

BEYOND DEINSTITUTIONALIZATION: THE FRAGMENTATION OF TEXAS'S
MENTAL HEALTH REFORM MOVEMENT, 1945-1984

by

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I. INTRODUCTION AND HISTORIOGRAPHY

Introduction

The mental health system in the United States is in crisis; as states struggle to fund mental health programs, growing numbers of persons with mental illness have less access to mental health facilities and treatments. As a result, people with mental illness instead receive care in emergency rooms, in state penitentiaries, or go without care.¹ Local, state, and federal government officials—as well as non-profit organizations and charity groups—consistently express their genuine commitment to the needs of the estimated 43.7 million adult Americans diagnosed with mental illness.² But their efforts to enact mental healthcare reform remain limited and ineffective, at best. Calls for an overhaul of the mental health system focus on the staggering number of mentally ill persons in prisons, homeless persons with mental illness, and the increasing frequency of mass shootings like those that occurred at Virginia Tech University in 2007 and Sandy Hook Elementary School in 2012. Reformers have repeatedly cited the fragmentation of mental health services as the greatest obstacle to instituting effective policies.³ Given this decentralized system, professionals across the nation struggle to piece together services in an effort to create a more efficient system.

¹ National Alliance on Mental Illness, *State Mental Health Cuts: A National Crisis*, 2011, 3-4, <http://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=126233> (accessed October 23, 2015)

² U.S. Department of Health and Human Services, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, by Substance Abuse and Mental Health Services Administration, 2013, 10, <http://www.samhsa.gov/data/sites/default/files/NSDUHmhr2013/NSDUHmhr2013.pdf> (accessed October 19, 2015).

³ U.S. Department of Health and Human Services, *Mental Health Services Provided Across State Government Agencies*, by The National Association of State Mental Health Program Directors Research Institute, 2009, 3, <https://store.samhsa.gov/shin/content/SMA09-4464/SMA09-4464.pdf> (accessed October 19, 2015).

The fragmented nature of the mental health system is rooted in the history of the community-based reform movement that began in the 1960s. Two generations ago, after years of broad commitment to the promise of psychiatry and deep anxiety about its limitations, reformers instituted a system of community-based mental healthcare. Reformers hoped that the new system of community-based treatments would provide more effective care to people, instead of the expensive, ineffective, and isolating care they saw being provided in state hospitals. For a time, the reform movement enjoyed a unified vision for mental health reform. By the 1970s, however, the movement had fragmented into distinct, but related efforts to deinstitutionalize patients and to protect patient rights.

The trajectory of reform and its fragmentation occurred in three stages. In the 1940s and early 1950s, reformers forged a common purpose around the need for more influence of psychological expertise and more effective mental health institutions. At its peak of influence, in the early 1960s, psychiatric care came under intense and sustained attack. Reformers persisted in the face of this resistance by pushing for community-based healthcare. Yet two drives—for deinstitutionalization and patient rights—undercut support from the government and the public and divided the previously unified reform movement in the 1970s and early 1980s. Reformers’ hopes for a more effective mental health system that focused on providing comprehensive services at the local level have been all but forgotten. Instead, the divided mental health reform movement led to a system that requires patients to overcome significant obstacles to get care. In the words of one 2009 Substance Abuse and Mental Health Services Administration (SAMHSA) report, patients need “a tremendous amount of perseverance...to navigate the maze from

a therapist's office to the psychiatrist, to the Social Security office, to the housing office, to vocational rehabilitation, to Medicaid, and so on."⁴ The current situation demands that reformers gain important historical context in order to understand how and why the forces behind community mental health reforms produced the fractured mental health services of the present.

Historians have an opportunity to contribute to mental health reform by providing insight into the causes of the fracture of mental health reform. Texas, in particular, played an integral role in the relatively unified push for mental health reform during the 1950s and 1960s, as well as during the fragmentation of mental health services during the 1970s and 1980s. Texas's substantial commitment to mental health reform once allowed the state to be a national leader in expanding mental health services. In 1969 locally-led mental health boards operated twenty-one mental health and mental retardation centers in sixteen counties across Texas, with state expenditures just shy of \$4 million for community-based mental health treatment centers.⁵ Since that year, however, the Texas legislature has consistently reduced funding for its mental health services, which has led to a large-scale reduction of available services. Today the state ranks 47th in providing access to mental health services. In addition to the lack of access to mental health services, the state is ranked 49th on per capita expenditures for mental health costs and spends only \$38.38 per patient, less than a third of the \$122.90 national average.⁶ The

⁴ U.S. Department of Health and Human Services, *Mental Health Services Provided Across State Government Agencies*, 3.

⁵ The Texas Department of Mental Health and Mental Retardation 1969 Annual Report, Folder Mental Health and Mental Retardation, Gov. Preston Smith Records, Box 1994/120-3, Texas State Library and Archives Commission, Austin, TX.

⁶ The National Alliance on Mental Health, *State Mental Health Cuts: The Continuing Crisis, November 2011*, by Ron Honberg, Angela Kimball, Sita Diehl, Laura Usher and Mike Fitzpatrick, appendices ii-v, <http://www.nami.org/getattachment/About-NAMI/Publications/Reports/StateMentalHealthCuts2.pdf> (accessed October 19, 2015).

state's dramatic decline in funding for mental health services demands further analysis of Texas's role in mental health reform to understand how and why fragmentation of services occurred.

Austin State Hospital (ASH), Texas's oldest state mental hospital, provides an excellent example of how national trends in community mental health reforms unfolded at the local level. ASH's history exemplifies all three of the eras of community mental health reform. Between the 1940s and early 1960s, mental health reformers used ASH as a typical example of an imperfect but functional state hospital as they called for federal and state governments to join in the push for community-based mental health care and alternative treatment methods. Once the common cause of community mental health became a national imperative with the passage of the Community Mental Health and Mental Retardation Center Act of 1963, ASH became an example of a progressive-minded institution that embraced new ideas. However, as ASH gained a reputation as a forward-thinking hospital, it simultaneously became the center for public controversy for reforms during a sanity hearing that brought to light the underlying tensions that ran against reformers' efforts. Finally, a growing rejection of psychiatric-led mental health reform brought attacks from the New Left and New Right. New Left patient rights advocates targeted ASH for failures to protect patients' autonomy. At the same time, a new conservative political movement sought to reduce funding for mental healthcare. These dual forces undermined the common purpose that had driven the reform movement and fractured the goals of mental health reformers. What resulted was a mental health system that legally protects individual patient rights, but that fails to provide the locally-based, comprehensive mental health program that reformers had once envisioned. Using

the history of ASH as a case study, this thesis will explain how and why previous reformers' efforts first joined in a common cause and then fractured. This history arguably reminds contemporary observers that even Texans had once joined in common purpose to build a well-funded, community-based mental health system that would be fair to patients and provide significant benefits to the state as a whole.

Historiography

Currently, no single field of history analyzes the history of mental health reform in the context of the broader fragmentation of U.S. politics and social dynamics that historians have identified in the 1970s. Consequently, the history of mental health reform requires an analysis of several historiographical subfields. Of particular importance is Daniel T. Rodgers' *Age of Fracture*. Rodgers argues that ideological, social, and political shifts in the 1970s led to a society in which large-scale social projects fractured into a widely held focus on individualized forms of politics, economic activity, and social purpose. "What characterized the age of fracture was not a literal thinning out of associational life," he asserts, "What changed, across a multitude of fronts, were the ideas and metaphors capable of holding focus the aggregate aspects of human life as opposed to its smaller, fluid, individual ones."⁷ Rodgers provides a framework for the loss of the broad sense of purpose shared by reformers in the 1960s. The fragmentation in the 1970s and 1980s when mental health reform came to focus on protecting individual patient rights, or on deinstitutionalization, coincided with a process Rodgers describes as "the range across which the intellectual assumptions that had defined the common sense of public intellectual life since the Second World War were challenged, dismantled, and

⁷ Daniel T. Rodgers, *Age of Fracture* (Cambridge, MA: Belknap University Press, 2011), 6.

formulated anew.”⁸ Rodgers does not focus his analysis on mental health reform, but his argument opens analytical space for a new history of the history of ASH and the community mental health reform in the late-twentieth century.

The history of mental health reform is more than just another arena in the increasingly familiar tales of post-World War II liberal reform. Conflict over the path of mental health reform contributed to the disaggregation of political and intellectual discourse that Daniel T. Rodgers describes as an “age of fracture.” “The rebellious upheavals of the 1960s,” among which conflict over mental health care and patient rights must be included, “unsettled the debate over conformity and social character and worked to bring explicitly political questions of obligation and justice to the fore.”⁹ For Rodgers this has meant that the widely-held commitments to large-scale political and intellectual projects fragmented during and after the 1960s. The grand missions that defined the postwar period—the Cold War, the heroic stage of the modern Civil Rights Movement between 1954 and 1965, the development of the American suburban way of life—began to disintegrate in the 1970s as people rejected larger constructions of power (e.g. “big” government, national unions, and expert authority) and turned to “individuals, contingency, and choice” as the way to foster justice, opportunity, and innovation.¹⁰ The shift away from grand shared missions changed everything from partisan politics to the discourse Americans used to define their relationship to the government. And that shift both shaped, and was shaped by, the debates over mental health reform.

⁸ Daniel T. Rodgers, 2.

⁹ *Ibid.*, 182.

¹⁰ *Ibid.*, 5.

Though Rodgers does not focus closely on the history of mental health care, an examination of Austin State Hospital both reinforces and complicates Rodgers's broad narrative. In part, the history of mental health reform highlights the ways that federally-directed efforts to create reforms marked a transitional point in this history, one where reformers turned away from broader conceptions of power (e.g. the federal government) and instead embraced ideas that sought to empower individuals. As confidence in their common goal faltered, reformers moved away from the view that government-sponsored, top-down reform via community-based mental health care ought to be a shared mission. Instead, mental health reform focused on reinforcing the rights of individual patients in state institutions, and their common goal disintegrated as reformers argued about the role of state and federal governments in light of an emerging rights-based mental health reform. Rodgers' work thus provides a strong framework for understanding how mental health reformers set out to make sweeping reforms in the 1960s, and later fractured in the 1970s and 1980s as reformers debated individual patient liberties.

The history of mental health reform is also informed by insights from the histories of the New Deal and the Civil Rights Movement. Two works in particular, Ira Katznelson's *Fear Itself* and Risa Goluboff's *The Lost Promise of Civil Rights*, are particularly useful. *Fear Itself* helps explain how the rising support for mental health reform movement in the late 1940s and 1950s grew out of a shared perception of crisis among a large and diverse cross-section of American politics. *The Lost Promise of Civil Rights* details a shift in the African American Civil Rights movement from one focused on substantive, collective economic rights (the right to make a living, for example) to one focused on what came to be called "civil rights"—the right to vote, the right to equal

access to public accommodations, and the right to redress against employment and other forms of discrimination as an individual. The patient rights movement, an offshoot of the Civil Rights movement of the 1960s, grew out of a similar dynamic. As mental health reform centered on an individual rights-based movement, activists created a more just system for patients and a mental health system that was less equipped to provide effective treatments.

