community to serve as the local match.[62] By FY 1972, the total budget of the agency was $1,856,479, of which $875,131 was grant-in-aid funding from the state that required local matching funds of $323,798.[63] The budget included local funds of $121,954 and federal funds from a variety of agencies totaling $844,707. Mental health programs made up approximately one-half of the budget. They included a mental health screening service, protective mental health services for the aged, a halfway house, a drug abuse project, an area-wide model mental health project, four local community mental health clinics, and funds totaling $360,152 to pay for contract inpatient services at area hospitals.[64]

Commissioners Court Becomes the Board of MHMRA

As MHMRA was moving forward with new funding and new programs, Commissioners Court's neglect of the organization allowed the number of board members to decline from the original nine to six, and one of them was no longer attending board meetings. Spencer Bayles M.D, an MHMRA board member, surmised that Commissioners Court had not appointed new board members because County Judge-Executive Bill Elliott was at odds with some of the commissioners.[65] However, instead of appointing new board members, Commissioners Court dissolved the existing board and named themselves the board for MHMRA in 1972. They took this action because the

[62] "Harris County Mental Health and Mental Retardation Center Financial Statements as of August 31, 1972, together with Auditors' Report," Arthur Andersen & Co., October 19, 1972: Note 3. Harris County Court Files for MHMRA Dec 9, 1965 to Dec 1973, Harris County Archives, Houston, TX.

[63] Ibid.

[64] Ibid. "In Support of an Intensive Treatment Facility in Harris County,"11.

[65] Jim Craig, "Mental Health Board Quorum Lacking," *The Houston Post*, December 11, 1971: 3A. Harris County Squatty Lyons Scrapbook June 1970 to February 1972, Harris County Archives, Houston, TX.

state was increasing funding to the county for MHMRA to $1.7 million for FY 1973, and this would require a match from the county of $641,000. MHMRA would not have enough value from subcontracting entities to provide that amount of match, and Commissioners Court did not want to put money directly into MHMRA. By becoming the board, the Court could use the county's Psychiatric Diagnostic Clinic to provide the requisite match.[66] Commissioners Court could have transferred the clinic to the board of MHMRA and accomplished the same purpose without becoming the board itself. However, R. J. Greer (1925-2007), the administrator of the Diagnostic Clinic, had enough political power with Commissioners Court to keep his organization under its direct control. Greer "did not want anybody put between himself and the county judge."[67] The program would eventually come under MHMRA, but in the meantime, Commissioners Court added direct oversight of MHMRA to an already full agenda, meaning they continued to pay little attention to it.

Before the takeover by Commissioners Court on September 1, 1972, and upon the retirement of Merton Trast, the original board hired John Carver, a Ph.D. psychologist, who at the time of his hiring served as president of the National Council of Community Mental Health Centers.[68] Carver's focus was on prevention and not "treatment because it

[66] Letter from County Judge Bill Elliott to Commissioners W. Kyle Chapman, Jamie H. Bray, Wm. F. Elliot, and E. A. Lyons, Jr., August 21, 1972, and the accompanying resolution adopted that same day by Commissioner's Court, 857-03-2170. Harris Commissioner's Court Files for MHMRA Dec 9, 1965 to Dec. 1973, Harris County Archives, Houston, TX.

[67] Unrecorded interview with notes taken by Curtis Mooney with Bill Schapp, Mental Health Policy Advisor to Harris County Judge Ed Emmett, January 27, 2016.

[68] Spencer Bayles, M.D., Video Interview by Dan Creson on August 20, 1988, AVV.MS108.005, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX. John Carver would go on to create the "Carver Model" of Policy Governance Model that trains boards in organizational government whereby the board focuses on major strategic issues and establishes the goals of the organization then delegates to management the operations with no "meddling" by the board. The CEO is exclusively responsible for achieving the goals of the organization as determined by the board. "The Policy Governance® Model," The

was too expensive, and he wanted to serve more people," according to MHMRA board member Spencer Bayles. The three existing private CMHCs in Harris County that received funding from federal grants (Mid-Houston, Baytown, and Hedgecroft Hospital) all became part of MHMRA. However, their programs became more prevention-oriented.[69] Total revenue for MHMRA more than quadrupled from $1.8 in FY 1972 (September 1, 1971 to August 31, 1972) to $7.4 million in FY 1974. The increase in funding from 1972 to 1974 came from the county government appropriation, which grew by over $1.8 million thanks primarily to the county's funding for Harris County Psychiatric Diagnostic Clinic now flowing through MHMRA. State grants-in-aid funds increased by more than $1.8 million, and federal funding increased by over $1.7 million over the same time. These large increases did not bring significant new funding for the treatment of mental illness, however, which only increased by $218,174 from FY 1972 to FY 1974. During that same time, the fund balance (assets over liabilities) grew by almost $930,000, and the expenses for administration grew by $625,583.[70] MHMRA's program expenses increased significantly in services to prevent and treat drug abuse and alcoholism. The state grant-in-aid money did not require expansion of treatment of mental illness, and new monies were available from the federal government that focused on drug abuse and alcoholism. In reality, the program's funding increased with the

Authoritative Website for the Carver Policy Governance® Model, Updated April 4, 2016. Accessed November 19, 2018, https://www.carvergovernance.com/model.htm.

[69] Spencer Bayles Video Interview.

[70] Harris County MHMR Financial Statements and Audit, August 31, 1972: Exhibit I. Arthur Anderson, October 19, 1972, Harris County Commissioners Court Files for MHMRA December 9, 1965 to December 1973, Harris County Archives, Houston, TX. "FY 73 Audit for MHMRA," LaFrance, Walker, Jackley & Saville, Certified Public Accountants, November 26, 1973: Exhibit I, Harris Commissioner's Court Files on MHMRA 1974-1, Harris County Archives, Houston, TX. "Audit Report—FY 74, August 31, 1974," LaFrance, Walker, Jackley & Saville, Certified Public Accountants, January 6, 1975: Exhibit I, Harris Commissioner's Court Files as MHMRA 1975, Harris County Archives, Houston, TX.

addition of new categories of programs; however, for the mentally ill, there was little improvement from the new funds. A scandal would reveal that not all was well with the leadership of the agency. The Executive Director of the agency essentially led the agency with little input from Commissioners Court then serving as the board of MHMRA.

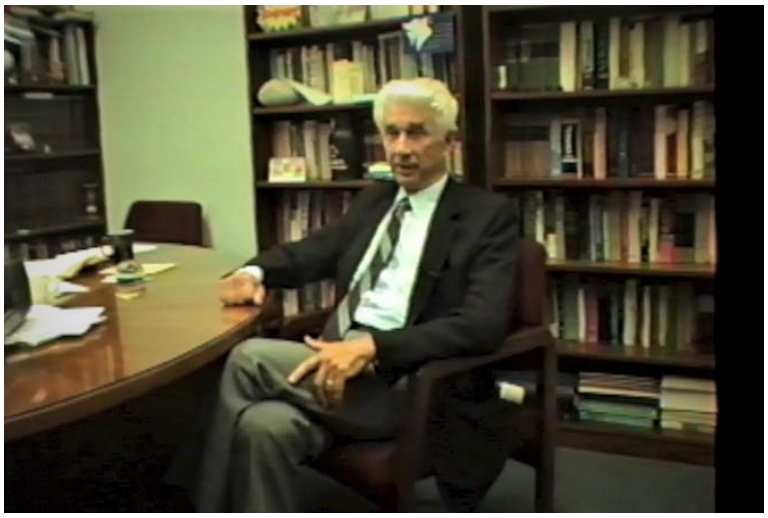

Figure 16 Spencer Bayles M.D.[71]

Scandal and a New Board at MHMRA

Shortly after County Judge Jon Lindsay (b. 1935) assumed the office vacated by Bill Elliot at the end of 1974, staff discovered that state checks were missing and possibly stolen from MHMRA.[72] Staff in the accounting office of the agency discovered the missing checks in February of 1975, five months after the thefts started.[73] Alan Caliva, who was serving as the personnel officer for MHMRA, resigned from the agency shortly after admitting to stealing the checks and depositing them into his account.[74] Carolyn

[71] Picture from the Spencer Bayles Video Interview.

[72] Letter from Jon Lindsay, chair of the board of MHMRA, to the members of MHMRA Board of Trustees, February 27, 1975, Harris Commissioner's Court Files as MHMRA 1975, Harris County Archives, Houston TX.

[73] "Harris Employee Diverts Funds," *Houston Chronicle* (February 14, 1975): 1.

[74] "Agency Office Resigns, Admits Misuse of Funds," *Houston Chronicle* (February 15, 1975): Section 5, p.5.

Taylor, who worked at MHMRA at the time, remembers hearing that the human resources director of MHMRA had deposited the state checks in his account to buy horses.[75] According to *Texas Monthly*, Caliva was from a prominent Houston family whose uncle had worked for the county. He stole $65,000 worth of checks and repaid $11,000. This was not the first time MHMRA had experienced a theft, for the previous summer the grand jury had charged John Lester, a developer and the property owner for the MHMRA's main offices of transferring $100,000 to his account from MHMRA's account to serve as a "compensating balance for a loan to himself from another bank." Presumably, Lester repaid the money, for there were no indictments returned against him.[76] Caliva was indicted in March of 1975. In July, the court ordered him to repay $59,671, for the 18 checks that he had stolen.[77]

County Judge Lindsay took the opportunity to ask the commissioners sitting as the MHMRA board to appoint a special advisory committee to study four key areas:

1. Determine whether the agency was performing its mission,
2. Determine the effectiveness of the current leadership,
3. Determine what should be done to "ensure the smoothest possible relations" between MHMRA, TDMHMR, TRIMS, and other government entities related to mental health and [intellectual disability], and
4. Determine whether the commissioners should continue to be the board of MHMRA.[78]

The board appointed a committee from the community with no direct connection to MHMRA to do the study. With one exception, those appointed were representatives of

[75] Carolyn Taylor Interview by Curtis Mooney, December 17, 2015. Interview available at the McGovern Center at the TMC Library, Houston, TX.

[76] Richard West, "The Monthly Reporter--Mental Health Agencies in Trouble," *Texas Monthly* (May 1975): 20.

[77] Richard West, "The Monthly Reporter—Low Talk," *Texas Monthly* (July 1975): 14. I could find no record noting that the funds were repaid.