In *Fear Itself* Katznelson argues that New Deal era policies shaped people's actions and political perceptions from the Cold War to the present. Though Katznelson does not focus specifically on mental health reform, his assertion that the perception of impending crises underlined the motivations for political action help explain the basis for the mental health reform. Katznelson argues that fear drove the policies of the New Deal. Katznelson dates the New Deal as the era from Frankl D Roosevelt's inauguration to Dwight Eisenhower's presidency and asserts that the time period "reflects an unremitting sense of fragility," derived from the crises the American public faced in the 1930s and into the postwar period.¹¹ Out of this fear, he asserts, numerous New Deal policies "molded the institutions, conventions, and habits that continue to demand thoughtful choices in a world scored by fear."¹² Mental health in the 1940s became a public health crisis, out of which calls for reform emanated from a diverse group of people concerned with mental health. This common recognition of a crisis led to a shared purpose amongst reformers to seek out new alternatives to state hospitals. Katznelson's argument provides a context for the rise of mid-twentieth-century mental health reform by explaining how a

¹¹ Ira Katznelson, *Fear Itself: The New Deal and the Origins of Our Time* (New York: W. W. Norton and Company, 2013), 38.

¹² Ira Katznelson, 486.

society wrought with anxiety turned to the federal government and experts in the hope of solving major crises.

Risa L. Goluboff's *The Lost Promise of Civil Rights* helps contextualize the patient rights movement. Goluboff focuses on the early- and mid-twentieth-century African American Civil Rights movement from the 1920s to the 1954 Supreme Court decision in *Brown v Board of Education*. She argues that civil rights struggles prior to the Cold War defined economic rights as part of civil rights. On the way to the suit in *Brown v Board*, however, the National Association for the Advancement of Colored People (NAACP) shifted the focus of the Civil Rights movement from one based on equal economic rights to one based on equal citizenship.¹³ "In opening the way for the attack on Jim Crow as formal, government enforced segregation," Goluboff argued, "*Brown* short-circuited [civil rights] lawyers' efforts" focused on gaining equal economic rights for African American workers.¹⁴ Goluboff's argument describes how the NAACP's efforts in *Brown* created a limited Civil Rights movement, a movement that won greater access to government institutions for African Americans, but failed to address the economic discrimination, exploitation, and violence that perpetuated Jim Crow.

The advent of the patient rights movement paralleled Goluboff's argument. Between the 1940s and the 1960s, reformers conceived of mental health as necessary for the commonwealth of the American republic. Community-based mental health reform promised better care for individuals and a healthier society overall. In the 1960s, the individual civil rights of institutionalized persons became a public concern. This concern

¹³ Risa Goluboff, *The Lost Promise of Civil Rights* (Cambridge, Mass.: Harvard University, 2007), 14-15.

¹⁴ Risa Goluboff, 15.

culminated in the late 1970s and early 1980s as the American Civil Liberties Union (ACLU) and the Mental Health Law Project focused on establishing patient rights through litigation. Though their efforts created a more just system for patients, it focused mental health reform on the rights of institutionalized persons and the state instead of on states' roles in providing effective treatments to their citizens and the community as a whole. Goluboff's analysis of how civil rights movements expanded in one area and contracted in others therefore provides a framework for the patient rights movement of the 1970s and 1980s.

The history of mental health reform illuminates a key, yet unexamined history in the changing relationship between individuals and the state. The disaggregation of mental health services reveals the deterioration of broad public purpose that shaped the New Deal Era and that paralleled the move from collective welfare to individual rights in the narrative of the civil rights movement. By studying how and why mental health reformers' common purpose crumbled during the 1970s and 1980s, historians can shed light on a broader narrative of the changing relationship between the state and individuals, and understand how such a shift affected mentally ill citizens.

The Rise of the New Right and Mental Health

The fracture of the national mental health reform movement cannot be explained without an understanding of the rise of the New Right that began in the 1960s, if not before, and gained momentum in the 1970s and 1980s. Conservative resistance to mental health reform did not begin in the 1970s. In fact, as historian Michelle M. Nickerson has shown, the origins of right-wing dissent against federal mental health programs began as early as the 1950s. Furthermore, Michael Schaller explains that conservatism grew as a

response to economic and social pressures that increasingly caused many Americans to view welfare programs, including state mental health programs, as unnecessary and expensive. Historians of the New Right provide insight into the context for the effect of anti-government policies on mental health reform that would culminate with Ronald Reagan's defunding of mental health programs as a whole.

Nickerson details the origins of McCarthyist resistance to mental health reform in the late 1950s and early 1960s. Conservative women's groups, for example, responded to psychiatrists' growing influence in the Alaska Mental Health Enabling Act of 1956. Nickerson argues that by examining the predominantly female-led, grassroots conservative rejection of mental health reform, "historians can gain deeper insight into the diversity of voices that have influenced larger political movements."¹⁵ Though Nickerson's focus is on bringing historians' attention to twentieth-century female conservative movements, her examination of the growth of conservative resistance to mental health reform is essential for understanding the effects of the rise of the New Right on mental health reform in general. Nickerson sheds light on the conservative distrust of the federal government and psychiatric leadership in mental health reform. Though Nickerson does not discuss the effects of conservative resistance to mental health reform, their rejection of elitism and federal intervention played a large role in the fracturing of mental health reformers' efforts during the 1970s and 1980s.

Schaller's *Right Turn* details the growth of conservatism in the late twentieth century. He asserts that conservatism grew as a response to the failed policies of the New

¹⁵ Michelle M. Nickerson, "The Lunatic Fringe Strikes Back: Conservative Opposition to the Alaska Mental Health Bill of 1956," in *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America* (New York: Routledge, 2004), 130.

Deal and President Lyndon B. Johnson's Great Society. "The 'long' 1980s," Schaller asserts, "both politically and culturally began in the 1970s...At both the local and national levels, government promoted a more conservative vision of justice, personal responsibility, and business power."¹⁶ Furthermore, Schaller details the growing pressures American families faced in lieu of "growing federal deficits...slow economic growth...rising rates of crime, divorce welfare, single parenting, and drug use."¹⁷ Schaller's examination of the rise of the New Right in the 1970s contextualizes the disaggregation of mental health reform in the late twentieth-century. Growing skepticism regarding social welfare programs, coupled with the retraction of support and funding for social programs, provided the basis for the external pressures that fractured the common purpose of reformers.

The History of Mental Institutions and Psychiatry

Historians of mental institutions and students of the growing resistance to psychiatry both raise, but do not fully explain, the ways that the patient rights movement redirected the focus of mental health reforms and fractured their shared sense of purpose. Authors such as Michel Foucault, R. D. Laing, and Thomas Szasz criticized psychiatrists' role as leaders in psychiatric mental health reform. They perceived psychiatric practices and confinement in state hospitals as means of control for psychiatrists acting as normalizing forces in society, and they argued that state hospitals represented the state's

¹⁶ Michael Schaller, *Right Turn: American Life in the Reagan-Bush Era, 1980-1992* (New York: Oxford University Press, 2007), vi.

¹⁷ Michael Schaller, v.

attempt to control abnormal behavior. Reformers have in particular cited the works of Laing and Szasz as inspirations for the patient rights movement.¹⁸

Histories of state hospitals gives a sense of how and why ASH became enmeshed in community mental health reform, as well as connect the hospital to larger narrative of state hospitals. In particular, the works of Gerald Grob, Benjamin Rothman, and Sara Sitton shed light on the growth of mental institutions and their purpose in society over time. Grob, a leading scholar in mental health history, analyzes mental health policy from a federal perspective, detailing the gaps in reformers' efforts on a national level. Rothman analyzed the rise of asylum care in the early nineteenth-century, and argued that the inclination towards asylum care indicated a response from people in the early American republic to institute order in a world they saw as increasingly disordered. Sitton, a psychologist, wrote one of the few and most recent books on ASH. Using ASH as a case study, she argued that power relationships behind hospital walls proved far more complex than scholars often acknowledged, and detailed the ways that patients, hospital staff, and administrators navigated complex power dynamics to form a distinct community. Though these scholars offered great insight into the history of mental health policy and mental institutions, none of them analyzed the mental health in the broader context of political and social fragmentation that occurred in the 1970s and 1980s.

In the 1960s, a growing movement for community mental health centers inspired interest in the history of mental health hospitals. Most famously, Michel Foucault's *History of Madness* (1961) introduced the notion that asylums served to confine and control deviant populations as opposed to treating them. Foucault's discussion of

¹⁸ See David Pharis, "History of Mental Health Legal Issues," in *State Hospital Reform: Why was It So Hard to Accomplish?* (Durham, North Carolina: Carolina Academic Press, 1998), 54.

madness as a cultural construct challenged psychiatric authority. In *History of Madness*, Foucault asserted that what a society defines as “madness,” and a how society identifies and addresses mental illness, are both cultural constructions shaped by power relations, not objective science. The nature of madness has changed over time, Foucault argued, as the state sought to control people deemed socially delinquent, or “other,” while justifying their actions under the guise of “protection” for vulnerable people.¹⁹ He also revised the understanding of the history of mental hospitals by presenting the intertwined origins of prisons and hospitals, further linking psychiatric practices to control mechanisms instituted by the state.²⁰ Foucault criticized psychiatry as a field of study. “Psychoanalysis,” he argued, “cannot and will never be able to hear the voices of unreason nor decipher on their own terms the signs of the insane.”²¹ These criticisms called into question the legitimacy of institutional care, as well as the ultimate purpose of mental hospitals and psychiatrists, for the New Left.

Social historians also came to describe asylums as a kind of penal institution at the same time that the ex-patient and anti-psychiatry movements of the late 1960s and 1970s fostered a similar argument. Works like R. D. Laing’s *The Self and Others* (1969) and Thomas Szasz’s *The Myth of Mental Illness* (1974) helped build a movement to transform mental health care in the U.S. Szasz and Laing, both psychiatrists, followed Foucault in arguing that mental illnesses were socially constructed rather than concrete medical illnesses. Laing’s writings focused on the subjectivity of psychoanalysis. This subjectivity, he suggested, undermined the authority that many psychiatrists claimed as

¹⁹ Michel Foucault, *History of Madness* (New York: Routledge, 2009), 421.

²⁰ Michel Foucault, 76.

²¹ *Ibid.*, 511.

leaders of mental health reform.²² Laing's arguments raised questions regarding psychiatry's imposed definitions of normal and abnormal. Szasz, in particular, shaped the discussion of mental health reform by asserting that mental illness did not exist.²³ Instead, he believed that psychiatry's purpose stemmed from a need to control individuals exhibiting "deviant" behavior. Szasz reinforced Foucault's assertions that psychiatry existed to support the status quo of social norms. Furthermore, Szasz asserted the idea that institutional care violated the rights of mentally ill people. Although Szasz and Laing did not directly interact with the historiography of state hospitals, their works informed historians' more critical perceptions of psychiatry and mental hospitals in the 1980s.