[78] Letter from Jon Lindsay, February 27, 1975.

the advocacy groups for those served by MHMRA.[79] This advisory committee divided into four subcommittees and met more than 14 times. It received testimony from more than 60 witnesses, visited facilities, and studied documents. In the end, it determined that the current leadership was honest but "not effective and was seriously impairing the organization achieving its goals of service." It also noted, "Emergency services for the mentally ill … are practically nonexistent." The committee also found that while there was competent staff in adult mental health, "they [had] not actually solicited referrals, [had] concentrated on a selected clientale (sic), and [were] completely unprepared to accept the caseload of chronic psychotic patients from TRIMS" without more staff and training. Though the committee's report did not identify the selected clientele, from the context, one assumes they had focused on the less seriously disturbed. The report questioned why the Harris County Psychiatric Hospital (HCPH) (formerly Harris County Psychiatric Diagnostic Clinic) existed apart from MHMRA. It also noted that the commissioners had not effectively served as a board since executive director Carver had related only to the county judge-executive as board chair, and the latter had not kept the other commissioners apprised properly of circumstances at MHMRA. The committee

[79] Commissioners Court named Mrs. Joe Kegans, an attorney in private practice and member of the Governor's Advisory Committee on Mental Health and Mental Retardation chair of the special committee. The Court named the following as members: Steve Braswell, vice president of Prudential Insurance and chair-elect of the Mental Health Association, Cy Hancock, executive director of Region 4 Education Services, Dr. Forrest Harris, a psychiatrist in private practice and former deputy director of TDMHMR for mental health, Dr. Francine Jensen, director of the Harris County Health Department, Letitia Plummer, director of guidance for Houston ISD, Gay Rutherford, president of the Houston Association for Retarded Citizens, Teresa Quijano Yeasley, staff psychologist with the Texas Rehabilitation Commission's area office in Houston, and Bob Seale, a pharmacist and owner of Woodforest Rexall Drug Store. The latter was Judge Lindsay's appointee and differed from the rest since he had no direct link to the population served by MHMRA. Memo from John Lindsay as Chair of the MHMRA Board of Trustees to the Members of the Board, March 26, 1975, as approved by Commissioners Court on April 10, 1975. Harris County Jon Lindsay MHMRA Inactive File 983.22, Harris County Archives, Houston TX.

recommended a new board that had sufficient time to devote to a growing agency with a critical mission to fulfill.[80]

Commissioners Court accepted the recommendation of the advisory committee of the need for a new board and appointed that board to lead the agency effective September 10, 1975.[81] The new board accepted the recommendation of the committee and moved John Carver to a non-managerial position to serve in an advisory capacity. It moved Director of Support Services for MHMRA, Eugene Williams, to the position of acting executive director.[82] Early in 1976, the board removed the acting title and named Williams, the executive director. Williams, who came from the business side of MHMRA with no clinical training, would serve in this role until 1988 when more scandals would lead to another leadership change and the appointment of more new board members by Commissioners Court.

The New Harris County Mental Health Needs Council Called for More Resources

In addition to a new board, Commissioners Court also created the Mental Health Needs Council (MHNC), an advisory group made up of representatives of critical mental health providers in the county, to advise the MHMRA board and Commissioners Court. This new body completed a survey of available resources for those with severe mental

[80] "Overview of the Report of the Special Committee to Study the Mental Health and Mental Retardation Authority of Harris County," "Report of the Sub-Committee on Administration," "Report of the Governance Subcommittee," July 27, 1965, Harris County Jon Lindsay MHMRA Inactive 031/015, 983-22,1979-1981, Harris County Archives, Houston, TX.

[81] Commissioners' Court Resolutions passed August 21, 1975, recorded in Volume 89, page 218. Harris County Commissioners' Court Files as MHMRA 1975, Harris County Archives, Houston, TX.

[82] "Overview of the Report of the Special Committee July 22, 1975."

illness in Harris County in 1977.[83] MHNC noted that 3,770 additional indigent persons needed short-term inpatient treatment in 1977 than had received it. They determined that to serve the indigent mentally ill population of Harris County adequately required 313 public beds instead of the 93 available in 1977. In 1980, with no new public beds added in the interim, MHNC stated that the need had reached an additional 407 new "tax-supported" psychiatric inpatient beds, bringing the whole community need to 500 public beds.[84] The failure of the Legislature to fund the recommendation for a public psychiatric hospital in Houston in 1957 was still a critical issue for the community.

Conclusion

Houston and Harris County provide an excellent study of the beginning of community mental health in Texas and the nation. Federal funding was available to both state-funded and privately funded organizations. There was an assumption on the part of the federal government that the states, local governments, and private entities would

[83] MHNC found that 771 psychiatric treatment beds provided care for 9,132 patients with an average length of stay of 18.2 days in 1977. Of the total number of beds, 678 were private and located in eleven facilities that were either psychiatric sections of general hospitals or private psychiatric hospitals. The public or indigent patients received treatment in the 60 beds at TRIMS and the 33 beds at Ben Taub, the Harris County Hospital District general hospital in the Texas Medical Center. The latter had six emergency psychiatric beds and 27 longer-term beds. There were 7,306 admissions to the private hospitals and 1,826 admissions to the available public beds. In addition, the Harris County Psychiatric Hospital (HCPH) provided diagnostic and holding services for patients committed by the courts. This program held patients until their admission to Austin State Hospital (ASH) or TRIMS. In 1977, there were 1,497 admissions from HCPH to ASH and 184 to TRIMS. Also, 389 beds at the United States Veteran's Hospital in Houston provided general psychiatry treatment for veterans. By estimation, residents of Harris County occupied 73% of those beds. There were also 53 beds providing 24-hour residential care to the mentally ill with 88 admissions in 1977. Halfway houses with 74 beds received 341 admissions in 1977. "A Report of the Mental Health Needs Council, Inc. 3208 Austin Street, Houston, TX, April 4, 1979: 7-8, 20-21, Harris County Jon Lindsay MHMRA Inactive 031/015, 983-22,1979-1981, Harris County Archives, Houston, TX.

[84] "News Release Monday, August 25, 1980, excerpted from: Needs for Mental Health Services in Harris County, 1980," Mental Health Needs Council, Inc., McGovern Institutional Collection, No. 15, TRIMS Series 1, Box 24, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

provide funding to sustain the work created by federal funding. State funding in Texas was quite limited, and the Legislature chose to fund only CMHCs created under HB 3 by local governmental entities. The financial commitment made by St. Joseph Hospital and its community partners was not sustainable as the federal funding ended, and they were not eligible for state funding. MHMRA struggled to get started first because of constitutional issues, but later because of a lack of support from Commissioners Court and its governance issues. Despite significant grant funding increases in the 1970s, MHMRA failed to create programs to address the critical needs of the seriously mentally ill.

This chapter points to two funding decisions critical to the failure of the CMHCs to develop as hoped. First, the assumption by the federal government that the states, local governments, and other entities would provide the financial resources to sustain the programs started with federal funding was an error. The federal government needed to provide longer-term funding and more direction on how to develop sustainable funding. Second, the failure of the state of Texas to work through private organizations that could use their resources to create quality programs meant that local community mental health centers in Texas would struggle just getting started. They would also not have access to core funding beyond what the state Legislature approves biennially.

IX. THE IMPACT OF DECISIONS MADE AT THE LOCAL AND STATE LEVELS, AND POOR FUNDING BY THE LEGISLATURE SEVERELY LIMITS HARRIS COUNTY AND HOUSTON IN CREATING THE PROGRAMS NEEDED BY THOSE SUFFERING FROM SEVERE MENTAL ILLNESS

Introduction

The desire for a state-supported psychiatric hospital for Houston finally came to fruition in the 1980s. However, the new 250-bed hospital created in the Texas Medical Center was a short-term treatment facility that differed from what the community wanted and left the city and county with ongoing needs. Also in the 1980s, Austin State Hospital's discharge of patients by transporting and leaving them at the bus station in Houston[1] as part of the state's response to the *R.A.J* lawsuit led to many of those discharged living on the streets and challenged MHMRA to serve the needs of this growing population. Another scandal at MHMRA significantly damaged the agency itself and its work with other agencies in the community. MHMRA finally accomplished its long-term dream of creating an expanded emergency room and crisis care center for the SMI in the county, but a significant portion of the program ended quickly due to financial difficulties. State politics in the first decade of the twenty-first century led to even more cutbacks in services from MHMRA.[2] While Harris County provided a higher level of funding for MHMRA than any other CMHC in the state received from their local

[1] John Whitmire, "Mental Patients Released to the Streets," *The Houston Post*, December 1, 1984.

[2] Garnet Coleman Interview by Curtis Mooney, February 25, 2016, Interview available at the McGovern Center at the TMC Library, Houston, TX.

supporting body, the Texas Legislature provided less funding per person to Harris County than all other CMHCs because of the community's growing size and the Legislature's unwillingness to change the funding formula.[3]

Recent increases in funding from the state in response to school shootings, and the federal Medicaid waiver to prepare Texas for Medicaid expansion under the Affordable Care Act brought improvements in the treatment of those with an SMI in Houston and Harris County. However, the failure of the state to expand Medicaid, as many other states have done, means the Legislature is forgoing millions in federal funding needed desperately by those suffering from severe mental illness. The temporary nature of the Medicaid waiver and the failure to allocate state resources to support the new programming created by this funding source clearly shows that the Texas Legislature has not accepted the challenge of serving the needs of those with an SMI in the largest county in the state and the third-largest county in the nation. Also, a study authorized and funded by Harris County Commissioners Court determined that public services for the county's impoverished severely mentally ill are woefully inadequate to meet the need.

The County and State Work Together to Build a Public Psychiatric Hospital in Houston

The call for more resources and a 500 "tax-supported" psychiatric bed hospital for Harris County matched the 1957 plan approved by the Legislature for a state mental hospital in Houston. Though the Legislature had approved the plan, they had never

[3] Unsigned Resolution of the Harris County Commissioner's Court, December 1984, "Exhibit A: Grant-in-Aid for Fiscal Years 1986 and 1987 Based upon Per Capita – Using 1985 TDH Population Projections," "County Donations/Appropriations to MHMRA Centers," Harris County Judge Jon Lindsay Papers, MHMRA 84 989 18 984, Harris County Archives, Houston, TX.

funded it.[4] TRIMS had expanded its primary role of research and training by adding outpatient services and by leasing space for 60 beds at the Center Pavilion Hospital near the Texas Medical Center in 1968 to provide inpatient psychiatric treatment.[5] In 1973, Houston legislators added $250,000 to the construction budget for TDMHMR to plan for a "proposed Intensive Treatment Center" in the Houston area.[6] The study, performed by Bernard Johnson, Inc., a Houston based architectural firm, found that before it could plan for a treatment center, it needed to understand the role of TRIMS.[7] Was it a research facility only, or was it to be the primary public psychiatric hospital for Harris County? At that time, the state wanted it to focus on research, and the county wanted it to be the long-sought-after hospital. The answer would come only when they joined forces.

The possibility of building a new facility in the Texas Medical Center (TMC) that would serve both the state and Harris County's needs emerged in 1980 when leadership of TRIMS and TMC contacted Lt. Governor Bill Hobby (b. 1932) about a TRIMS-

[4] HB 169, 55st Regular Session (1957), Bill Files, Texas Legislature, Archives and Information Services Texas State Library. The bill also authorized the construction of a 500-bed community mental hospital; however, the legislature failed to appropriate funds for the facility at that time. That bill eventually became the authorization used to construct the 250-bed Harris County Psychiatric Center (HCPC) in the 1980s. Spencer Bayles, M.D., interview by Dan Creason August 20, 1988. AVV.MS108.006-005, Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[5] "Preliminary Summary Report: Role and Program Study for Texas Research Institute for Mental Sciences," (1974): 1, 4-5. McGovern Institutional Collection, No. 15, TRIMS Series 1, Box 11-B, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[6] HB 139, 63rd Regular Session (1973), Bill Files, Texas Legislature, Archives and Information Services Texas State Library. Appropriation Bill Article II: II-23.

[7] In 1973, TDMHMR Commissioner David Wade saw its role as research, training, and treatment services for the Houston area and envisioned a new 500-bed hospital. However, Commissioner Kenneth D. Gaver, who took over in 1974, saw the original legislative intent of TRIMS to be only research and training. Commissioner David Wade letter to Richard T.D. Eastwood, executive vice presiden, and director of the Texas Medical Center, March 1, 1973. Memo from Lynn Darden, chairman of the Business Committee to Edwin R. Van Zandt, chair, and members of the Texas Board of Mental Health and Mental Retardation, October 24, 1975. McGovern Institutional Collection, No. 15, TRIMS Series 1, Box 11-B, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

TDMHMR-TMC psychiatric facility.[8] TDMHMR wanted to expand the TRIMS facility, and Harris County needed to replace the inadequate HCPH located at Jeff Davis Hospital. Hobby, who had a keen interest in education, a commitment to Houston, and long-term service to the state as Lt. Governor, expressed his support for the new project to TDMHMR,[9] but he did not want that agency to run the new hospital. He asked Louis A. Faillace M.D., the founding chair of Psychiatry and Behavioral Science at the University of Texas Medical School in Houston (UT-Houston), to meet with him near the end of the Legislative session of 1981. At that meeting, he offered the hospital to Faillace, who told him it would cost 20 percent more to build and 20 percent more to operate to provide the training for residents, and Hobby agreed.[10] The Texas Legislature added a rider to TDMHMR's construction budget to build the Houston Psychiatric Hospital in or near TMC. The Legislature appropriated $12 million for construction and required that the Board of Regents of the University of Texas approve the plans for the hospital. The rider required the facility to operate through an agreement between TDMHMR and the University of Texas and for it to serve as a teaching hospital for UT-Houston's Department of Psychiatry and Behavioral Science. It authorized TDMHMR and UT to enter agreements with Harris County or other groups.[11] This collaboration would produce a smaller than needed hospital, but one that provided excellent short-term treatment for

[8] Memo from Joseph Schoolar and Jack K. Williams to Lt. Gov. William Hobby, December 30, 1980. McGovern Institutional Collection, No. 15, TRIMS Series 1, Box 11-B, The John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX.

[9] Letter from Lt. Gov. Bill Hobby to Mr. L. Gray Beck, chair of the TDMHMR Board in Austin, February 16, 1981, Harris County Jon Lindsay Files, Medical Center, TEMHMR Correspondence 982 22, 1981, Harris County Archives, Houston, TX.

[10] Louis Faillace interview by Curtis Mooney. Interview available at the McGovern Center at the TMC Library, Houston, TX.

[11] HB 656, Article 11, Rider 9, 11-26 to 27, May 29, 1981, 67th Legislature, Regular Session (1981) Bill Files, Texas Legislature, Archives and Information Services Division, Texas State Library and Archives Commission.

those suffering from an SMI in Harris County, increase the research on mental illness, and improve the training of psychiatrists and allied professionals in Houston and Texas.

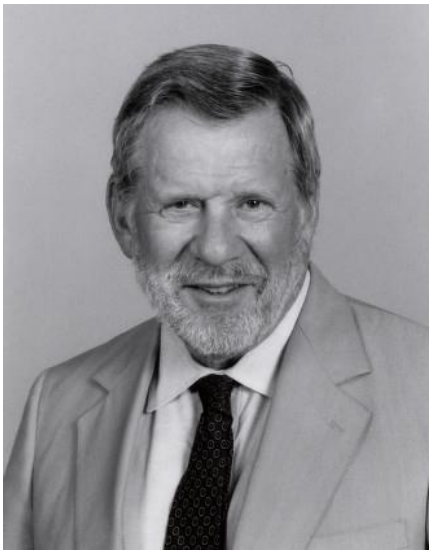

Figure 17 Lt. Governor Bill Hobby [12]

Harris County Commissioners Court agreed to provide another $12 million for construction. Initially, it also agreed to provide funding for half of the staffing and to pay for half of the operating costs of the hospital. The county, however, became concerned about the ongoing costs. Judge Lindsay worked with Lt. Governor Hobby to change the agreement so that UT-Houston would operate the hospital, and Harris County would contribute only 15 percent of the operating costs.[13] That percentage was equal to the amount the county was then spending to operate HCPH. The agreement called for MHMRA and others to refer patients to the hospital, but UT-Houston's Department of

[12] *William P. Hobby Jr.*, [1995-1997], University of Houston People, Special Collections, University of Houston Libraries, accessed November 26, 2019, https://digital.lib.uh.edu/collection/p15195coll6/item/45.

[13] Louis Faillace Interview by Curtis Mooney. In this interview, Faillace states that the county agreed to provide 20 percent; however, in a previous interview in 1987, he stated 15 percent, and that is the number that has been paid by the county. Louis Faillace interview by Dan Creson in 1987. Daniel L. Creson, M.D., Ph.D. Papers MS 108, The John P. McGovern Historical Collections and Research Center (McGovern Center) at The TMC Library, Houston, TX.

Psychiatry and Behavioral Science would provide the treatment and refer the patients back to MHMRA for aftercare. Instead of a 500-bed hospital, however, the combined resources of the state and county funded only 250 beds, and it would be a community hospital, serving patients only short-term with no provision for expansion of facilities for the care of those needing longer-term help. Those needing longer-term treatment still had to travel three hours to a regular state hospital. In 1982, there were 129 beds for short-term care of the indigent mentally ill in the county, but 90 of those at HCPH and TRIMS would become part of the new facility.

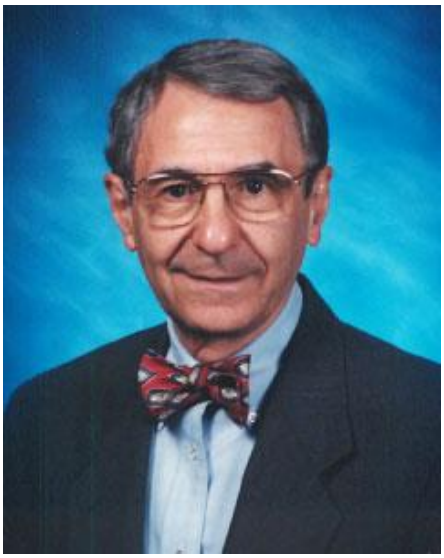

Figure 18 Louis Faillace M.D.[14]

Originally, TRIMS was to continue as a separate facility after the new hospital opened. However, a significant research scandal over research methods and questionable collection of data by research scientist Robert C. Smith M.D., and the failure of TRIMS Director, Joseph Schoolar M.D. to respond to the scandal in a timely manner led to its defunding by the National Institute of Health (NIH) and closure by the Texas

[14] The University of Houston, accessed October 10, 2019, https://med.uth.edu/psychiatry/faculty/louis-a-faillace-md/

Legislature.[15] With the new hospital opening soon and the need for funds to operate it, this was the wrong time for TRIMS to have such problems. The Legislature moved TRIMS inpatient resources to HCPC, and another portion of the TRIMS funding went to UT-Houston for research and outpatient services and was renamed the University of Texas Mental Sciences Institute (UTMSI) within TMC.[16] When HCPC opened in 1986, instead of adding public beds that studies had identified as needed, there were only 160 new beds, and 25 of those were flexible, with HCPC leadership able to admit anyone it chose.[17] HCPC fell far short of the growing needs of those with an SMI in Harris County

[15] Dr. Robert C. Smith, a TRIMS scientist, who was a psychiatrist and held a Ph.D. in Sociology, was researching the drug haloperidol for the treatment of schizophrenia under a grant from NIH and two private pharmaceutical companies. NIH required that the Institutional Review Board (IRB) at TRIMS approve and monitor all research involving human subjects. A staff member working for Smith, Dr. Chandra Misra, raised concerns about discrepancies within the data in 1983. When Dr. Smith ignored Misra's concerns, Misra took them to Dr. Neil Burch, who chaired the IRB, and Smith subsequently fired Misra for bad work performance. Burch then took Misra's concerns to Dr. Joseph Schoolar, the director of TRIMS, and the IRB told Schoolar of the need for an investigation. Schoolar granted Misra a grievance hearing, but there is no information as to the results of that hearing. Schoolar arranged for both an external and internal investigation of Smith's research, and those investigations found that Smith was withholding data from the IRB and refusing to cooperate with the board. They also noted the lack of policies and procedures for research problem issues. The IRB suspended Dr. Smith's research in August of 1984, and two days afterward, Schoolar, reassigned Burch from his role on the IRB and began to work toward reinstating Smith's research. Three different teams reviewed Smith's work, and all found concerns. NIMH formally suspended the grant to Smith in February of 1985, and the Texas Legislature received a report critical of Schoolar's leadership stating that his actions "cannot be characterized as 'timely' and that there was very little follow-up or control to ensure that his decisions were fully implemented." The report noted that TRIMS leadership had "acted in good faith, but Schoolar's 'desire to be fair to everyone, especially Dr. Smith, has caused him to delay taking definite action to resolve the allegations. Ruth SoRelle and Mark Carreau, "Probe Threatens $700,000 in Grants," *Houston Chronicle,* March 17, 1985: 1, 18, clipping located in McGovern HCPC Collection 1C67 Unprocessed Box 9 of 10 HCPC Scrapbooks ClipBook 1950 to 1985. Ruth SoRelle, "State Report Faults Handling of Investigation by TRIMS," *Houston Chronicle*, date unknown, clipping located in McGovern HCPC Collection 1C67 Unprocessed Box 9 of 10 HCPC Scrapbooks ClipBook 1950 to 1985.

[16] Dan L. Creson, "University of Texas Mental Sciences Institute," *Handbook of Texas Online*, accessed August 8, 2018, https://tshaonline.org/handbook/online/articles/sbumk. Rosalind Jackler and Mark Sanders, "Cutbacks Sought for State Mental Health Agency," *The Houston Post,* February 28, 1985: 15A, clipping located in McGovern HCPC Collection 1C67 Unprocessed Box 9 of 10 HCPC Scrapbooks ClipBook 1950 to 1985.

[17] Faillace interview by Curtis Mooney. Ruth SoRelle, "New Psychiatric Hospital Called Band-Aid," *Houston Chronicle,* April 18, 1982.

in 1986. With the county's population growing by 66 percent to 4.617 million from 1986 to 2018, it meets even less of the need today.

State Hospital Discharges to the Houston Bus Station Point to Low State Funding

The need in Harris County for more services for those with an SMI became more evident as the state hospitals, following a federal court order in *R.A.J. v. Miller* to increase the patient-staffing ratio in the state hospitals,[18] began to discharge patients back into the community by leaving them at the downtown Houston bus station. In December 1984, Houston newspaper articles stated that Austin State Hospital had transported discharged people with a mental health condition from Houston back to the city twice a week by van for the past year, and left them at the bus station without any money and no place for shelter. Among those discharged patients were some "who require[d] medication and supervision." The police called the situation a "time bomb," noting that families met some of the former patients, but many without families "just wander off down the street."[19] This dumping of patients from the public psychiatric hospitals had occurred in many other states in the 1970s as federal court orders required specific actions within the hospitals.[20] Commissioner Gary Miller M.D. of TDMHMR stated that it was the responsibility of Harris County MHMRA to provide for patients after they left

[18] R.A.J. v. Miller, Order from Hearing on Stipulated Recommendations of Remedies, June 1984, cited in David Pharis, "The Excursion into the Community," in David B. Pharis, *State Hospital Reform: Why Was It So Hard to Accomplish?* (Durham: Carolina Academic Press, 1998):160.

[19] Whitmire, *The Houston Post*, December 1, 1984.

[20] Murray Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press, 1981), 134. Alan A. Stone, "Recent Mental Health Litigation: A Critical Perspective," *American Journal of Psychiatry* 134, no. 3 (March 1977): 276.

the hospital, and he had developed the "3550 program" to provide funds for their care.[21] MHMRA officials said, "They did not have the money to provide care for all of the patients being discharged by the state."[22] TDMHMR declined MHMRA's request for up to $5 million in emergency aid to provide 218 additional residential beds "for the homeless mentally ill," noting that they did not have $5 million to send to MHMRA.[23] After discussions, TDMHMR and MHMRA agreed to open a new "Specialty Clinic" at 410 Pierce Street in Houston just a few blocks from the downtown bus station to focus on crisis intervention for patients returning to the city from the state hospital. TDMHMR also agreed to send plans for aftercare services with each patient. The funding for the new clinic would come through MHMRA from funds TDMHMR provided to MHMRA to keep patients from going to the state hospital.[24] The new clinic did not end the growing homeless population and the increasing number of mentally ill in the Harris County Jail, for MHMRA did not have the resources to meet all of their needs.