Social historian David Rothman's 1971 study, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, presented the postmodern argument that the creation of asylums during the Jacksonian-era had little to do with providing care for the mentally ill. Rothman insisted that the growth of asylums in the nineteenth century was a response to cracks in the rational Lockean ideology that spurred the American Revolution. The development of abject poverty, crime, disease, and insanity in the new nation challenged the assumptions of Enlightenment principles. The asylum, Rothman asserts, served a means of confining and controlling segments of society deemed obstacles to the progress of reason by "curing" them of their irrationality. Asylums supplied a means of hiding the disorderly in an age that hailed the orderly and rational; and though on the surface asylums promised to give order to those living in chaos,

²² R. D. Laing, *The Self and Others*, (New York: Pantheon Books, 1969), 23.

²³ Thomas Szasz, *The Myth of Mental Illness Foundations of a Theory of Personal Conduct* (New York: Harper Perennial, 1974), 101.

Rothman argued that their principle function was confinement.²⁴ Rothman adopted a critical view of asylums—popularized by scholars like Laing, Szasz, and Foucault—that perceived the state’s role in psychiatric care as distinctly sinister. Such perceptions of mental hospitals contributed to a growing rejection of psychiatric power.

Gerald Grob focused on the transformation from nineteenth century asylums to twentieth century mental hospitals. Grob’s *Mental Illness and American Society, 1875-1940* (1983) examined the medicalization of psychiatry in conjunction with the decline of public faith in state hospitals during the twentieth century. Grob perceived both state hospitals and the field of psychiatry as being in a state of constant flux. He found that state hospitals, and mental health care more broadly, were shaped by numerous factors, such as from doctors working within the mental health system, patients housed in institutions, psychiatrists who sought to professionalize and attach the field to scientific medicine, and from public perceptions of hospitals as hopeless custodial institutions. Most importantly, he asserted that even though individual actions shaped mental hospitals in various ways, no one understood how their actions would affect the future.²⁵ Grob illustrated the growth in the number of state asylums as they spread from the East into the South and the West. In psychiatry, he spotlighted a trend away from institutionalization as a kind of cordoning off of the mentally dangerous toward the treatment of mental illness as a disease. He also acknowledged that the population of twentieth-century mental hospitals differed considerably from their nineteenth-century counterparts, a fact often overlooked by other historians. Key to his argument is the notion that as

²⁴ David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, rev. ed. (David J. Rothman, 1971; New York: Walter de Gruyter, 2002), xxiv.

²⁵ Gerald Grob, *Mental Illness and American Society, 1875–1940* (New Jersey: Princeton University, 1983), xi-xii.

psychiatrists shifted toward providing medical treatments for mental illness, they unknowingly dismantled the justification for custodial care by prioritizing treatment and release of patient over indefinite care.

Grob's 1994 book, *The Mad Among Us: A History of the Care of America's Mentally Ill* assessed deinstitutionalization as just the most recent shift in mental health policy. He asserted that one of the problems of mental health policy is that it historically relies on curing mental illness, an unrealistic goal that inspires the characteristic naïve optimism of reforms that eventually dissolved into disillusionment.²⁶ *The Mad Among Us* was Grob's starkest attempt to use his analyses of mental health policy to reach a public audience and influence policy. His work shows how psychiatrists' changing definitions of, and treatment for, mental illness affected the ability to reform the mental health system. Yet Grob did not examine the ruptures in mental health policy in the context of the social and political shifts of the 1970s and 1980s. Though he offers analyses of specific policies, he failed to view the trajectory of mental health reform and its disaggregation as the product of a larger cultural and political shift.

In 2006, Grob and psychologist Howard H. Goldman revisited the politics of mental health reform in, *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?* Their work focused on how federal policy and federal politics shaped mental healthcare policy from World War II through the early twenty-first century. The authors acknowledge the fragmentation of mental healthcare, but find the community mental health movement as the cause of fragmentation.²⁷ They suggest that

²⁶ Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994), 311.

²⁷ Gerald Grob and Howard Goldman, *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?* (New Jersey: Rutgers University Press, 2006), vii.

the ideas of community mental health reformers proved too radical, too difficult to institute, and that they forced a retraction of federal support as the momentum for community mental health reform sputtered. This perspective does not attempt to view the breakup of services in the larger context of the fragmentation of the 1970s. In fact, the general disintegration occurred as community mental health reform faced a growing rejection of psychiatry, changing perceptions within the ranks of reformers, and as concerns of about rising costs alarmed state and federal government officials. Grob and Goldman's argument is essential but insufficient to adequately explain the fracturing of mental health reform.

Psychologist Sara Sitton conducted one of the few histories of ASH in her book, *Life at the Texas State Lunatic Asylum, 1857-1997* (1999). Sitton analyzed the history of ASH from the institution's founding to the late 1990s in an attempt to understand the relationship between hospitals' evolving roles from the nineteenth century to late 1990s. Sitton argued that the ASH shared many similarities with other hospitals and the national historical narrative of state hospital reform. She asserted that the institution's downfall stemmed from a chronic lack of funding and an inability to reduce its patient population that occurred in the midst of changing professional views on health care treatments.²⁸ With unique source materials—such as oral histories, photos, superintendents' records and personal notes, historic structure reports, and governmental reports—Sitton showed that ASH maintained a community based on care and respect despite external political pressures. The effects of deinstitutionalization, she argued, offered mixed results where some patients managed to find effective therapies within community centers, and other

²⁸ Sara Sitton, *Life in the Texas State Lunatic Asylum, 1857–1997* (Texas A&M University Press, 1999), 9.

patients afflicted with more severe mental illnesses lost the safety and support they found within the state hospital.²⁹ *Life in the Texas State Lunatic Asylum* provided an “insider” perspective into how patients and staff shaped state hospital life.

But Sitton’s overall argument does not place ASH in its historical context, and in doing so misses an opportunity to connect the history of ASH with larger historical trends. While understanding how people navigated the complex power relationships behind hospital walls is an important aspect of mental hospital history, so too is the hospital’s role in community mental health reform and the eventual disintegration of the movement. Understanding how a hospital like ASH played role throughout the trajectory of mental health reform provides historians with unique insight into the connection the disaggregation of mental health reformers and the fragmentation of other civil rights activists.

Conclusion

By connecting histories of the 1970s, the New Right, the anti-psychiatry movement, and of mental hospitals, this thesis seeks to explain the variety of tensions that ruptured the once unified community mental health reform movement. ASH faced many of the same struggles and changes as other state mental institutions. But the Austin hospital was unique in that the combined factors of reform converged in Austin in ways they did not converge elsewhere. A critical analysis using ASH as case study offers insight into the forging of reformers’ sense of purpose, the struggles of reformers and resistance to their efforts, and finally the disaggregation of community mental health

²⁹ Sara Sitton, 8.

efforts as patient rights and conservative interpretations of spending and civil rights, that helped to produce a fractured mental health system.

II. CLIMBING OUT OF THE SNAKE PIT: AUSTIN STATE HOSPITAL'S PATH TOWARD COMMUNITY-CENTERED MENTAL HEALTH CARE

Mental health became a major public concern in post-World War II America as people from a variety of backgrounds balked at the outdated, ineffective, and expensive care provided in state hospitals. This concern was led primarily by psychiatrists, whose profession grew in popularity and influence after World War II and advocated for revolutionary new forms of mental health treatments. A wide range of Americans, shocked at the poor quality of care for many patients in mental institutions and frustrated with the inability to solve the crisis of state hospitals, called for a national movement for mental health reform. Psychiatrists, national political leaders, state officials, journalists, even novelists—this broad group of people formed the basis of the growing national mental health reform movement. “For many,” stated historian Gerald Grob, “the specialty of psychiatry seemed poised to cross a threshold...to bring the benefits of new therapies to large numbers of... mentally disordered persons.”³⁰ Mental health reform gained momentum across the nation as its diverse constituency unified behind the shared belief in community-based care as an alternative to state hospitals.

Reformers in the 1940s and 1950s began to view state hospitals as deeply troubled institutions that could not be repaired. State hospitals across the nation generally faced ballooning patient populations, decreased funding, and wavering public support. By the middle of the twentieth century, reformers identified two overlapping, but often conflicting missions: to treat and release patients, while also providing long-term care for “indigent” individuals. The tensions between the hospitals’ two main missions remained

³⁰ Gerald Grob, *The Mad Among Us: A History of the Care of America’s Mentally Ill*, (New York: The Free Press, 1994), 231.

constant throughout the postwar era. The frustration that stemmed from the inability to bring mental hospitals out of their long-standing crises led reformers to view state hospitals as inherently flawed, and inspired them to turn to community-based treatments as the solution to the nation's ongoing mental health crisis. For about a generation after World War II, this reform movement can be understood to have been a kind of shared, national goal.

By the 1950s mental health professionals had conceptualized an entirely new method of psychiatric treatments that would provide community-based care to individual patients. Championed by many psychiatrists, this new model of mental health inspired reformers to adopt community mental health alternatives as a common goal for mental health reform. Psychiatrists and other reformers endorsed community mental health centers as a replacement for state hospitals because, unlike state hospitals, they promised to offer more effective treatments for mental illnesses, focused on preventative treatments instead of custodial care, and preserved a person's dignity and autonomy. "There was a pervasive faith," remarked historian Gerald Grob, "that American society stood on the threshold of a new era that would end the segregation of mentally ill in remote custodial institutions, bring them the benefits of psychiatric advances, and integrate them into the mainstream community life."³¹ Reformers' common purpose became feasible as the federal government increased its financial and political support for community mental health reforms. The federal government's support ultimately paved the way for a psychiatric mental health reform movement that envisioned community-based alternatives as its common goal.

³¹ Gerald Grob, 221.

In Texas, Austin State Hospital (ASH) became the focal point in discussions of mental health reform when sociologist Ivan Belknap conducted a study of ASH that received national attention from community mental health reformers. Belknap's study resonated with mental health reformers because ASH served as a "typical" example of a state hospital, one that was flawed and struggled with funding and patient populations, but also one that maintained standards well above the nation's worst mental institutions. As the state's oldest and flagship mental institution, ASH exhibited the issues that historically plagued mental hospitals in Texas and represented the general issues faced in mental hospitals. Belknap's examination of ASH occurred in the context of national discussions for reform provided reformers with the necessary concrete evidence to argue for the creation of a new, community-based model for mental health.

The history of ASH reflects many of the trends that define the history of psychiatric institutions across the nation. ASH as a case study illuminates why and how community-based mental health became the basis of reformers shared goals. In Texas ASH became a target for reform because of its reputation as an imperfect but functional institution that generally mimicked the history of state hospitals across the nation; it allowed community mental health advocates to prove that state hospitals were inherently flawed and argue for the construction of a community-based mental health system that resonated on a state and national level.

The Rise of Psychiatry and Federal Involvement in Mental Health Reform

National calls for mental health reform arose and intensified in response to the growing frustrations and disdain for state hospitals. The harsh conditions within the wards of state hospitals warranted a broad array of criticism from journalistic exposes, to

academic critiques, to rebuke from the general public and incurred larger federal involvement in state sponsored mental health care. The frustration with mental hospitals expressed by a broad array of critics built helped forge a shared sense of purpose between reformers that identified community alternatives as its goal.