While opening the new Specialty Clinic took the crisis out of the public view, the event brought to the forefront the fact that MHMRA's state funding per capita was much lower than other CMHCs in the state. For FY 1985, MHMRA of Harris County had

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[21] David Pharis, "The History of the R.A.J. Lawsuit in Texas," in *State Hospital Reform: Why Was It So Hard to Accomplish?* ed. David B. Pharis (Durham: Carolina Academic Press, 1998): 70-71. TDMHMR was under court order to reduce the staff to client ratio in the state hospitals. Instead of increasing funding to the state hospitals to reduce the staff to client ratio, Commissioner Gary Miller had developed the 3550 plan, which would provide the CMHCs $35.50 for each day less of hospital usage over the previous quarter. This plan required the CMHCs to provide the services needed to keep the patients out of the hospital, however, the funding lagged by at least one quarter, and that amount did not necessarily provide for the level of care the patients needed in the community.

[22] Anne Marie Kilday and Jill Dawson, "Mental Patients Set Adrift: State Hospital Discharges onto Houston Streets," *Houston Chronicle*, December 4, 1984: 1, 8.

[23] Michael Haederle, "State Says Special Aid Not Likely for County Mental Health Agency," *The Houston Post*, December 6, 1984.

[23]Whitmire, *The Houston Post*, December 1, 1984.

[24] Mark Sanders, "Houston to get Mental Health Clinic: It Will Probably Help Quite a Bit," *The Houston Post*, December 19, 1984.

received $4.3786 per person in the county in grant-in-aid funding from the state, which was the lowest amount received by all but one center that had received just startup funding. MHMRA received only 15 percent of the appropriated resources to serve 20 percent of the state's population. Other CMHCs grant-in-aid funding per capita for the same year ranged from $4.8060 for the El Paso Center for MHMR to $11.9323 for Central Texas MHMR in Coleman, Texas, a very rural area.[25] The number of admissions and funding by Texas of state hospital patients from Harris County was also lower than in three other metropolitan areas. The admission rate to the state hospitals for Harris was 72.9 per 100,000 population compared to 202.5 for Bexar County (San Antonio), 122.1 for Dallas County, and 391.6 for Travis County (Austin). Institutional cost per capita for Harris County was $6.40 compared to $17.79 for Bexar County, $13.72 for Dallas County, and $34.35 for Travis County.[26]

State funding for Harris County for mental health was not proportional to less populated areas of the state. That proportion would change somewhat with the opening of HCPC, but it had remained an issue for the county. How did such a discrepancy develop, and why has it continued for so long? Harris County was one of the first counties to receive state grant-in-aid funding. While it received the most substantial amount of funding from the beginning, the funding was not proportional to the number of people in the county compared to other counties. The Texas Legislature provided only limited funding to TDMHMR for CMHCs, but TDMHMR sought to provide some funding to all

[25] "Exhibit A: Grant-in-Aid for Fiscal Years 1986 and 1987 Based upon Per Capita – Using 1985 TDH Population Projections," Harris County Judge Lindsay MHMRA 84 989 18 984, Harris County Archives, Houston, TX.

[26] Ibid. "Exhibit C: State Hospital Admissions and Funding," Harris County Judge Lindsay MHMRA 84 989 18 984, Harris County Archives, Houston, TX.

who qualified under their established requirements. Many counties and regions cover large areas but have fewer people to serve. CMHCs in those areas received more funding per person. Harris County's growth, however, has far exceeded such areas, but the Legislature has never provided the funding needed to fund all of the CMHCs at the level needed. With no additional funding from the Legislature to rectify the inequity in funding, TDMHMR and the subsequent leadership for mental health in Texas would have had to take money from other CMHCs to raise Harris County to the equivalent level of other areas, something they have not done. Dallas, San Antonio, and Austin all have state psychiatric hospitals within their county or a short distance away. Those areas, closer to the state hospitals, have more patients from the area in residence, whereas Houston is three hours away from the nearest state hospital, so they have historically had fewer patients served. The lack of appropriate state funding for Harris County MHMRA means that many people do not receive the services and support they need.

Fraud, Poor Judgment, and Scandal at MHMRA and Baylor College of Medicine Lead to More Struggles for Resources for the Mentally Ill

MHMRA cannot blame the lack of funding by the state for all of its problems. In the summer of 1988, Houston newspapers broke the story of MHMRA buying a building to serve as an outpatient facility for $3.3 million that earlier the same day had sold for $2.1 million.[27] Commissioners Court called for changes in the board, and the police and the district attorney began investigating the situation. For the next three years, Houstonians read news stories about significant problems at MHMRA. They told of lies,

[27] John Macklin, DA's Probe: Did Building Cost Too Much," *The Houston Post*, July 29, 1988: 1A, 21A. Pete Slover, "Prosecutors Probe MHMRA Land Deal – Fraud Suspected in Sale of Building," *Houston Chronicle*, July 30, 1988: 25.

negligence in oversight, the appointment of new board members, and the firing of the executive director. They also told of the arrests of the top two officials at MHMRA and the subsequent conviction of a developer, John P. Chambers, and his "silent partner," who had put together what turned out to be three fraudulent sales to MHMRA.[28]

The issue began in the late 1970s when MHMRA's Executive Director, Eugene Williams, developed a contract with Baylor College of Medicine to provide psychiatrists and psychologists to serve at each of MHMRA's clinics.[29] In Texas, non-medical corporations cannot employ a doctor to treat patients directly, so corporations such as MHMRA, without medical leadership, contract with medical schools or other physician-led entities to provide the medical personnel to treat patients.[30] The faculty member from Baylor who oversaw the contract was George Leslie Adams, M.D., professor of community and social psychiatry at Baylor College of Medicine, who would become Chambers' silent partner. In addition to the principal contract to supply psychiatrists and psychologists, Adams also had an individual contract with MHMRA that paid him $35,000 a year to serve as a management consultant.[31] Baylor, in turn, employed Williams to teach a course in mental health administration, for which he was paid $17,500 a year.[32] Adams and Williams were the two individuals who negotiated and oversaw the contract between the two entities. The personal contracts and the corporate

[28] Stephen Johnson, "2 are Convicted in Health Agency Land Deals – MHMRA Sweetheart Transactions Cited," *Houston Chronicle*, March 21, 1991: 25. Stephen Johnson, "Ex-Mental Health Chief Cleared of Theft Charges," *Houston Chronicle*, November 19, 1991: 1.

[29] Pete Slover and Stephen Johnson, "DA Seeks Baylor-MHMRA Records," *Houston Chronicle*, August 24, 1988: 1A, 8A.

[30] "The 'Corporate Practice of Medicine' is Prohibited in Texas," Bertolino LLP A Law Firm of Attorneys and Counselors, October 23, 2017. Accessed August 13, 2018, https://www.belolaw.com/posts/corporate-practice-of-medicine-prohibited-in-texas/.

[31] Slover and Johnson.

[32] Ibid. Stephen Johnson, March 21, 1991.

one created a close, unquestioning relationship between the two and put Adams in a strong position within MHMRA. All of the assigned staff from Baylor were within the community and social psychiatry program and worked as clinicians in various roles at MHMRA under Adams' leadership. When the contract ultimately ended in 1990, 25 clinicians from Baylor lost employment there.

Scott Hickey, a Ph.D. psychologist, assigned by Baylor to work at MHMRA, pointed to a practice not questioned by Williams nor covered in the newspapers. The psychiatrists from Baylor would transfer patients, who had outside funding for evaluations or received Supplemental Security Income (SSI) and qualified for Medicaid, to their private practice. In doing this, the psychiatrists received payment under the Baylor-MHMRA contract for seeing patients with no outside funding source and received additional payments for those who did have funding directly from the funder.[33] This arrangement provided more income for the psychiatrist and deprived MHMRA of revenue.

[33] Scott Hickey, Ph.D. psychologist who worked under the Baylor contract with MHMRA and later served in administration at MHMRA said that this was the practice for the psychiatrists assigned to MHMRA by Baylor, however he was not sure if this was something that involved all of the psychiatrists, Scott Hickey interview by Curtis Mooney on December 17, 2015. Interview available at the John P. McGovern Historical Collections and Research Center (McGovern Center) at the TMC Library, Houston, TX. Louis Faillace M.D. also stated that he also was aware that this occurred, Faillace Interview by Curtis Mooney.

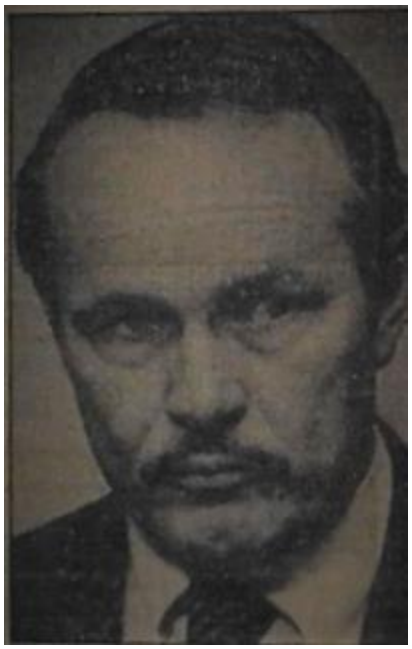

Figure 19 Eugene Williams, Executive Director of MHMRA [34]

Other information emerged, however, that raised even more questions about MHMRA and its leadership. Further reporting by *The Houston Post* noted that Eugene Williams' salary was $105,000 and not the $49,000 he had reported to County Judge Jon Lindsay, making him higher paid than any county official other than the medical examiner.[35] Judge Lindsay, with the backing of Commissioners Court, pushed the MHMRA board to fire Williams, and when it did not quickly agree to do so, the Court replaced three of the board members, including the chair, whose terms had expired. The newly reshaped board fired Williams.[36] News then broke that Williams and the business director at MHMRA had purchased annuities with funds from the agency for which there was no apparent formal board approval. Their arrests were major news stories before the

[34] *Houston Post*, May 31, 1985.

[35] John Mecklin, "MHMRA Chief under Fire in Salary Dispute," *The Houston Post*, August 19, 1988: 1A, 23A.

[36] John Mecklin, "MHMRA Board Votes to fire Director Eugene Williams," *The Houston Post*, September 14, 1988: 1A, 12A.

case against them fell apart when records showed that the board had approved the purchases in order to provide them higher compensation than TDMHMR allowed CMHCs to pay their employees.[37]

The major scandal, however, was the land sales that defrauded MHMRA of millions of dollars. District attorney John Holmes brought charges against Williams as a co-conspirator with Chambers and Adams on the land sales.[38] Following conviction, both Chambers and Adams received probation, and the court ordered them to make restitution.[39] When there was no trail of money from the sales leading to Williams, the judge dismissed the case against him.[40] In defending its actions, the MHMRA board stated that it had paid more money for facilities than appraisals indicated was the actual value, in the belief that they could not obtain financing otherwise because their funding required ongoing approval by the state and county.[41] The board never sought other advice or funding but went on the word of Williams and Adams. The judge's ruling assumed that Williams was the victim of his friend and trusted colleague's advice.

The lack of appropriate fiduciary oversight, fiscal controls, and regular reporting to both TDMHMR and Commissioners Court created an atmosphere where the board of MHMRA failed to exercise its fundamental responsibility to make informed decisions and to guard the integrity of the agency. Commissioners Court changed its policies on

[37] TDMHMR forbade CMHCs paying more in salary than the state agency paid to similar employees. Stephen Johnson, "MHMRA Charges Dismissed – Judge Says Evidence Shows Agency Duo Did Nothing Wrong," *Houston Chronicle*, July 15, 1989: 1.

[38] Stephen Johnson, March 21, 1991.

[39] Stephen Johnson, "Developer, Psychiatrist Dodge Prison in Land Deal Fraud Case – Probation Given by District Judge," *Houston Chronicle*, May 17, 1991: 30.

[40] Stephen Johnson, November 19, 1991.

[41] Pete Slover, "MHMRA Land Probe Widened," *Houston Chronicle*, August 2, 1988: 1, 5. John Mecklin, "Chairman: MHMRA 'Scam' Victim: Officials defend agency's real estate policies," *Houston Post*, August 9, 1988: 1A, 8A.

real estate purchases by subordinate organizations to require approval by the Court.[42] It also removed those board members who would not vote to relieve Williams of his job. However, none of the board members of MHMRA received any other sanctions. Williams, who had no previous criminal record, had lost his job, and he moved away from Houston. His failure to question the advice of a contractor, his failure to search for appropriate funding, and his lying to Commissioners Court to deceive the state all cost MHMRA. It significantly destroyed the trust of the community in the agency.

Impact of the Scandals on MHMRA

The negative publicity and the concern raised in the community would be a stain on the agency for years. TDMHMR approved funding for MHMRA for only the first quarter of FY 1988, noting concerns about the lack of development of crisis care and the lack of timely appointments for those discharged from the state hospital. The department specifically called for "a thorough examination of the management and organization of the outpatient clinics, particularly in relation to the Baylor College of Medicine contract."[43] TDMHMR restored the full funding after the first quarter, and in December 1988, the board of MHMRA hired Jan Duker (1926-2013), a Ph.D. psychologist who had headed the Mississippi Department of Mental Health from 1980 to 1986, to begin work as executive director in January 1989. She stated that one of her priorities was "re-establishing credibility" for MHMRA.[44] She stated that she would begin by making sure

[42] Pete Brewton and Brenda Sapino, "Higher Cost 'Puzzled' Appraiser," *Houston Post,* August 2, 1988: 1A, 11A.

[43] Jo Ann Zuniga, "MHMRA Assured Services, Crisis Care are being Upgraded," *Houston Chronicle*, September 24, 1988: 27A.

[44] Jo Ann Zuniga, "MHMRA Panel Hires a New Chief," *Houston Chronicle*, December 14, 1988: 35A, 45A.

there were "no conflicts of interest among agency employees."[45] To deal with a "budget shortfall," she ended the existing contract with Baylor College of Medicine that paid the medical school $1.76 million a year and negotiated a new one with Baylor that would "pay for services on an hourly basis" instead of the "flat fee" they were paying before. She expected to save $500,000 annually by changing the contract.[46]

Duker expressed her concern to the board of TDMHMR in September 1989 that the operating budget it had just adopted provided far less than what Harris County needed. She restated the discrepancies in funding for Harris County MHMRA versus the other centers across the state. She was able to receive an additional $500,000 for her efforts, which was far from the amount needed.[47] Without additional funding, MHMRA had a $5.6 million deficit as 1989 ended. Duker made extensive cost-cutting measures in 1990 that included "reducing travel," "delaying capital improvements," and "moving its offices from the posh Wesleyan Tower at 24 Greenway Plaza" with its $9,000 per month rent to a building already owned by MHMRA.[48] The cutbacks were not without problems. A Houston Psychiatric Society committee report stated that services at MHMRA had "sunk to an 'all-time low.'"[49] For MHMRA staff, Duker's leadership created a turbulent atmosphere in which to work. When she arrived, she told the administrative staff that they "were all thieves, liars and crooks," and they were paid too

[45] Mike Yuen, "County's MHMRA Names Mississippian as New Director, *The Houston Post*, December 15, 1988: A-13.

[46] Stephen Johnson, "MHMRA Fights Budget Problem: Agency to Renegotiate Controversial Baylor Contract," *Houston Chronicle*, February 17, 1989: 25A, 27A.

[47] Kim Cobb, "State MHMRA Approves Budget - Harris County Per Capita Funding Falls far Below Median," *Houston Chronicle*, September 23, 1989: 27A.

[48] "County's Mental Health Agency Erases $5.6 Million Deficit," *Houston Chronicle*, January 18, 1990: 12B.

[49] D.J. Wilson, "Report Criticizes County MHMRA: Says services now at 'all-time low,'" *The Houston Post*, November 1, 1990.

much. Duker was critical of everyone, including those who did not know about the scandals.[50]

A critical problem under Duker's leadership was damaged agency relationships with other organizations. One of the most significant involved a dispute over the county's funding of HCPC. The county was to provide 15 percent of the annual cost, but Duker demanded more accountability about costs from HCPC. In July 1991, MHMRA agreed to pay half of the money HCPC needed to keep from closing beds if the hospital "provide[d] adequate financial records and show[ed] that the money [would] be spent exclusively on patient care."[51] In February 1992, HCPC was again facing cutting services. They claimed they were facing a budget crunch brought on, in part, because MHMRA was not paying the money it was required to pay.[52]

New Executive Director Brings Much-needed Stability to MHMRA, But Funding Woes Continue

Duker resigned in the summer of 1992 to work for a New Mexico state facility.[53] The board of MHMRA hired Steven Schnee, a Ph.D. psychologist who had worked in Texas mental health since the 1970s in both community mental health—as executive director of a CMHC in Central Texas—and more recently as Superintendent of the San Antonio State Hospital.[54] Schnee would serve in his new position from 1992 until his retirement in 2017. When he arrived in September 1992, he found instability and a lack

[50] Carolyn Taylor interview.

[51] Stephen Johnson, "Pact with MHMRA May Save Cutbacks at Psychiatric Hospital," *Houston Chronicle*, July 3, 1991: 9C.

[52] Stephen Johnson, "County Mental Hospital Faces Service Cuts, Layoffs," *Houston Chronicle*, February 3, 1992: 1.

[53] Stephen Johnson, "County's Mental Health Chief Since 1989 Leaving Next Month," *Houston Chronicle*, May 22, 1992: 36.

[54] Steven Schnee interview number 1 with Curtis Mooney on October 8, 2015. Interview available at the McGovern Center at the TMC Library, Houston, TX.

of confidence within the agency. There was "significant tension between the agency and its relationships everywhere." Schnee stated that his immediate predecessor "had come in with a hatchet." "Many of the agencies' facilities were in horrible condition, and the psychiatric staff was minimal and part-time." He noted that there were no quality controls, and every place seemed overcrowded. There was no contract with HCPC, and the leadership there had refused to work with his predecessor. He worked out a new agreement with the leadership at HCPC and began the slow process of rebuilding the morale both within and outside the agency.[55] Though the agency was free from scandals under Schnee's leadership, funding was a constant problem. Schnee noted in 1995 that his agency had "only enough money to treat less than 30 percent of patients considered to be [the] priority."[56]

MHMRA Struggles in an Attempt to Fulfill the Long-term Need for a Crisis Care Center

One goal of the community that had existed for years was to improve emergency and crisis care. The building of HCPC near one of the city's affluent African American communities had raised such opposition from the residents that the contending parties came to a verbal agreement that the hospital would not have an emergency room.[57] The only public emergency beds available to treat patients with an SMI were at Ben Taub Hospital, which had 12 beds for all of Harris County. Thus, MHMRA's opening of a new emergency facility on October 4, 1999, represented a significant improvement for those in the county with an SMI. The new emergency center, the Neuropsychiatric Center

[55] Steven Schnee interview number 2 with Curtis Mooney on November 10, 2015. Interview available at the McGovern Center at the TMC Library, Houston, TX.

[56] John Williams, "Harris County Stands to Reap Big Gain in Mental Health Funds," *Houston Chronicle*, January 19, 1995: 1.

[57] Steven Schnee interview number 2.

(NPC) of MHMRA at Ben Taub Hospital, was to serve 50 outpatient or walk-in patients with 16 beds in the first-floor emergency center, and another 34 beds that would provide 3 to 5 days of short-term crisis stabilization on the second floor.[58] TDMHMR provided $3 million for the reconstruction of the space, and MHMRA borrowed the remainder of the $2 million-plus costs to prepare the building for occupancy.[59] When the first floor opened, utilization was much higher than anticipated, serving 1,000 to 1,200 a month in emergency care instead of the staffed and planned for 600 to 800 per month.[60]

The second-floor Crisis Stabilization Unit (CSU) did not open for several months. When it did open, it helped to reduce admissions to HCPC, and the combined emergency and CSU programs kept 80 percent of those seen from entering the state psychiatric inpatient system. However, the funding from TDMHMR had not grown as anticipated, and the earned income for the program proved much lower than planned. In early 2001, MHMRA closed the CSU because of the financial drain on the entire system. Harris County Commissioners Court had provided $2,673,404 per year of the $10,000,000 budget for NPC, but the "state general revenue" available to MHMRA "ha[d] not increased in flexible ways to permit the level of tax support commensurate with the indigent care need and utilization of these emergency services." MHMRA had anticipated

[58] Rad Sallee, "Mental Health Facility to Open with Ceremony Monday," *Houston Chronicle*, October 2, 1999: 38A.

[59] The funds from TDMHMR came from the proceeds of the sale of the former TRIMS facility in the Texas Medical Center to the University of Texas to serve as the home for the University of Texas Mental Sciences Institute. "Executive Director's Report," Harris County MHMRA Board of Trustees Meeting, October 22, 1996, The Harris Center for Mental Health and IDD Executive Offices, Houston, TX.

[60] "Executive Director's Report," Harris County MHMRA Board of Trustees Meeting, July 25, 2000:4. The Harris Center for Mental Health and IDD Executive Offices, Houston, TX

$3M in earned income from NPC, but the number of indigent patients was "much greater than anticipated," and the resources from insured patients were far lower than expected. [61]

MHMRA requested help from TDMHMR with funds committed to Harris County but not used by them. Utilizing NPC and working with HCPC, Rusk State Hospital, and Probate Court, MHMRA had underutilized the state funds for inpatient treatment at Rusk State Hospital for Harris County patients. Rusk State Hospital had funds appropriated for Harris County patients within its budget, but by keeping the patients out of the state hospital, approximately $1 million annually in the Rusk State Hospital budget went for patients from other CMHCs in the Rusk catchment area. MHMRA appealed to TDMHMR to send those funds to them so that the CSU could remain open.[62] Unfortunately, for MHMRA, the state budget appropriated specific sums to Rusk for its operations, so TDMHMR did not have the authority to transfer those funds that, in reality, the state hospital had already spent or were committed to spending. This situation left MHMRA struggling to provide for the increasing number of indigent, severely mentally ill patients whom police routinely brought to NPC.

With the decrease in capacity, NPC went on drive-by status frequently when it was full. Patients waiting for a bed to open at HCPC took up the space needed for new patients. The ones not seen at NPC remained at home or on the streets with no treatment. Steve Schnee, Executive Director of MHMRA, stated, "I'm deeply concerned about what is happening to public and private mental health care in Harris County. …It's a sad reflection at a time when we can do so much for people with psychiatric disturbances."

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[61] Letter from Steven Schnee to Ms. Heather Havofsky, January 19, 2001: 1-2. Attachment to the MHMRA Board of Trustees Minutes of January 23, 2001. The Harris Center for Mental Health and IDD Executive Offices, Houston, TX

[62] Ibid: 2.

These patients were a danger to themselves or others, and frequently, their behavior led to their arrest and placement in jail when they did not receive the treatment they desperately needed. [63]

Figure 20 Steven Schnee, Ph.D. Executive Director of MHMRA [64]

A study in 2000 found that if Harris County had received the average per capita funding allocation for community MHMR centers in Texas of $14.61 instead of its $11.65, it would have received an additional $9,820,189,[65] which would have funded the entire $10 million operating costs for both programs of the NPC.[66] Instead, today, without the CSU beds, there are only 28 beds of emergency care (12 at Ben Taub and 16 at NPC)

[63] Todd Ackerman, "Psychiatric Center goes on Drive-By: Agency turns away even sickest indigent patients," *Houston Chronicle*, July 16, 2002: 13A.