The notion that the community provided a better therapeutic environment than hospitals came from psychiatric observations of soldiers in World War II. The use of psychiatric treatments in World War II demonstrated the field's effectiveness in treating the mental health issues of combat soldiers. This led to a growing belief in psychiatry's potential from within the federal government through endorsements from the Army and Navy. Many fields in the social sciences, such as psychiatry and sociology, grew rapidly in the late 1940s and led efforts in mental health reform. Psychiatry, a particularly influential field, increased in popularity in the years following World War II after psychiatric therapy proved effective in treating soldiers experiencing combat fatigue. Military psychiatrists observed that many soldiers who had previously appeared "normal" often experienced severe mental health issues stemming from the intense stress placed upon individual soldiers during combat.³² For psychiatrists, "the policy lesson seemed clear: environmental conditions...were the primary causes of mental disorder." The increasing perception that a person's environment played a key role in mental health treatments, "prepared the way for the social emphasis that came to dominate psychiatric epidemiology during the 1950s and 1960s."³³ Psychiatrists thus found that effective mental health treatments had to address the social contexts that influenced a patient's

³² Allan V. Horowitz and Gerald N. Grob, "The Checkered History of Psychiatric Epidemiology," *The Milbank Quarterly* 89 no. 4 (December 2011): 639.

³³ Allan V. Horowitz and Gerald N. Grob, 639.

mental health in order to be effective. The emerging community-oriented perception of mental health proved antithetical to treatments provided in mental hospitals that remained largely custodial, and allowed psychiatrists to imagine new possibilities for mental health care.

Psychiatrists learned through treating soldiers for combat trauma that the context of patient's environment greatly influenced a person's mental health. This suggested to psychiatrists that effective treatments necessitated addressing a person's mental health concerns within the social context of their communities. "For the first time in history," wrote psychiatrist Dr. Robert H. Felix, "a nation is attempting to bring the benefits of the new science psychiatry to its whole people." Felix, as did many other psychiatrists, believed that "the experience of the Army and the Navy during World War II proved beyond any question that...the man on the road toward mental illness can be restored to useful life," through new psychiatric treatments.³⁴ Calls for a community-based mental health program were therefore rooted in a growing belief that confinement and isolation proved counter intuitive to improving mental health.

Concerns about state hospitals' conditions also caught the attention of the federal government. The passage of the Mental Health Act in 1946 marked an increase in the federal government's concern for the conditions in state hospitals. The act created the National Institute for Mental Health, and provided additional funding for research in psychiatry and mental health fields.³⁵ The act provided additional funding for states, and it laid the groundwork for research for the community mental health movement. It was

³⁴Robert H. Felix, "Psychiatry Comes of Age," *The Science News-Letter* 54 no. 6 (August 7, 1948): 90-91.

³⁵Gerald Grob, *The Mad Among Us*, 210.

designed to encourage research relating to the cause, treatment and diagnosis of mental illness. The act also provided funding for training programs and for the establishment of clinics and treatment centers.³⁶ Though the Mental Health Act did not envision community mental health centers per se, it allowed the federal government to encourage experts to explore solutions to the problems of the mental health system and expanded federal involvement in mental health reform.

Despite calls for reform from psychiatrists, new approaches to mental health were often not available in state hospitals. Even by the mid-1950s, eighty-four percent of psychiatric specialists in America were not practicing in mental hospitals where eighty-five percent of mentally ill patients were housed. One reformer, sociologist Ivan Belknap who used ASH as a case study to exemplify the obstacles of mental health reform wrote, “the modern concepts of psychiatry [were]... unworkable in the hospital.” Patients at ASH—which Belknap extended to most institutions—were treated in an “impersonal fashion” without any sense of flexibility from hospital staff.³⁷ Reformers increasingly viewed state hospitals as incompatible with community-based mental health reforms, and reformers viewed community-based care as the best means of effectively treating mental illness.

Novelists and filmmakers also expressed their discontent for state hospitals. *The Snake Pit* in 1948, both a widely popular novel and film, critiqued state hospitals as quasi-penal institutions and represented them as inherently flawed institutions. The novel, written by Mary Jane Ward in 1946, became a critically acclaimed film in 1948. It tells a

³⁶ Gerald Grob, *The Mad Among Us*, 210.

³⁷ Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: McGraw-Hill Book Company, 1956), 205-208.

fictional story based on Ward's own experiences in Rockland State hospital located in Orangeburg, New York. Her story was reprinted in the reader's digest, which then attracted some 15 million readers.³⁸ One reviewer noted that the *Reader's Digest's* version of Ward's story, "is one of the most extraordinary stories that they have ever condensed."³⁹ Ward's novel tells the story of Virginia, a woman who suffers a nervous breakdown and then is admitted to a women's state hospital in New York. One review in the *Chicago Tribune* reveals the impact that the novel had on the public. "Stories... like, the Snake Pit should awaken us to the need of the proper care of the insane," stated one review. "The public is slowly becoming aware that most of our mental hospitals are doing a frightfully bad job and need thoro[sic] overhauling."⁴⁰ Stories like Ward's helped spread perceptions that care in mental hospitals was insufficient, and added to growing frustration for state hospitals.

The Snake Pit, both the film and the book, provided its audiences with shocking interpretation of state hospitals that brought national attention to the need for state hospital reform. A *Dallas Morning Times* article highlighted the negative implications of state hospitals as portrayed in the film. Virginia, "might have recovered," the paper concluded, "had the asylum not been modeled after Nazi concentration camp." The article also notes that "prison like confinement," prevented Virginia from making a speedy recovery.⁴¹ The *Christian Science Monitor* declared the film, "a documentary

³⁸ "The Snake Pit (1948) Trailer. Starring Olivia de Havilland," *YouTube*, Uploaded Sept. 24, 2011. <https://www.youtube.com/watch?v=1CBLJoNETqU>.

³⁹ Frederic Babcock, "Among the Authors," *Chicago Daily Tribune*, Apr 21, 1946.

⁴⁰ Kelsey Guilfoil, "Journeys in Dark Realms of Insanity," *Chicago Daily Tribune*, Aug 18, 1946.

⁴¹ John Rosenfeld, "Screen in Review," *Dallas Morning News*, January 15, 1949.

rather than entertainment.”⁴² *The Snake Pit*’s portrayal of state hospitals as quasi penal institutions incurred public outrage and fostered calls for mental health reform.

Journalists critiqued mental hospitals through documentary exposés, which also helped forge a common purpose between reformers. Albert Deutsch’s *The Shame of the States*, one of the most well-known and popular examples of these journalistic critiques, documented the conditions in the nation’s worst mental hospitals and compared them to Nazi concentration camps. *The Shame of the States* targeted both public and scholarly audiences with its extreme portrayal of state hospital dysfunctionality. *The Shame of the States* noted that eighty-five percent of mentally ill Americans resided in state mental institutions, which testified to the need for mental health reform.⁴³ One of Deutsch’s most powerful articles detailed the deplorable conditions of the wards in Philadelphia State Hospital for mental Diseases, also known as “Byberry.” It was of Byberry that Deutsch said reminded him of Nazi concentration camps. “I entered buildings,” wrote Deutsch, “swarming with naked humans herded like cattle and treated with less concern, pervaded by a fetid odor so heavy so nauseating, that the stench seemed to have almost a physical existence of its own.”⁴⁴ In his discussion of state hospitals’ failures, he outlined two opposing goals of state hospitals that prevented them from being effective. On the one hand, state hospitals sought to provide curative treatments, and on the other they sought to provide long-term custodial care for patients. Deutsch also stated that “curative” treatments should be the most important function of state hospitals, and advocated for

⁴² “The Snake Pit,” *The Christian Science Monitor*, Jan 03, 1949.

⁴³ Albert Deutsch, *The Shame of the States* (New York: Harcourt, Brace and Company 1948), 26-30.

⁴⁴ Albert Deutsch, *The Shame of the States*, 42.

riding hospitals of the custodial nature altogether.⁴⁵ Deutsch's work helped foster growing calls for an overhaul to state hospitals across the nation.

Deutsch offered an alternative through what he called, "a therapeutic community."⁴⁶ This "Ideal State Hospital," as Deutsch referred to it, operated differently from other state hospitals in that, for one, it theoretically existed in a society where budget shortfalls, state politics, and a lack of psychiatric advancement did not exist. Secondly, Deutsch believed that state hospitals, in order to be successful, would have to participate in their local community, provide total freedom for patients with the exception of those patients who truly posed a threat to society, and would rely on the patients' family to provide a therapeutic environment.⁴⁷ He envisioned an early form of a community mental hospital, a notion that resonated throughout the 1950s and 1960s.⁴⁸ Deutsch's work helped connect the growing frustration for state hospitals to the community-based alternatives envisioned by psychiatrist. His work identified therapeutic communities as the common goal for mental health reform.

The impact of *The Shame of the States* reached concerned citizens across the nation, and was familiar to at least some Texans. One editorial in *The Dallas Morning News* informed readers that "His book should go far in awakening... the need for more and better state hospitals."⁴⁹ Like Ward's novel, Deutsch's investigation inspired several news articles published that year regarding the need for mental healthcare reform. An article published in July 1948 in the *Dallas Morning News* wrote of the crisis faced by

⁴⁵ Albert Deutsch, *The Shame of the States*, 137.

⁴⁶ *Ibid.*, 184.

⁴⁷ *Ibid.*, 186-187.

⁴⁸ Gerald Grob, *Mental Illness and American Society*, 200.

⁴⁹ Wayne Guard, "Books in News: Disgraceful Conditions in our State Hospitals," *The Dallas Morning News*, November 25, 1948.

state hospitals in Texas, where patient populations had outpaced state facilities.⁵⁰ Another author wrote a scathing critique of Texas's state hospitals in 1948 citing "state hospitals" tendency towards "asylums instead of places of curative treatment."⁵¹ Those in Texas concerned with the state hospital crisis found common ground with national advocates, and viewed the promise of community-based treatments as the best alternatives to the problems of Texas's mental health system.

By the 1950s, community-based alternatives became increasingly popular amongst reformers. Many mental health professionals, frustrated with the lack of progress in state hospitals, called for public support for the creation of a community-based hospitals to replace centralized state hospitals. Dr. Charles Gochen, a leading member of the American Psychiatric Association, envisioned in 1958 that, "the problem [of state hospitals] in the future will be solved by 1) community clinics...2) day hospitals... and 3) small psychiatric units in general hospitals."⁵² Another example of a public endorsement for community mental health reform appeared in 1960 when Frank L. Clements, an Austin community services consultant for the Texas Association for Mental Health, said that mental hospitals needed to improve in three areas; "treating the ill, in providing community aid..., and developing preventative methods."⁵³ Community-based alternatives to mental hospitals became the shared purpose for a broad number of reformers. The shared purpose took shape in the 1950s as reformers, increasingly disillusioned with state hospitals, began to view community centered and non-custodial as a necessary step in mental health reform.

⁵⁰ "Those Hospitals Now?" *The Dallas Morning News*, July 17, 1948.

⁵¹ "Texas Lags in Help for Mentally Sick," *The Dallas Morning News*, November 26, 1948.

⁵² Helen Bullock, "Trends to Obviate Mental Hospitals," *Dallas Morning News*, 3 April, 1958.

⁵³ "Authority Pictures Lag in Mental Illness Work," *Dallas Morning News*, 21 June, 1960.

By the onset of the 1960s, mental health policy began to change as people turned to the community as an answer to state hospital woes. Many professionals in the mental health field embraced notions of community mental hospitals. In the *Journal of Social Issues*, social psychiatrist Milton Greenblatt made recommendations for hospitals transitioning to the community-centered model. Greenblatt defined a community mental hospital as, “one closely in touch with the community, guiding the community in its mental health developments.”⁵⁴ Greenblatt cited that, “the concept of the therapeutic community ha[d] already received explicit attention” from various mental health reforms, which testifies to their shared sense of purpose.⁵⁵ He also believed that, “the attainment of a ‘community mental hospital,’ is the necessary outcome of social advances heretofore achieved within the hospital.”⁵⁶ By the late 1950s and early 1960s, community mental health hospitals became the unifying goal of mental health reformers and inspired a broad movement to seek alternatives to state hospitals.

The shared sense of purpose of reformers became a national imperative when John F. Kennedy signed the Community Mental Health and Mental Retardation Act of 1963. Through the act, the federal government promised to subsidize state efforts to construct community mental health centers and phase out state hospitals.⁵⁷ In support of the bill, President Kennedy held a news conference in March of 1963 in which he condemned centralized state hospitals stating, “We have to offer something more than crowded custodial care in our state institutions.” Kennedy went on to recommend the

⁵⁴ Milton Greenblatt, "The Transitional Hospital," *Journal of Social Issues* 16, no. 2 (June 1960): 64.

⁵⁵ Milton Greenblatt, 62.

⁵⁶ *Ibid.*, 64.

⁵⁷ Sarah Sitton, *Life at the Texas State Lunatic Asylum, 1857-1997*, 143.

approach of community care over state hospitals: “Our task is... to treat [mentally ill people] more effectively and sympathetically in the patient's own community.”⁵⁸ When the Community Mental Health Centers Act passed, it firmly planted the federal government’s involvement in treating persons with mental illness. Furthermore, the act went virtually unchallenged, attesting to the widespread support of community mental health reform.⁵⁹ Kennedy’s support illustrates that by 1963 that community mental health reform became a national imperative and that community-based alternatives to mental hospitals became the share goal of reformers across the nation.

The shared sense of purpose amongst reformers made the national community mental health movement possible. This sense of purpose originated from a broad array of reformers that saw state hospitals as increasingly flawed. The frustration that reformers felt with mental hospitals caused them to turn away from traditional models of centralized state hospitals and embrace new alternatives. Once community centers became the common goal of mental health reformers, their purpose received national attention and became the official mental health policy of the federal government.

Austin State Hospital’s Role in Mid-Twentieth Century Mental Health Reform

The history of ASH reflects the general historical trends of mental health institutions nationally. The impetus for mental health reform at ASH began with the federal government’s growing involvement in state-sponsored mental health reform. The growing concern was also reflected in state politics and local audiences concerned with growing demands for state resources from state mental institutions. The state government

⁵⁸ “President John F. Kennedy’s 51st News Conference, March 6, 1963,” *YouTube.com*, <https://www.youtube.com/watch?v=4yhSzjmNjjI>, Uploaded May 18, 2009.

⁵⁹ Gerald Grob, *The Mad Among Us*, 258.

remained unable to embrace the new conceptions of mental health, and hoped that, with enough funding, state hospitals could be improved and made effective again. This policy, though necessary for improving state hospital facilities and training professional staff, did not alleviate the state mental health system from its ballooning custodial population. The frustrations that stemmed from the inability to enact real change without adhering to the calls to overhaul Texas' psychiatric institutions created a more sympathetic environment for community-based mental health reform.

Austin State Hospital, originally named The Texas State Lunatic Asylum, was founded in conjunction with a larger nineteenth-century reform movement that attempted to provide care for America's mentally ill population. Established in 1857 as the first facility of its kind in Texas, the asylum emerged as part of a national reform spearheaded by Dorothea Dix.⁶⁰ Dix, and others like her, believed that, given the right care and medical attention, "indigent" people could be cured of their ailments.⁶¹ The opening of asylums across the nation marked the first attempt at government-sponsored aid for the mentally ill. From the onset, asylums promised to cure people of mental conditions.⁶² Despite these goals, the inability to cure mental illness led mental hospitals to serve a custodial role for their patients, which led to overcrowding and contributed to long-standing public perceptions that asylums (and later mental hospitals) were perpetually overcrowded and unsanitary.

⁶⁰ Sarah Sitton, *Life at the Texas State Lunatic Asylum, 1857-1997* (College Station: Texas A&M University Press 1999), 1.

⁶¹ David A. Rochefort, *From Poorhouses to Homelessness: Policy Analysis and Mental Health Care*, 2nd ed. (Westport, Connecticut: Auburn House, 1997), 22.

⁶² Sarah Sitton, 11.

The growth of Texas State Lunatic Asylum provides an excellent example of tensions inherent in asylums that led to community mental health reforms in Texas. As early as 1867 the asylum experienced its first struggle with overpopulation when it held thirty-five male patients and thirty-five female, but only had a total of sixty beds.⁶³ Conditions grew worse over time. Between 1866 and 1867 only six patients were admitted to the hospital. Between 1876 and 1877, however, the total number of admissions jumped to 39, and between 1887 and 1888 the total admissions reached 151. Despite efforts to combat overcrowding, by the time Texas State Lunatic Asylum became Austin State Hospital in 1925, the patient population reached 598.⁶⁴ Increasing patient populations remained a constant problem for ASH, as was the case in most state hospitals across the nation, into the mid-twentieth century; by 1948, ASH held a patient population of 3,150 that raised concerns from hospital superintendent, Dr. A. T. Hanretta.⁶⁵ The inability to reduce overcrowding added to a growing frustration regarding state hospitals in Texas.

Texas' state hospitals could not adequately decrease their patient populations because many of their patients relied on the custodial care of state hospitals. A significant population at ASH from the 1930s to the 1950s consisted of senile patients, who required constant care and could not realistically be released from hospital care. In a survey taken by the Board of Control in 1943 regarding the improvement of state facilities, Judge Eugene C. Connolly remarked that the state should come up with a way to care for senile

⁶³ Historic Structures Report, *Austin State Hospital Historic Administration Building of 1857 Austin, Texas: A Historic Structure Report*, by The Williams Co., AIA (Austin, 1987), 7.

⁶⁴ Dr. A. T. Hanretta to the Legislative Budget Board, June 9, 1950, box 1, folder "Superintendent Correspondence" Sarah Sitton Papers, Austin History Center.

⁶⁵ "Old Folks Crowding Out Mentally Ill," *The Austin Statesman*, June 16, 1948.

patients, “without having them committed as insane.” Chairman of the State Board of Control Weaver H. Baker responded to Connelly’s suggestions, “There has been a need for senile aged in Texas for many years,” but according to the law senile patients, “must be committed insane before they can be committed in at all.” Baker also suggested that Judge Connolly make his concerns known to his representative in the state legislature.⁶⁶ Despite state hospitals’ mission to provide treatments and release patients, they were also tasked with caring and housing people suffering from incurable conditions. Unable to shed their custodial purpose, state hospitals became examples of why community-based alternatives were necessary in Texas.

By the 1940s, national calls for improvements in mental health treatments caused investigations in to state hospitals. The investigations revealed the inadequacies of state hospital care and the centralized model for care, citing the hospitals’ growing patient population and ineffective treatments as failures. In 1943, the United States Public Health Service conducted a survey of Texas State Hospitals, and provided a detailed report of ASH’s condition and made recommendations for the institution’s improvement. The report indicated that ASH’s buildings had not been improved in the previous four years, and that the main building (the current administration building) “contained serious fire risks,” especially near the men’s wards. Each physician was responsible for anywhere between 110 and 500 patients, depending on the needs of the hospital. Many patients waited “in jail or elsewhere” before being admitted to ASH, though the waiting list had

⁶⁶ Letter from Weaver H. Baker to Judge Eugene C. Connolly, July 29, 1944, Texas State Board of Control Records, Box 1991/016-49, Folder Archives and information Service Division, Texas State Library and Archives.

been reduced in recent years.⁶⁷ Most importantly, the diversity of the patient population at ASH proved an additional challenge for reformers, because of the difficulties in securing the various resources necessary to provide a wide array of treatments. The investigators distinguished between four different types of patients: “the disturbed” meaning those suffering from chronic mental illness, tuberculosis patients, voluntary patients, and “aged” patients. Investigators remarked that “little is done for the disturbed,” but that “little restraint” was used on these patients, indicating patients at ASH did not use punitive measures to enforce control over patient populations.⁶⁸ The investigators’ report described a hospital that was far from perfect, but it also detailed one that was far from negligent or abusive. However, ASH’s persistent struggle to provide custodial care for its growing patient population detracted from its ability to effectively treat its patients, which added to reformers’ frustrations.

These inadequacies led to calls from state officials, such as Governor Shivers, to include mental health reform as a public necessity for Texas’ citizens. State hospital reform played a role in Shivers’ campaign, and he was quoted saying that Texas was “First in oil, forty-eighth in mental hospitals... first in raising goats, last in caring for state wards.”⁶⁹ Shivers renewed commitment to Texas’ mental hospitals, special schools, and tuberculosis wards and sought to enhance the state's mental health infrastructure to strengthen reformers' role in Texas' mental health system. Shivers reorganized the state’s mental board from the State Board of Control to the Board for Texas State Hospitals and

⁶⁷ United States Public Health Service, *A Survey of the State Mental Institutions of Texas, 1943*, by Samuel W. Hamilton, Box 1, Folder “Government Reports, 1943-1950, 1970-1976, Undated,” Sarah Sitton Papers, Austin History Center.

⁶⁸ United States Public Health Service, *A Survey of the State Mental Institutions of Texas, 1943*.

⁶⁹ As cited in Sam Kich, *Yellow Dogs and Republicans: Allan Shivers and Texas Two-Party Politics*, (College Station: Texas A&M University Press, 2005), 54.

Special Schools (BTSHSS) in hopes of creating a basis for new mental health reform.⁷⁰ The new board immediately sought to enforce institutional standards for all state hospitals. "At the present time," one board member asserted, "the standards maintained are inadequate for the care and treatment of patients... maintained by the State of Texas."⁷¹ The creation of the BTSHSS signified a renewed of political commitment to addressing Texas' failing mental health system, and that the state shared in the common purpose of mental health reformers.

Though many reformers advocated for community-based alternatives for mental health, such ideas could not be instituted overnight. "Resources of funds, competent personnel, etc, are also extremely limited," wrote sociologist Irvin V. Shannon as he explained the lack of growth in community-oriented mental health services in 1951. "The backlog of individuals in the community needing and wanting treatment is so large and growing at such a rate," Shannon observed "it is inevitable that most of the resources will go into treatment-directed facilities."⁷² States, including Texas, accordingly focused depopulating senile patients and updating aging facilities. "If we built properly and staffed adequately," suggested Dr. Goerge W. Jackson of the BTSHSS, "we'd have enough space [in state hospitals] now."⁷³ The state, out of necessity, focused its efforts first improving its state hospitals. However, while a necessary step in mental health

⁷⁰ Sarah Sitton, 134.

⁷¹ Minutes, Meeting of the Board for Texas State Hospitals and Special Schools July 26, 1951, Texas Board for Texas State Hospitals and Special Schools Records, Box 1998/147-1, Texas State Library and Archives, Austin, Texas.