[64] Todd Ackerman, "Fort Worth Administrator named next Harris County Mental Health Leader: Wayne Young to succeed Steven Schnee at Harris Center for Mental Health and IDD," *San Antonio Express-News,* September 28, 2017*,* accessed September 20, 2019*,* https://www.expressnews.com/local/prognosis/article/Fort-Worth-administrator. Article originally published in the *Houston Chronicle*. https://www.houstonchronicle.com/news/health/article/County-mental-health-agency-hires-new-CEO-12239289.php.

[65] "Exhibit 3: Estimated Cost of Funding Mental Health Authorities at The FY 2000 Texas Average Per Capita Community Services Allocation ($14.61)," Final Report: Recommendations of the Task Force on Equity of Resource Allocation Submitted to the Texas Board of Mental Health and Mental Retardation, June 29, 2000. Attachment to the minutes of August 30, 2000: 16, The Harris Center for Mental Health and IDD Executive Offices, Houston, TX.

[66] Letter from Schnee to Havofsky: 2.

for the indigent in a county of over 4 million people and almost 7 million people in the metro area.[67]

MHMRA Forced to Cut Services Because of Funding Shortfalls

By the summer of 2002, MHMRA's resources were so "strained" that the agency was turning away new nonemergency patients. That June, the agency had received over 9,000 calls for help, but they had "little ability to respond to so many calls." Schnee stated, "It's a tragedy. … It says poor people will have to get sicker before they get treatment, and then a lot of them will end up in jail." Schnee pointed directly to "underfunding" by TDMHMR as the cause of the problem. "The state spends about $12 per resident to treat mental illness in Harris County compared with the national average of $27." He noted that the dramatic growth in the population of the county and "the 500-bed reduction in private psychiatric care in recent years" had also contributed to the lack of resources to serve the mentally ill. State Representative Garnet Coleman, who was vice-chair of the Texas House Committee on Public Health and who suffers from depression himself, stated, "This shows where Texas is … [w]e're one of the largest states in the richest country in the world, and this is how we treat people. We're talking about closing down intake for folks who will end up on the street and in harm's way. It's unconscionable."[68]

[67] The new state psychiatric hospital expected to open in early 2022 will be located next to HCPC in the Texas Medical Center. The article announcing its groundbreaking makes no mention of it providing emergency care, so presumably, the previous understanding with the community around HCPC not to provide emergency care in that location is still in place. Natalie Weber, "Ground Broken at Mental Health Facility," *Houston Chronicle*, June 27, 2019: A003.

[68] Todd Ackerman, "County Mental Health Agency Turning Away Some Patients," *Houston Chronicle*, July 13, 2002: 1.

Figure 21 State Representative Garnett Coleman [69]

With the state's financial problems of 2003 as an excuse, and the Republican's gaining control of both houses of the Legislature, the Lt. Governorship, and the Governorship for the first time since Reconstruction, the Republicans forced significant changes and reductions in the health and human service agencies of the state. Representative Coleman stated that while there was a shortfall in the budget for 2003, it was a desire by the Republicans "to cut all health and human service programs" that led to the passage of HB 2292 in 2003. This piece of legislation brought a significant consolidation of agencies under one overarching executive commissioner responsible to the governor. In mental health, it dramatically limited services and eligibility for services to a smaller portion of the mentally ill. It changed budgeting from the practice of the Legislature, adding funds based for population growth and needs to zero-based budgeting each bi-annual session. Above all, it cut needed services to mentally ill Texans.[70]

Coleman noted that Texas, like all states in 2003, received federal fiscal relief because of the financial situation in the nation that year. Texas received over $500 million from the federal government, but instead of adding that to the state's

[69] "Texas House Member, *Texas House of Representatives*, accessed September 20, 2019, https://house.texas.gov/members/member-page/?district=147.

[70] Garnet Coleman Interview by Curtis Mooney.

appropriation in the budget, the Legislature decreased its appropriation by that amount. The state also had more federal funds with a change in Medicaid to a more favorable matching rate, which meant that Texas had to spend less to get the same coverage under Medicaid. While the Republican leadership claimed that through extensive administrative changes, they could reduce cost, "it was really an exercise in cutting services more than anything else." Within the state hospitals, the Legislature also made an additional change by placing more funding in the state budget for restoring competency for prisoners to stand trial and less for treating the mental illness of those who had not committed a crime.[71] Since 2003, competency-restoration beds have grown so that they outnumber the beds available for the non-criminal population of the state.

TDMHMR called for 10 percent reductions in budgets in 2003.[72] MHMRA closed two of its eight clinics that were serving 1,640 clients. The agency had already reduced expenses by over $4 million in 2002, and it had laid off 90 full-time staff. In 2003, MHMRA created a mobile unit to serve some of those affected by the closings and staff reductions, but the agency expected it and the NPC to be overwhelmed with patients. The program director of the mobile unit said, "My worst nightmare is we're going to do all this to connect people to services and there won't be any services to connect them to."[73] Because of the actions of the Republican-controlled state Legislature in 2003, MHMRA could only provide services with state-appropriated funding to priority population, those

[71] Ibid.

[72] MHMRA Board of Director Minutes, January 28, 2003: 4, The Harris Center for Mental Health and IDD Executive Offices, Houston, TX.

[73] Leigh Hopper, "Two Clinics for Indigent Being Shut—Mental Health Agency Reacts to Budget Crisis," *Houston Chronicle*, February 27, 2003: 21.

with schizophrenia, bipolar disorder, and severe depression.[74] They could provide only crisis care for those suffering from other diseases that can be as debilitating at any given time, if not over the life of the individual.

The funding of services for the mentally ill in Texas began to change following the passage of the Affordable Care Act. As part of that act, the federal government sought to help the largest states prepare for moving toward expanded Medicaid, by providing a waiver that allowed local, previously unmatched portions of mental health expenditures, including such funds in the MHMRA budget, to serve as a match to draw down more Medicaid funds. In Houston, the Harris County Hospital District took the lead in gathering the required new proposals to provide a new medical system and program innovations, including those for mental health.[75] This was to be a short-term program to prepare Texas for expanded Medicaid, but when the Supreme Court ruled that such expansion was voluntary, the Republican-led Legislature refused to expand Medicaid even though the federal government would have funded most of the cost. The federal government has continued to allow Texas to use this funding mechanism, but it is set to end in 2022. The failure of Texas, the state with the largest number of uninsured in the nation, to expand Medicaid to provide medical care for millions, makes one skeptical that it will provide the resources to maintain these new programs for treating those with an SMI in a growing state that has so long ignored the needs of so many.

Even with the new level of funding, Rep. Coleman noted in 2016, "Texas has a long way to go. The state had moved from forty-eighth in the nation to forty-third …

[74] House Bill 2292, 78th Legislature, Regular Session (2003) Bill Files, Texas Legislature, Archives and Information Services Division, Texas State Library and Archives Commission:676-677.

[75] Ibid. Chapter 7 provides a more detailed explanation of the Medicaid 1115 Waiver funding mechanism.

before 2003, and then it went backward in 2003. We are not at the level of funding we had in the 1990s."[76] Steve Schnee noted that HCPC opened with 250 beds and not the 500 planned. He further stated that in Harris County,

> The number of acute care beds for the public sector is down two-thirds of what it was 28 years ago [when HCPC opened]. Why are we surprised there are so many people in jail, homeless, or on the streets. There are causes and effects. These are not folks who choose to have a serious mental illness and then wake up someday and say I do not want to have this anymore. There are huge numbers of people that we can never get to who need help.[77]

The Criminalization of Mental Illness Today

When severe mental illness goes untreated, it does not go away. Persons with an untreated SMI tax their families both financially and emotionally, to the point that those families often cannot provide the help needed. Society has little tolerance for individuals whose illness causes them to act erratically and break community norms and laws. Their actions lead to arrests and incarceration at the Harris County Jail, where they do receive treatment from MHMRA. That jail is the largest mental health facility in the state of Texas, serving approximately 2,400 mentally ill patients per day out of a total population of 9,000 inmates. The mentally ill are "arrested six times more often than those without a mental illness," and they remain in jail, on average, "40 percent longer than those without mental illness." The average cost to house and treat a mentally ill inmate in Harris County is $232 per day, while the cost for a day of incarceration of the general population is $57.[78] The $232 per day includes the regular cost of incarceration plus the

[76] Garnet Coleman interview.

[77] Steve Schnee 2nd interview.

[78] The increased costs for the mentally ill reflect payments for increased security, psychotropic medications, treatment, and oversight by medical staff. "Report on the Harris County Mental Health Jail Diversion Pilot Program for Fiscal Year 2016," Health and Human Services Commission, February 2017: 3.

costs of providing additional staffing, security, and treatment for mental illness for those incarcerated with a diagnosed illness. That cost compares favorably, however, to the budgeted average daily cost in a state psychiatric hospital in Texas that was $499 per day FY 2018 and $514 per day for FY 2019.[79] One assumes, however, while all of those in the state hospital would have an SMI, not all of the mentally ill patients in the jail would.

The state and county have taken some small steps to help the mentally ill avoid jail. In 2013, the Texas Legislature provided funding, contingent upon the Harris County Commissioners Court matching it, to create "a criminal justice mental health service" pilot program, in conjunction with the courts, local law enforcement organizations, and local providers of services to the mentally ill. This program focuses on "reducing the recidivism and frequency of arrests and incarceration of persons with mental illness in the Harris County Jail."[80] It uses several "evidence-based intervention models and best practices," including "integrated primary and behavioral health care," "permanent supportive housing," and various forms of therapy. A study of the project published by the Texas Health and Human Services Commission in 2017 showed that of the 4,155 persons referred to the program in 2015 and 2016, only 554 qualified to enter it. The study also showed that for participants, there was a small decrease in jail bookings and charges and a similar small decrease in felonies and misdemeanors. Most significant was an average decrease of 18.9 jail days for each person in the first year of the study. This

Accessed September 14, 2018, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/sb1135-harris-county-mh-jail-diversion-feb2017.pdf.

[79] SB 1, 85th Regular Session, (2013) Bill Files, Texas Legislature, Archives and Information Services Division, Texas State Library and Archives Commission, "State Appropriations Budget (FY: 09/01/2017 to 08/31/2019)," Article 2: IL 46.

[80] SB 1185, 83rd Legislature, Regular Session (2013) Bill Files, Texas Legislature, Archives and Information Services Division, Texas State Library and Archives Commission.

reduction yielded savings to the county of $571,564.[81] In addition to reducing the number of jail days, the program also led to shorter hospital stays.[82]

Harris County also added a mental health court in 2012 that works with a small number of volunteers, severely mentally ill patients who have committed a felony and are on probation. The court supervises their activities closely as the probationers work with community mental health providers. These providers provide comprehensive evaluations, intensive treatment by mental health professionals, and substance abuse treatment for persons with both mental illness and addiction disorders. The goal of the program is to "ensure public safety and minimize recidivism while diverting defendants with a mental illness from incarceration."[83] While these actions have helped, they can by no means reduce the number of those with an SMI in jail without a tremendous expansion of the programs.

At Present, Harris County Fails to Meet the Intensive Needs of the Indigent with an SMI

Harris County Commissioners Court engaged the Meadows Mental Health Policy Institute for Texas (Meadows) to complete a study of Harris County's public mental health systems in 2014. The study found that 87,283 adults were suffering from an SMI and 56,044 children with a severe emotional disturbance in Harris County who were at or below 200 percent of the Federal Poverty Level. Meadows determined that with

[81] "Report on the Harris County Mental Health Jail Diversion Pilot Program for Fiscal Year 2016:" 1.

[82] Ibid: 17.