⁷² Irvin V. Shannon, "Research Aspects of Community Planning for Mental Health," *Journal of Educational Sociology* 24 (May 1951): 500-501.

⁷³ Richard Morehead, "Mental Health Problem Faces Hospital System," *The Dallas Morning News*, August 19, 1951.

reform, improving state hospitals alone did not offer long-term solutions to Texas' mental health crisis.

The BTSHSS set out to improve state hospitals, but soon found that improvements alone only offered temporary fixes to a problem that required a long-term solution. In September of 1949 the goals outlined by Governor Shivers and the BTSHSS faced the same hurdles of funding and growing patient populations that had long plagued state hospitals. One newspaper reporter detailed the inadequate funding for state hospitals, citing that, in addition to operational funds, the board required at least \$20,000,000 for the construction of new buildings. Estimates for the state's annual income in 1950 anticipated revenue somewhere between \$40,000,000, and \$50,000,000. In light of criticisms that commitment to state hospitals would push the state into deficit, Governor Shiver's "urged the new state hospital board to figure its needs as economically as possible."⁷⁴ Even in the attempt to provide renewed commitment and reform state hospitals, the governor and the BTSHSS could not escape the dichotomy of the opposing forces inherent in state hospitals. As improvements for state hospitals only offered temporary fixes, state officials and mental health reformers became increasingly disillusioned with state hospitals.

The BTSHSS began investigating the conditions of Texas State Hospitals in 1950. It found that state hospitals across Texas suffered from overcrowding and an overall saturated patient population. The report cited ASH as among the largest state hospitals in Texas, and held largest population of 3,188 patients.⁷⁵ Patient readmission became a

⁷⁴ Richard Morehead, "Governor's Hopes Fade on Holding Taxes Down," *The Dallas Morning News*, September 14, 1949.

⁷⁵ Board for State Hospitals and Special Schools Statistical Information, 1950 "Comparison of the 9 Mental Hospitals According to the Classifications Listed in Column 1 as of Nov.1, 1949" Texas Board

constant struggle after 1946 when admission rates reached over 1,000 patients and remained as high for the remainder of the decade.⁷⁶ The number of newly admitted patients also proved problematic when in 1942 the number of new admissions increased steadily and peaked in 1949 when newly admitted patients reached over 4,000 annually.⁷⁷ Austin State Hospital mirrored statewide trends in its population; out of its total population of 3,188, 58 percent belonged to the continuous treatment category.⁷⁸ The BTSHSS understood that state hospitals inevitably faced the challenges of rising costs, the need for greater access to treatment, and demands for new facilities, but without a viable alternative the BTSHSS had little choice but to focus on state hospital improvement. However, the futility of maintaining state hospitals reinforced calls to seek out alternatives that would revolutionize the mental health system.

In a meeting on June 14, 1952, the BTSHSS set new priorities after their meeting with State Legislative Board in hopes of alleviating conditions in state hospitals. However, as the board focused on improving the existing hospital system, the state found itself committing more funds to improve state hospitals that yielded few long-term

for Texas State Hospitals and Special Schools Records, Box 2005/096-2. The report also provides the demographic information for each state hospital, special school, and mental health facility in the state. The total population of all state hospitals numbered 15,152. Among the largest state hospitals in Texas, Austin State Hospital held the largest population of 3,188 patients, followed by San Antonio State Hospitals which held 2,929, Wichita Falls State Hospital held 2,525, and Rusk State Hospital had 2,472, and finally Terrell State Hospital which held some 2,005 patients.

⁷⁶ Board for State Hospitals and Special Schools Statistical Information, 1950 “Admissions, Texas State Mental Hospitals, 1940-1949”, Texas Board for Texas State Hospitals and Special Schools Records, Box 2005/096-2.

⁷⁷ Board for State Hospitals and Special Schools Statistical Information, 1950, “Admissions, Texas State Mental Hospitals, 1940-1949”, Texas Board for Texas State Hospitals and Special Schools Records, Box 2005/096-2.

⁷⁸ Board for State Hospitals and Special Schools Statistical Information, 1950, “Comparison of the 9 Mental Hospitals According to the Classifications Listed in Column 1 as of Nov.1, 1949”, Texas Board for Texas State Hospitals and Special Schools Records, Box 2005/096-2; 57.8 percent of patients housed in all Texas mental health facilities were classified as continuous treatment cases. See, Board for State Hospitals and Special Schools Statistical Information, 1950, “Percentage of Patients of Nine Mental Hospitals” Texas Board for Texas State Hospitals and Special Schools Records, Box 2005/096-2.

results. The BTSHSS petitioned to allocate the \$600,000 Reserve Fund for state hospital use. In addition, they emphasized, “the care and treatment of the criminally insane,” and “a policy for immediate and long range care and treatment of seniles [sic] and custodial cases.”⁷⁹ The priorities outlined for the BTSHSS’s discussion with the Legislative Board shows the diversity in patient needs state hospitals sought to provide. Many of the patients outlined in the report, like senile and "custodial case" testifies to the dual expectations of hospitals that continued to beleaguer the state sponsored mental health care. The inability of the BTSHSS to create real change made reformers’ calls to overhaul the state mental health system more appealing.

Therefore, when BTSHSS pledged increasing sums of money for state hospital improvements, many concerned with mental health reform--including several board members--felt uneasy about the state’s ability to provide for the rising costs of state intuitions. In September 1953, the board reviewed the request for “urgent improvements” at various state institutions. The board then approved a total of \$155,000 dollars for improvement projects, and affirmed a \$1,957 bid for nurses’ station counters, as well as a buildings program totaling \$10,235,000, of which ASH received \$800,000 for a new Administrative Building to accommodate another 125 patients, and \$900,000 for a new men’s ward building which would house 375 additional patients.⁸⁰ One *Dallas Morning News* detailed the frustrations of the increasing costs of improving state hospitals and the lack of progress in reducing patient populations. “The \$35,000,000 seven year building

⁷⁹ Minutes, Meeting of Board for Texas State Hospitals and Special Schools, June 14, 1952. Texas Board for State Hospitals and Special Schools Records, Box 1998/147-1.

⁸⁰ Minutes, Meeting of Board for Texas State Hospitals and Special Schools September 19, 1953. Texas Board for State Hospitals and Special Schools Records. Box 1998/147-1.

program,” the author wrote, “is not keeping pace with demands for bed space.”⁸¹ Even though the BTSHSS and state hospital personnel generally sought to improve the care offered at state institutions, they found that simply improving upon the old state hospital system was not enough to enact a lasting change for mental health in Texas.

Out of this frustration, reformers turned to a new type of state hospital, one that psychiatric reformers asserted emphasized cooperation between communities and state psychiatric hospitals. One work that placed Austin State Hospital at the center of this debate surrounding the trajectory of state hospitals came from Ivan Belknap’s *Human Problems of a State Hospital*.⁸² Belknap, a medical sociologist who studied Texas mental hospitals, highlighted the various problems with centralized state institutions for the mentally ill. Published in 1956, the study compiled three years of Belknap’s own observations of ASH, and compared the hospital to similar institutions throughout the United States. The problems of state hospitals, he asserted, arose out of their “historical growth” as institutions that were “themselves obstacles in the development of an effective program for treatment of the mentally ill.”⁸³ Belknap viewed the problems of state hospitals as historical in origin, and used ASH as a case study to prove the necessity of adopting community-based mental health initiatives in Texas.

⁸¹ Dawson Duncan, “Hospital Space Problem Unsolved, Board Reports,” *The Dallas Morning News*, 8 January 1954.

⁸² In the original publication, Belknap refers to the hospital as “Southern State Mental Hospital at Millville” in order to protect the integrity of ASH and its faculty. However, both secondary sources and primary sources reveal that Southern State Mental Hospital does not exist, and sources agree that the hospital conducted in the study was ASH. See: Sarah Sitton, *Life at the Texas State Lunatic Asylum, 1857-1997* (College Station: Texas A&M University Press 1999), 6; Howard Freeman, “Human Problems of a State Mental Hospital/Diagnosing Human Relations in Organizations: A Case Study of a Hospital.” *American Sociological Review* 22, no. 3 (June 1957): 351-352.

⁸³ Ivan Belknap, xi.

Belknap openly called for the creation of a community mental health program in Texas, citing ASH as an example as why mental health reform had to abandon the centralized state hospital model. Belknap admitted that improvements had been made in state hospitals in general, both in their treatment of patients and in providing better facilities. But, he also pointed out that part of state hospitals' inability to provide a cure for patients stemmed from a lack of scientific knowledge regarding severe mental illnesses. From his perspective, demands placed on state hospitals to cure and release patients were never realistic. The largest problems for state hospitals, for Belknap, derived from "the evolution of state care," which "has certainly not involved cumulative improvements, one upon another." Instead, Belknap described an evolution of state hospitals that looked, "more like a process of incoherent patchwork, interspersed with alternating periods of improvement and decay."⁸⁴ Successful treatment of mental health reform had been consistently undermined by public apathy, political manipulation, a lack of funds, and personnel shortages.⁸⁵ The custodial function of state hospitals, he asserted, remained directly incompatible with treatment because "Hospitalization was regarded as an end in itself," and few saw a need to incorporate positive forms of therapy.⁸⁶ Belknap's arguments made clear to mental health reformers that state hospitals could never provide adequate treatments for mental illness, and encouraged reformers to explore alternative solutions.

At Austin State Hospital, Belknap noted three problems of Texas State Hospitals that remained consistent through the institutions history: a lack of building space, the

⁸⁴ Ivan Belknap, 12-14

⁸⁵ Ibid.

⁸⁶ Ibid., 18.

administration's organization, and personnel.⁸⁷ His assertion corroborated evidence in the Public Health Service Reports, the BTSHSS minutes, and the Executive Staff Minutes of ASH. In each, lack of ample space and funding for hospitals, and the shockingly high doctor to patient ratios, created the biggest dilemmas. ASH treated these deficiencies, Belknap asserted, "as if they were merely temporary disturbances in an otherwise ordered system."⁸⁸ Consequently, an unofficial policy developed in Texas state hospitals whereby administrators would resort to "putting off" dealing with major issues or providing temporary fixes to hospitals' organization until problems became so great that the administration and state legislature were forced to face them. Belknap also showed that the organization of the hospital centered less on medical treatment and more on custodial asylum, and described ASH "as a modernized more humane custodial asylum."⁸⁹ Belknap's study proved that the hospital was, in fact, designed to care for patients in the long term, despite the demands of the public and the goals of the mental health field to treat and release patients. He thus asserted that mental health reform in Texas should adopt the new methods of community based care that promised more effective treatments.

Belknap's work significantly highlighted the treatment of patients, questioning the therapies used at ASH and the effectiveness of the hospital's programs, and further brought the inefficiencies of the state hospital system to the surface of state hospital reform. He reported that about 49 percent of cases admitted to ASH were furloughed or discharged within a year, and asserted that many patients were not in need of custodial

⁸⁷ Ivan Belknap, *Human Problems of a State Mental Hospital*, 27.