[83] "Felony Mental Health Court Overview," Harris County District Courts, accessed September 17, 2018, https://www.justex.net/courts/Drug/MentalHealth/OverView.aspx. "Felony Mental Health Court Program Description," Harris County District Courts, accessed July 9, 2019, https://www.justex.net/Courts/Drug/MentalHealth/Default.aspx.

MHMRA and Harris Health, the county's public hospital system, along with 12 federally qualified health centers (FQHCs), and three Medicaid managed care networks, 75 percent of the adults and 56 percent of the children received some level of services. While these individuals received some care, the remaining 21,820 adults in poverty and suffering an SMI, and 24,659 emotionally disturbed children in poverty had no access to treatment. Meadows determined that the system had "dramatically too little intensive service capacity." The study concluded:

> Relying primarily on MHMRA, Harris County has an estimated one-ninth of needed intensive service capacity, and one-tenth of supported housing capacity, compared to the level of severe need in the community and best practice benchmarks. As a result, high need cases cycle repeatedly through jails, hospitals, and inadequate care, costing $50 million in jail costs and $150 million in emergency room costs because the system is designed with too little core capacity.[84]

In reality, treatment is so underfunded in Harris County by the Texas Legislature that it offers a partial level of care to those it is required to serve by law while ignoring a large proportion altogether. The design of the system is not wrong; it is not funded at anywhere near the level required to treat people who have no other means of receiving such care. It is prudent to recognize the added burden of cost to the county for the lack of service capacity, which this study does. It was a study focused on systems, and the researchers interviewed key leaders within the county and sought data from a variety of sources to show the lack of capacity. However, Meadows did not interview those who have mental illness in the county, nor did they seek input regarding the tremendous burden those

[84] "Review of Harris County Mental Health Systems Performance—Final Report," Texas State of Mind: The Meadows Mental Health Policy Institute for Texas, May 2015: i-ii, accessed June 12, 2016, https://www.texasstateofmind.org/wp-content/uploads/2016/02/1-Review-of-Harris-County-Mental-Health-Systems-Performance.pdf.

persons suffering from an SMI in Harris County face every day. Their illnesses mean they will continue to go in and out of jail, emergency rooms, and HCPC with chaotic lives outside of those places of care and treatment. They will live on the streets or with their families if their families will take them in after years of suffering from their family member's illness.

Texas is a wealthy state; Harris County is the largest county in the state and the third-largest in the nation. It has a vast petroleum-based industry and the world's largest medical center. Nevertheless, with the state and county refusing to provide the intensive services needed, they condemn thousands of individuals to live with illnesses that go untreated in conditions that most of us cannot imagine. Without treatment, they live confused lives listening to voices that are not real, experiencing bouts of mania where they believe they can do anything, then fall to the depths of depression where they can hardly move. With extreme depression, they cannot take care of their basic needs. Navigating the medical system with a Medicaid card is not easy, for reimbursement rates are so low in Texas that few of the doctors they need to see will take it. Because of their mental illness, their physical health will suffer to the point that they will die much earlier than those without mental illness will. They will experience the problem of where do you go to the bathroom in a major city when you have no place to live, or where do you go when the heat index is over 100 and you are wearing or carrying everything you own. The police will arrest them for going to the bathroom on someone's yard, stealing food because they are so hungry, or frightening the sane by their words or actions. They will live utterly lonely lives with an illness they do not understand, and often with no one to

turn to for help. They face the risk of abuse by others on the street or of deciding that they can no longer face life and committing suicide.

Conclusion

Houston and Harris County, Texas, is one of the largest communities in the nation. It is a fast-growing metropolitan area of incredible wealth, with 21 Fortune 500 companies located there. Its port, located 50 miles from the coast, is the second-largest port by tonnage in the United States. It has the world's most extensive collection of health care facilities within the Texas Medical Center. This collection of resources, however, has not been the source of improved care and treatment for those living in poverty with a severe mental illness within the community. The largest mental health facility in the city, county, and state is the Harris County Jail, as the criminalization of mental illness has occurred here and across the nation. Structural and political changes at the state level have further reduced funding. However, recent temporary federal funding intended to prepare Texas for expanded Medicaid brought significant new monies to Harris County for mental health services. That funding has enabled an expansion of services using formerly unmatched county funding that has not required new state monies. This new federal funding has enabled the development of new programs to serve those with an SMI and allowed MHMRA to eliminate its waiting list. Unfortunately, this expanded resource will end in 2022, and a significant question remains--will Texas provide the funding needed to keep the new programs going?

The mentally ill in the county still have high needs, but this new funding has shown that improvements in their lives come with more funding. In the end, the treatment of the severely mentally ill is dependent on funding by Harris County, by the state of

Texas, and by the nation. At no governmental level are enough resources available to provide for the intensive needs of those who suffer from a group of devastating illnesses that destroy lives. These illnesses include schizophrenia, bipolar disorder, major clinical depression, severe personality disorders, and any mental illness that limits an individual from performing critical life activities. These illnesses require more than the prescription of medicine and occasional visits. They require on-going care and treatment appropriate for their needs in a world for which they are poorly prepared to exist, much less thrive.

X. CONCLUSION

Mental illness is a disease that defies most understanding. Though research is improving the understanding of its origin and its nature, we still do not have a complete understanding of its cause. Though medications and therapy can bring a reduction in the symptoms of the illness, there is yet no cure. While we refer to it as mental illness, in reality, it is a spectrum of diseases with varying acuity and debilitation. The individuals with a mental illness usually do not look any different from people without the illness. Nevertheless, mental illness, whether one of those considered a serious mental illness (SMI) or one that does not meet that threshold, can profoundly alter the lives of those who suffer from it, as well as the lives of their families.

In 1861, Texas joined the other states in opening its first public asylum for 60 residents because members of the Legislature believed the asylum offered a cure for mental illness. Here, under the care of a physician and staff, many individuals regained their sanity, though others did not. The latter remained in the asylum, and they gradually filled it, along with new admissions because of population growth. Over the next 90 years, the one small asylum grew to a small system of hospitals serving over 15,000 people at a time in what were overused facilities and substandard programs. Though the first asylums failed to provide a complete cure, they did provide basic care for those with an illness that destroyed lives. The only other choice was jail, where those with an SMI often found themselves awaiting an opening in a state hospital. Through the 1940s, Texans brought pressure on the legislature to add more beds to their state hospitals to move the mentally ill from the jails. However, few in Texas questioned what happened inside the state hospitals, assuming that all was well. For most people, the building of

facilities for the mentally ill took care of society's obligation to them. They were out of sight and out of the mind of the public.

World War II and the years following it brought the beginning of a significant change in the treatment and care of the mentally ill in Texas and the nation. The exposure of the overcrowding, inadequate facilities, poorly paid staff, and intolerable conditions within the state hospitals led to changes in the controlling authority over the state hospitals in Texas, and a tax on cigarettes allowed the refurbishment of the hospitals and the construction of some new buildings in the early 1950s. New medications, psychodynamic therapies, the growing belief that mental illness was far more prevalent than hereto believed, and the growing number of referrals to the mental hospitals led for the first time to the national government's focus on the treatment of mental illness. This focus, new laws, and new federal court decisions brought significant change to the treatment of mental illness in the United States and Texas.

This change led to a national movement away from institutional care towards the development of community mental health centers. Nationally, most psychiatrists and the medical community sanctioned this change. In Texas, those two groups led a yearlong planning effort funded by the federal government to create a community based mental health system within the state. At the same time, the two groups sought a stronger role for themselves in the leadership of the state's mental health programs. Texas' politicians in 1965 were content with the institutions then serving the state, and only created a new department and added community mental health at the insistence of this mental health planning effort. The national push for deinstitutionalization began with this movement to community mental health centers, but Medicaid and federal laws subsidizing nursing

homes and funding boarding homes fueled its growth. Federal court decisions also supported the deinstitutionalization movement through decisions that critically challenged institutional care. These rulings led to higher costs per individual served within the institutions. The changes within the hospitals improved the care of the inpatients; however, it dramatically reduced the number of beds for patients suffering from severe mental illness in Texas and other states, when the state legislatures would not fund the much more expensive care and community mental health centers at the level needed.

In Chapter I, I looked at the views from Grob, Andreasen, and Torrey concerning why we, as a nation, allow the treatment of mental illness to be so different from physical illness. Another aspect of why we treat mental illness so differently comes from the views of Thomas Szasz, who was prominent in the antipsychiatry movement, as noted in Chapter III. Szasz was a psychoanalyst who argued that mental illness does not exist. His views continue in the work of the Citizens Commission on Human Rights, which lobbies states not to fund the treatment of mental illness. This study of the treatment of severe mental illness in Texas and Harris County offers some additional support as to why we allow such different treatment of the mentally ill. Two prominent messages of the community mental health movement and the antipsychiatry movement were that institutions were terrible, and the mentally ill were not sick. The antipsychiatry movement of the era presented the mentally ill as persons who were just different, and therefore should not lose their freedom. While they argued that many of those previously hospitalized did not need extensive long-term treatment, they failed to recognize that some of those with a chronic illness needed care beyond that of a nursing home, boarding

homes, or the streets. Texans and frankly, most Americans heard the message that hospitals were a part of the past, as did the state legislators. If the mentally ill were not sick, then their actions were criminal, they were accountable for their activities, and jail or prison was now the appropriate place for them.

In Texas, the citizens heard or read too much about the problems with state and local agencies that treated the mentally ill. They read about the conflict between the board of the Texas Department of Mental Health and Mental Retardation (TDMHMR) and its executive directors over who would lead the department in its early days. After almost a quarter-century of conflict over the *R.A.J.* lawsuit, Texans and their Legislature longed for an end to bad news from Austin and the state hospitals. In Harris County and other locations, they learned of scandal after scandal associated with the county's Mental Health and Mental Retardation Authority (MHMRA) or other local CMHCs and the lack of funding for the treatment of mental illness. The public lost confidence in their agencies and paid little attention as local leaders called for even more money to care for people whom many assumed were better off in jail than on the streets.

However, the mentally ill did not go away just because there were no hospital beds for them, and the underfunded community mental health system did not keep hundreds of thousands of mentally ill people sane and able to function in society. Instead, with no treatment, the mentally ill became sicker and committed acts that brought the attention of the authorities to them. Instead of having a system to provide treatment for them, we arrested them and placed them in jail.

As long as the mentally ill did not disturb "normal" people, there was very little pressure from the citizens to the Legislature to change the situation. However, that did

change as the shootings in schools, churches, and other easy targets took place. The killing of the young schoolchildren at the Sandy Hook Primary School in Connecticut in 2012 within days of the Texas Legislature opening caught the attention of everyone. Texans found it too hard to consider that guns could be the problem, but obviously, something was wrong, and the Legislature settled on mental illness as the problem even though the vast number of mentally ill are not dangerous. Starting in 2013, the Legislature funded a significant increase in mental health resources, and it has continued to do so since that time. Those new funds, along with a temporary federal Medicaid waiver, dramatically increased resources for the mentally ill. One hopes this level of funding will continue to grow as the state grows. However, there is no state or national call to empty the jails and prisons of the mentally ill. There is also no call for the creation of programs that truly meet the needs of the SMI. There is a fear of the mentally ill with weapons, but no real compassion for them. The criminalization of mental illness has not led to a state or national movement to recognize that mental illness is indeed an illness that, like any other illness, deserves the appropriate treatment and care.

How do we Fix this System?