⁸⁸ *Ibid.*, 54

⁸⁹ *Ibid.*

care. Those people that remained longer than a year had an increasing chance of being transferred to one of the “wards of final destination.”⁹⁰ Patients that became permanent wards of the state hospital, of which ASH held some 1,700, generally fell into four different diagnoses: schizophrenia, psychosis with cerebral arteriosclerosis, senile psychoses, and psychotic disorders associated with mental deficiencies. Of these patients Belknap distinguished between “hopeless cases” and “institutional cures,” or those patients who remained healthy so long as they remained under the constant care and supervision of the hospital.⁹¹ Belknap's study told that ASH, as a case study of state hospitals in general, provided care for their patients, but that the institution also created and perpetuated the problems it faced. This realization caused many mental health reformers in Texas to view community-based mental health reforms as necessary to fulfilling the goals of mental health reform.

ASH executive meeting notes reinforce many of Belknap’s assertions about ASH. At a meeting held November 13, 1958, Dr. Sedberry, a chief psychiatrist at Austin State Hospital, discussed the need to spread out patients across Wards A, B, G, H, and F because, “C- D & E are always overcrowded.”⁹² In the minutes from November 19, 1958, the executive staff discussed the problems of Austin State Hospital’s high admission, stating, “The figures shown reveal that [Austin State Hospital has] the highest percentage of admissions as compared with other institutions.”⁹³ Controlling patients in such crowded conditions often proved difficult. In a meeting held on October 29, 1958, the

⁹⁰ Ivan Belknap, *Human Problems of a State Mental Hospital*, 59.

⁹¹ *Ibid.*

⁹² Minutes of Executive Staff November 13, 1958, Box 1, Folder “Executive Staff Meeting Minutes,” Sarah Sitton Papers, Austin History Center.

⁹³ Minutes of Executive Staff November 19, 1958, Box 1, Folder “Executive Staff Meeting Minutes.”

executive staff discussed the problems of patients climbing on the roof of hospital buildings. To curb patients' excursions to the hospital's roof, the staff suggested, "some sort of protective shields... under the roof," or "plow shears... cut in half and placed on the top of the posts," or as suggested by Superintendent Dr. Hoerster suggested, the use of "grease paint might be another solution."⁹⁴ The executive staff, stretched thin with not enough resources, focused on maintaining control over patients and regulating their behavior. Yet, staff's ability to control patient populations had its limits, and the hospital's staff only acted in reaction to tragedy instead of providing treatments to prevent it. At the conclusion of the staff's meeting in November 5, 1959 the staff discussed a patient suicide. The patient "used a spoon to cut his wrists." Dr. Hoerster's response was short and logical; "attendants should pick up the silverware while patients are still seated... to make sure that all silverware has been collected before patients leave."⁹⁵ Underfunded and overburdened, ASH's main concern was to keep patients safe rather than provide them with effective treatments.

Belknap concluded that, in order to become efficient treatment centers, mental hospitals had to shed their custodial role. To do so, Belknap pointed to the patients' community as a resource, where the care of a patient would fall under the responsibility of the family. "From the time of its foundation the hospital has defined as an institution which must carry out two contradictory... and unrelated functions," Belknap concluded. "One... of treating the mentally ill. The other... of serving as a more efficient poor

⁹⁴ Minutes of Executive Staff October 29, 1958, Box 1, Folder "Executive Staff Meeting Minutes, 1958-1959," Sarah Sitton Papers, Austin History Center.

⁹⁵ Minutes of Executive Staff November 5, 1959, box 1, folder "Executive Staff Meeting Minutes, 1958-1959."

farm.”⁹⁶ To remedy state hospitals’ contradictory goals, Belknap advocated for community-based model of mental healthcare. Belknap defined the community-based model as “involving treatment in the community environment of the patient, with hospitalization reduced to a phase, rather than a center for treatment.”⁹⁷ Belknap’s assertions targeted ASH as a prime location where reformers could experiment with community-based mental health reform.

Belknap offered an alternative that allowed community-based mental health programs to proliferate without requiring states to build their mental health infrastructure anew. He envisioned a mental health organization that would be “kept in local communities” and should be “financed jointly by state and community.” These organizations would be “under... the control of a central state commission for mental health.”⁹⁸ These hospitals that he called “decentralized hospitals” would then be rid of providing custodial care. “Family, visiting-nurse, and foster-home care in the locality,” Belknap asserted would replace “much of the present ward care.” He also believed that those patients who were not in need of psychiatric care but required additional living assistance should be treated in their communities as well under the responsibilities of “Old Age Assistance, Old Age and Survivors Insurance, and Federal rehabilitation programs.”⁹⁹ Belknap thus offered an alternative that re-envisioned state hospitals as offering services that complimented community mental health services, and made community mental health reforms feasible.

⁹⁶ Ivan Belknap, *Human Problems of a State Mental Hospital*, 204.

⁹⁷ *Ibid.*, 205-208.

⁹⁸ *Ibid.*, 212-213

⁹⁹ *Ibid.*

Belknap's thesis was part of a growing mental health reform movement that accepted community mental health care as a viable alternative to mental hospitals. One sociological review wrote of Belknap's argument in 1957, "many observers will agree with the author that overgrown state hospitals are the chief obstacle in the progress toward mental health today."¹⁰⁰ *Human Problems of a State Hospital* reached the ears of those concerned with state hospitals in Texas. In *The Dallas Morning News*, one author suggested that "few books are in need of a wide market as much as this one."¹⁰¹ Belknap's alternatives appeared ever more plausible as greater numbers of reformers accepted community mental health as their shared goal.

The changes in mental health policies were also made known to the public. One newspaper report in 1962 detailed the Texas' strategy for long-term mental health reform. The directors of the Texas Association for Mental Health recommended a plan focused on establishing preventative care, rehabilitation, and out-patient programs in local communities. The article recommended that the state legislature prepare "a community mental health act in Texas... so that community services for the mentally ill be developed," and coordinated by the state.¹⁰² Thus by the early 1960s, mental health reform in Texas shifted away from centralized state hospitals, as well as an optimistic belief that communities would provide the necessary support for the mentally ill that state hospitals could not.

State officials, equally frustrated with state hospitals, aligned with reformers' shared purpose of community-based mental health. Governor Connally, JFK's political

¹⁰⁰Raymond W. Murray, "Human Problems of a State Mental Hospital," *American Catholic Sociological Review* 18, no. 2 (June 1957): 180.

¹⁰¹ William B. Ruggles, "Book that Needs Big Market," *Dallas Morning News*, 22 April, 1957.

¹⁰² "Coordination of Services for Mental Health Urged," *Dallas Morning News*, 1 August, 1962.

ally in Texas, echoed the federal government's endorsement for community mental health centers. In 1965, Connally recommended an increase in the State of Texas' budget by \$254 million to sponsor state social services, including mental health reform.¹⁰³ Connally, "urged social and welfare agencies," like mental hospitals, "to find a positive approach to Texas' biggest problems." He argued for the use of "imaginative, relentless research' in a complex of social ills, most of which contribute to a chain reaction effect," that affect other social problems, such as crime, education, health, and mental illness.¹⁰⁴ "There is no limit to what we can achieve in physical, social and mental health through research and its proper application," Connally told newspapers in 1963.¹⁰⁵ The large expansion of state support for social programs led by Governor Connally provided community mental health advocates with the financial and political support necessary to begin experimenting with locally-based mental health practices, and allowed reformers to lay the foundations of a new model for state-sponsored mental health.

Mental hospitals played a part in these new reforms by focusing their attentions on community involvement in mental health treatments. ASH served as a leading state hospital, and, under the leadership of Superintendent Dr. Sam A. Hoerster, worked towards reformers' goals of a decentralized, community based mental health system. The *Austin American Statesman* touted ASH as "one of the state-owned psychiatric in the nation," and "no doubt the showplace of Texas institutions from every angle."¹⁰⁶ ASH embraced the "new aspect of mental health" by instituting new psychiatric training that

¹⁰³ Brian McCall, *Power of the Texas Governor: Connally to Bush* (Austin: University of Texas Press: 2009), 19.

¹⁰⁴ Lorraine Barnes, "Governor's Social Goal Gets Praise," *The Austin Statesman*, 17 January, 1963.

¹⁰⁵ Lorraine Barnes, "Governor's Social Goal Gets Praise."

¹⁰⁶ Al Williams, "He Worked for Patients," *The Austin Statesman*, Dec 28, 1964.

transformed the hospital into “a place where someone could send their loved one and expect to get them back after successful treatment.”¹⁰⁷ ASH achieved these improvements through additional funding, staff training, and by relying “on the resources of the community to boost treatment.”¹⁰⁸ ASH became a leader in local mental health treatments and reform through the renewed commitment to mental health instigated by the community mental health reformers.

The growth of community mental health reforms largely reflects national trends. Reformers recognized the need to address the state hospital crisis in Texas, but the inability of state hospitals to shed their custodial roles caused many reformers to turn to alternative forms of mental health treatments out of frustration. Faced with the seemingly endless rising costs of improving mental hospitals, the Texas government turned to reformers and their shared sense of purpose for an answer to its state hospital woes. With the reformers common cause, and the support of both state and federal governments, community mental health became the objective for reformers in Texas. However, Belknap’s study and ASH’s ability to focus its efforts on community-based treatments created space for state hospitals in the community mental health reform movement and set an example for hospitals across the state.

Conclusion

The continued crisis of state hospitals led to a rising need to address the United States’ failing mental health system as a public concern. A broad number of people expressed this concern, which forged a broad call for the need to address the crisis in state hospitals. The inability to incur change within state hospital systems led to growing

¹⁰⁷Al Williams, “He Worked for Patients,” *The Austin Statesman*, Dec 28, 1964.

¹⁰⁸Al Williams, “He Worked for Patients.”

frustration with centralized models for mental health care, and reformers' common cause became a shared purpose to seek alternative models of mental health treatments. The shared sense of crisis and need for a solution to the problems of state hospitals became a shared sense of purpose as reformers began identified community-based alternatives as imperative for mental health reform.

ASH, as a hospital that was imperfect but functional and as one that mirrored trends in state hospitals nationally, provides a glimpse into how mental health reformers' forged their shared sense of purpose at a local level. ASH served as a good representation of the conditions of state hospitals, which allowed reformers to expose the inherent flaws in mental institutions. By pointing out these flaws, reformers like Ivan Belknap argued for the necessity of community mental health reforms. The shared goals of reformers in Texas coalesced around community-based alternatives as reformers proved that state hospitals were inherently flawed in their design as both custodial and treatment centers, and that the community served as the most plausible alternative to centralized state hospitals.

III. THE GROWTH OF COMMUNITY MENTAL HEALTH CENTER REFORMS AND RESISTANCE IN THE 1960S

Historians have generally analyzed the rise and fall of twentieth-century American liberalism by focusing on the ways that individualistic notions of citizenship affected society by examining the past through race, gender, and class condition, access to political power and economic opportunity. They have shown how Americans debated the role of government in everyday life in a wide variety of institutional settings, including public schools, prisons, housing, workplaces, and many more. Few, however, have examined what the longer arc of American liberalism, and the rise of late-twentieth-century conservatism, meant for mental health care. When they have examined the changing dynamics of the nation's mental health systems in the last half-century, scholars have tended to focus narrowly on the process known as 'deinstitutionalization.' The main actors tend to be budget-conscious and anti-government officials in the late 1970s and 1980s. As the relatively unknown history of mental health care reform in Texas shows, however, the movement for community-based government-funded mental health reform both complements and sheds new light on the broader history of American liberalism. The political wrangling over reform not only predated the conflicts over deinstitutionalization, the earlier battles were deeply revealing about the changing nature of individual opportunity and the role of the government in citizens' lives during the 1960s.