As noted in Chapter I, mental illnesses are some of the most common illnesses in our nation. I have family members who have a mental illness, as many other families do, but most of us keep it a secret. Through our silence, we are continuing to ignore one of the most critical factors in fixing the system. By not telling others, we perpetuate the stigma, shame, and irrational beliefs that surround mental illness. The individuals and families who deal with mental illness feel they are alone in their suffering, and our silence fails to raise a collective voice for the nation to deal with this dire situation. Not

more than a half-century ago, a diagnosis of cancer carried almost the same stigma as mental illness still does today. Today, thanks to research, improvements in treatment, and just the knowledge of how widespread the illness is, it is no longer something about which we do not talk. The National Alliance on Mental Illness (NAMI) is an organization started by family members of individuals with mental illness. They bring a loud voice for their ill family members. That voice, however, must become stronger, and it must speak out at every opportunity against the stigma surrounding mental illness and advocate for changes in our failed system of care.

Another critical need lacking in the current environment is leadership for change. Twice, with the building of asylums and hospitals, and later, the community mental health movement, America focused on mental illness intending to cure it or at least make it so that people could live "normal" lives in the community. Both times these movements became the nation's answer for mental illness, and they became almost evangelical movements. In both situations, the states and the nations followed the advice of the medical community. That advice first was to build specially designed facilities, asylums that became hospitals, where the mentally ill away from the home environment that had caused the illness, and under the care of a physician, could regain their sanity. Second, over a hundred years later, physicians recommended the creation of community mental health centers to provide treatment so that the mentally ill could live in the community. They now saw the hospitals as the treatment of the past.

Some psychiatrists today are again calling for change, but the splintered field of mental health has many voices, and the leadership calling for change is limited. Too many of the rest of us have grown silent, seeing little need to worry about the mentally ill

since they are now mostly in jail or prison. We do see them on the streets, where they join the rest of the homeless, but in our capitalistic culture, there are always losers who cannot make it, and most of us assume that charity or the "government" will help them.

The severely mentally ill do not need a new movement that promises a magic cure that does not exist, as the asylum and community mental health movements did. The reality is that in the United States, we need to change the funding mechanisms for the treatment of mental illness, and create a system that places the responsibility for the treatment and care of the mentally ill with those who have the capability of leading it: the medical community, just as physicians deal with other illnesses.

As noted in Chapter IV, Medicaid is the primary funding mechanism for the public treatment of mental illness in the nation. It is a needs-based program with no pre-set federal limit on funds available to each state. The state can receive unlimited reimbursement for federally approved programs as long as it provides the required match. In essence, Texas and other states determine the amount of federal funding available to them for all qualified applicants by the services they approve, and by the rates they pay providers. The legislatures also determine the funding for state hospitals, community mental health centers, and potentially other services. Principally, therefore, each state legislature determines the treatments their state will provide based upon the choices they alone agree to fund. The legislatures also approve the funding from the state's resources for state services at whatever level they are willing to spend. The reliance on Medicaid funding levels determined solely by each state legislature means that in many states, including Texas, there is a tremendous under-treatment in services for the mentally ill.

Despite this underfunding, it has become one of the most substantial expenses, so states have turned to managed care to control their expenses.

Behavioral Managed Care Organizations (BMCOs) manage the mental health expenses funded by Medicaid in Texas and most other states. These companies refer only to a select number of providers and closely monitor the care provided to keep the expenses down. BMCOs are paid a flat fee for each life they manage, so they have no incentive to provide the much more costly services needed by those suffering from an SMI. BMCOs also manage the treatment of mental illness for most private insurance companies, using the same principles. BMCOs route individuals seeking mental health treatment to an entirely different manager than that for physical illness, and those managers exercise much greater control over the choices of providers and services than do the managers of physical health.

This treatment of mental health separately from physical health is a significant problem for those with an SMI or any mental illness. Despite federal laws requiring parity between mental illness and physical illness treatment when they exist under two different systems, there is, in reality, no equality. As described in Chapter IV, both Medicare and Medicaid have rules limiting coverage for mental illness that do not apply to physical illness. Separate care and treatment for the mentally ill does not create better treatment and care; it creates a separate and unequal system for those who suffer some of the most debilitating illnesses our nation knows. A movement toward integrating physical health and mental health has begun in Texas and other states. These programs integrate mental health providers within the primary care setting. This team approach treats the whole person. The challenge in this new model, however, is similar to that of the current

one. How do we fund the more expensive care needed by those with an SMI that may include intensive case management, a place to live, and someone to make sure those ill are taking their medications and taking care of their essential needs? The Texas Legislature has refused to fund the treatment of mental illness at this level in the past. Its unwillingness to increase taxes in a fast-growing state, and its unwillingness to approve expanded Medicaid, mostly funded by federal dollars, provides ample evidence to predict that Texas will not fund the expensive care needed by the mentally ill in the future. To leave the future of the treatment of mental illness to the Texas Legislature or perhaps any legislature does not bode well for those afflicted with these tragic illnesses.

Though the United States spends more than any other nation on health care, its basis of healthcare is an entrepreneurial model where physicians, hospitals, pharmaceutical companies, and insurance companies all focus on providing services that make them the most money without regard to the real needs of the patients. Wealthy sections of cities have far more hospitals, more primary care physicians and specialists, and more pharmacies than income-deprived sections where there is often more illness, but money is less plentiful. Most persons with chronic mental illness and their families exhaust their resources and become dependent upon public resources, primarily Medicaid, for treatment and care. Medicaid funding in Texas means individuals have fewer physicians who will treat them and have minimal access to hospitals to serve them. A study requested by Harris County Commissioners Court recently documented that the county did not have resources to provide services to those in poverty whom by law they are required to serve. It also found that for those whom they served, the services were far

from adequate. Without proper treatment, many of those individuals are arrested, placed in jail, and ultimately for some, prison.

The best answer to proper funding for mental health is the creation of national universal health insurance with the full integration of mental health and physical health care. This change would place the responsibility for the patients in the hands of the physicians and ancillary service providers who oversee their direct treatment and care. Such a change to universal health insurance must provide adequate compensation for the highly skilled individuals who provide the treatment and care to both the physically and mentally ill. The United States is one of the few industrialized countries that does not have a universal health insurance program, and we spend far more than any other country on healthcare. In the United States, healthcare makes up 17.9 percent of the gross domestic product (GDP), which is six percentage points higher than any other industrialized nation. The nation spends more on healthcare than any other expense.

Nevertheless, the resulting healthcare is not as good as that of several other countries; however, it has made the healthcare industry quite wealthy. The profit of each component in our health care delivery system and the administrative costs of maintaining the many different elements of our medical model would go a long way toward treating those with an SMI in our nation. The universal health insurance debate in the United States began 100 years ago. Whether it will ever become a reality is a political question. The integration of mental health and physical health is a new trend that other nations are working to develop as well; it may be closer to reality than universal national health insurance in the United States.

Another concern is reducing criminalization through changes in the legal issues around the treatment of mental illness. Is being able to refuse specific treatments, or only being required to accept treatment if you are a danger to yourself or someone else by clear and convincing evidence protecting the civil rights of a person whose mind is not capable of making appropriate decisions for themselves? Is not living on the streets, dying years earlier than those without mental illness, and experiencing the effects of increasingly debilitating illness without medications not making one a danger to one's self? It is time for Congress and the courts to revisit decisions made at the height of the deinstitutionalization and the civil rights movements.

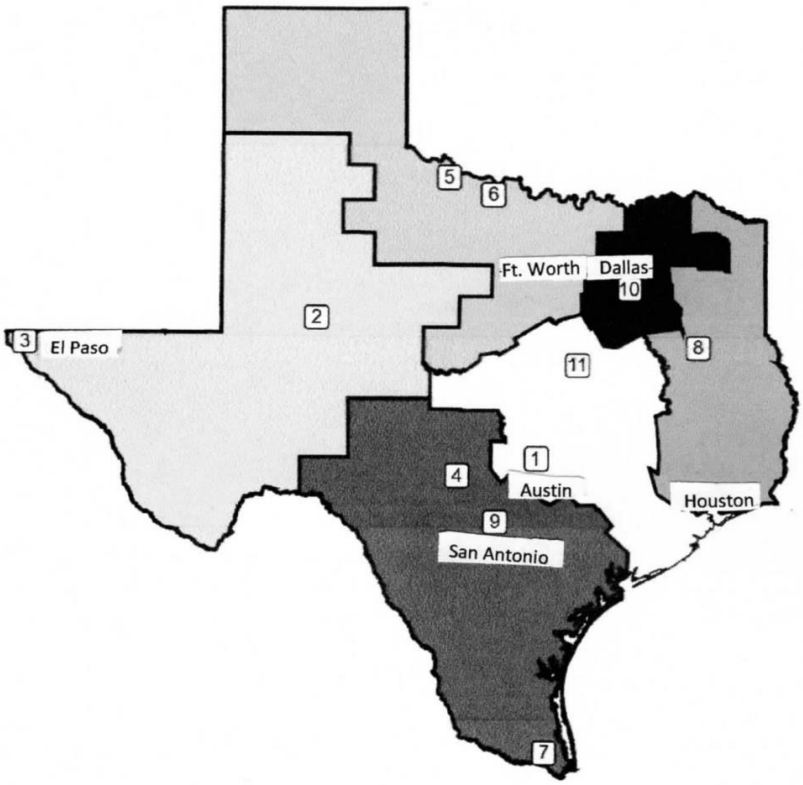
Making any change in the funding and the laws regarding the treatment and care of those suffering from an SMI will not be easy. However, the reality is that the current system is a national disgrace, as thousands of very ill people go untreated or poorly treated, and they break the law and go to jail and prison. With only 3 to 5 percent of the violent acts in the nation committed by persons with a severe mental illness, the mentally ill are not necessarily violent people.[1] However, with the gun laws as they are in the United States, the availability of such weapons makes it highly likely that mentally ill persons will continue to use them to tragic effect. The availability of guns is higher in the United States than virtually any other country, and the ease with which anyone, including a mentally ill person, can obtain one makes this a dangerous place to live.

All of the possible answers for funding the treatment of mentally ill individuals, placing responsibility for their care under properly trained providers and moving away

[1] "Mental Health Myths and Facts," Mental Health.gov—Let's talk about it, accessed July 9, 2019, https://www.mentalhealth.gov/basics/mental-health-myths-facts.

from the criminalization of the mentally ill, involve major decisions that only our elected and appointed officials can make. All of us must recognize that elections have consequences, and at this point, those consequences are very bad for individuals who have a mental illness.

Figure 22 State Hospitals in Texas and Counties Served [1]



HOSPITALS

1. Austin State Hospital
2. Big Spring State Hospital
3. El Paso Psychiatric Center
4. Kerrville State Hospital
5. North Texas State Hospital, Vernon Campus
6. North Texas State Hospital, Wichita Falls Campus
7. Rio Grande State Center
8. Rusk State Hospital
9. San Antonio State Hospital
10. Terrell State Hospital
11. Waco Center for Youth

COUNTIES SERVED

- Austin State Hospital
- Big Spring State Hospital
- North Texas State Hospital
- Rusk State Hospital
- San Antonio State Hospital
- Terrell State Hospital

NOTE: Facilities serving the entire state include Waco Center for Youth; Rusk State Hospital and North Texas State Hospital, Vernon Campus (both of which provide maximum security services); and Kerrville State Hospital, which provides transitional forensic services. In addition to serving their designated services areas, Big Spring and Rusk hospitals provide transitional forensic services, while Austin, El Paso Psychiatric Center, North Texas, Wichita Falls campus, Rio Grande State Center, Rusk, San Antonio, and Terrell provide competency restoration services to patients admitted directly from jail. North Texas State Hospital, Wichita Falls, provides an intermediate security program. Children's and adolescent services are provided at five hospitals, expanding the number of counties those hospitals serve.
SOURCE: Texas Department of State Health Services.

[1] "Appendix A: State Hospitals in Texas and Counties Served," State Hospitals: Mental Health Facilities in Texas: Legislative Primer, Austin: Legislative Budget Board, April 2016: 12.

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