Commitment to community mental health centers as part of postwar mental health reform in Texas reached its zenith in the early 1960s during what can be seen as the high point of American liberalism. After World War II, according to historian Ira Katznelson,

the growth and evolution of the federal government “proceeded in circumstances of reoccurring and escalating emergency without the benefit of an established starting point and without a fixed repertoire of public policies that were effective and legitimate.”¹⁰⁹ However, postwar liberals could “draw on a wide array of options developed by policy intellectuals...who sought to invent alternatives... in an insufficient status quo.”¹¹⁰ In the context of community mental health reforms, this meant that a wide variety of Americans perceived both a crisis in the dominant model of psychiatric mental health care at the time *and* the possibility to address that crisis by using federal power to reinvigorate psychiatric care at the community level. World War II marked an important turning point in the history of psychiatry, as many public observers and experts came to believe that psychiatric methods could help solve the grand problems of mass society. By the 1960s, a wide range of credentialed experts inside government and out had concluded that decentralization of mental health care could resolve the “stockpiling of patients” that was impinging upon patient freedom and limiting the effectiveness of large-scale hospitals as those crises has been identified in the 1950s. The top-down push for decentralization of the health care system thus fits squarely within the larger narrative of postwar liberal reform politics.

Mental health reform, which relied heavily at first on psychiatrists’ intellectual expertise, was countered on many different sides in the 1960s. The 1960s serves as the peak of government involvement and psychiatric expertise understood as a common societal purpose. However, even as psychiatric influence reached its apex in mental

¹⁰⁹ Ira Katznelson, *Fear Itself: The New Deal and the Origins of Our Time* (New York: Liveright Publishers 2013), 48.

¹¹⁰ Ira Katznelson, 48.

health reform, many including the general public, psychiatrists, and state officials questioned reformers' power. The challenges to psychiatric influence grew as reformers debated the purpose of reforms, as the changes to mental health reform required increasing funds from the state, and as the lack of protection for patients' civil liberties in psychiatric commitments became the subject of public concern. Time and time again, confidence in community-based models of mental health reform was undermined, even as reformers sought strengthen their ability to revolutionize mental health care.

The growing tensions between reformers and those who challenged their efforts converged in one unusual sanity hearing of Dr. Wendell Thrower in 1963. One of Texas's most sensationalized sanity hearings, Dr. Thrower's case, revealed the mounting pressures beneath the surface of mental health reform. Those contentions included fears regarding psychiatrists' growing power as agents of state mental health reform, a rejection of elite specialists and their growing role in everyday life, and anxieties regarding the ambiguous nature of psychiatric definitions. At the heart of these anxieties lay the contested ground between individual liberties and psychiatric authority, which came to dominate discussions of mental health reform and undermined the shared sense of purpose that reformers relied upon.

These debates over the methods, purposes, and control of mental health care were exacerbated by the increasingly limited access to state funding and political commitment. Though at first federal and state governments committed substantial resources to reform, funding waned over time, especially as the costs of community mental health reform grew to higher levels than originally expected. Reformers, whose shared visions were generally supported by the public, state officials, and mental health professionals in the

early 1960s, struggled to maintain a cohesive effort from a broad coalition of supporters by the end of the decade. Together, then, wide ranging questions about the nature of mental health care combined with limited access to funding caused the bonds that sustained mental health reform to fragment.

The zenith of reformers' power, and the resulting fragmentation of that common purpose, took shape in political conflicts over how to manage the local, state, and federal governmental collaboration that would make community mental health reform feasible. Politics further disrupted reform efforts as some people came to question the extensive investment of federal resources for community mental health centers in independent and dynamic local settings. And, at the same time, a push from a new patient rights movement called into question the overweening power of psychiatrists, as reform-minded psychiatric experts, along with patients and their allies, sought to address longstanding problems associated with mental health. The community mental health movement arose out of a rejection of the traditional model of centralized state mental hospitals and focused on expanded federal support for a new kind of community involvement in the care of people with mental illness. However, reformers' reliance on state resources and expert authority prompted questions from both a new right and a new left about the role of the state and expertise in mental health care. Thus did the once bold commitment to using federal resources to empower community-based mental health care fragment along unpredictable lines.

In Texas, which largely followed national trends of mental health reform, activists in the early 1960s had come to believe that community health centers provided the answers to the problems that had long challenged mental hospitals. Texas quickly

embraced the objectives of community-centered reforms and made great strides in establishing local mental health facilities, so much so that the Board of Mental Health and Mental Retardation (MHMR) claimed Texas as a national leader in mental health reform.¹¹¹ More funding for care at more flexible institutions promised to be more efficient, more just, and more effective. The federally funded, state coordinated effort between community mental health centers and Austin State Hospital (ASH), for instance, made substantial headway in reducing patient populations and created strange alliances in Texas for more effective health care between psychiatrists, government officials, and the public in favor of local treatment centers.

Though many reformers shared a common sense of purpose throughout the 1960s, community mental health reforms also led to a growing resistance against psychiatric power and state authority. As the power of psychiatrists and government officials grew stronger, many felt uneasy about how much power psychiatrists wielded, especially as government influence increased in mental health reform. Resistance also formed as community mental health care costs continued to grow. The expanding needs of community mental health centers coincided with declining commitment from Texas legislators to funding those centers, leading to growing tensions between reformers who fought for more access to a shrinking funding pool. Furthermore, the exact nature of community mental health centers remained contested as professionals argued over the role of mental hospitals in the reform, and as a new patient rights movement challenged the experts' model of community mental institutions. By the late 1960s and early

¹¹¹ The Texas Department of Mental Health and Mental Retardation 1969 Annual Report, 30, Folder Mental Health and Mental Retardation, Gov. Preston Smith Records, Box 1994/120-3, Texas State Library and Archives Commission, Austin, TX.

1970s—well before the more familiar process of “deinstitutionalization” was underway—the once strong and diverse support for government-funded community based mental health care had already begun to fragment.

The Peak of the Community Mental Health Reform Effort

By the beginning of the 1960s, the community mental health movement had gained substantial support from psychiatrists and sociologists. Ivan Belknap, for instance, used his position as a medical sociologist to study Texas mental hospitals in the late 1950s and argue that the problem mental hospitals faced in providing medical treatment for mental illness grew out of the institutions’ two contradictory ideals. Mental hospitals sought to provide short-term treatments to mentally ill people, while at the same time serving as custodial institutions where “indigent” persons could be kept away from “normal” society.¹¹² Many professionals agreed with Belknap’s assertions and argued for the need to reform mental hospitals by creating community-focused alternatives to mental hospitals.

Momentum for reform built in the late 1950s and led to the push for centrally-funded, but geographically dispersed and administratively independent community-based mental health facilities as an alternative to centralized mental hospitals. In theory, community based centers would operate in a way that would make state hospitals all but obsolete. Community-based reforms grew out of the widely held view that many patients residing in state hospitals did not require custodial care, and that state hospitals warehoused people who had the potential to be productive citizens. Reformers believed that they could use their expertise to liberate mentally ill persons from hospitals and

¹¹² Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: McGraw-Hill Book Company, 1956), xi.

provide more effective treatments. Community-based centers would focus on providing outpatient therapy and preventive care that encouraged what reformers defined as good mental health. This method promised to drastically reduce patient populations in state hospitals and provide better care to patients without isolating them in mental hospitals. In order for reformers' shared goals to become a reality, they had to combat the existing stigma of mental illness in public opinion, secure political support and funding, define the relationships between the State of Texas and psychiatrists in local communities, and mediate with existing mental hospitals.¹¹³

A major turning point for the reform movement came in 1960 with the election of President John F. Kennedy. As Kennedy knew from firsthand experience, the mental health system held immense power to shape the lives of patients like his mentally handicapped sister, Rosemary Kennedy.¹¹⁴ President Kennedy thus pushed through the key act that solidified federal support for mental health reform, the Community Mental Healthcare Act of 1963 as part of his "New Frontier" legislation. Contemporaries understood Kennedy's backing for community-based care as "the centerpiece" of a plan "for bringing the mentally ill back to a useful life, and preventing new cases [of mental illness] earlier." Such observers expected community mental health centers to allow patients to receive treatments while acting as productive, "useful" members of society.¹¹⁵ The notion that community centers could make mentally ill persons productive members

¹¹³ The various goals of community mental health reform provide an excellent representation of postwar liberal policy because they offered pluralistic and tolerant solutions to a crisis that focused on individual liberties and relied on the significance of state power to make progress.

¹¹⁴ Edward D. Berkowitz, "The Politics of Mental Retardation During the Kennedy Administration," *The Social Science Quarterly* 61 no. 1 (June 1980): 128; The efforts of mental retardation reformers should not be viewed as the same as mental health reformers, and Berkowitz elaborates in greater detail the division between mental health and mental retardation reform that came to exist under the same umbrella of federal programs out of a need to consolidate funding for both movements.

¹¹⁵ "JFK Asks Funds for Mental Health," *The Austin American*, February 5, 1963.

of their communities remained a central theme in the community mental health movement that unified reformers.

The increased federal commitment to mental health reforms provided the grounds that made it possible to turn psychiatrists' theoretical rethinking of mental health care into practical reform. Kennedy promised that at least half of the patient population in the nation's state hospitals would be released into society if mental health care followed the community care reform.¹¹⁶ The president's plan also made the federal government key to the implementation of the community mental health center reforms by granting substantial federal funds to state organizations, promising to subsidize up to 75 percent of states' costs in establishing community centers for the first year, with diminishing funds for the following four years.¹¹⁷ The substantial increase in federal support created an environment that made large-scale experimentation possible through mental health professionals who largely shared similar visions of community based mental healthcare.

Most reformers believed that local communities could support mental health centers with federal government aid, and increasingly they turned to federal funding to compensate for the deficiencies of local resources. The 1963 Mental Health and Mental Retardation Bill authorized up to \$230 million for the construction of mental health centers between 1965 and 1968. The act promised state governments grants of \$150 million to aid in the construction of mental health centers over three years, as well as \$26 million in grants for additional mental retardation research centers, \$32.5 million for research and treatment facilities working in connection with universities, \$67.5 million in grants for over four years for the construction of mental retardation treatment centers, \$53

¹¹⁶ "JFK Asks Funds for Mental Health."

¹¹⁷ Ibid.

million over three years for specialized training for teachers working with mentally impaired children and research for the education of mentally handicapped children.¹¹⁸ Texas received \$30 million to construct and staff community facilities through 1965.¹¹⁹ Whereas mental health had previously been considered a local or state issue, the federal government became a major factor in shaping mental health policy and provided key funds that made the shared purpose of community mental health reforms possible.

In addition to federal funds, pharmaceutical advancements also made treatments in community centers more feasible than they had ever been previously. Advocates for the new centers hoped that new antipsychotic medications, such as Thorazine, could make rehabilitation of severely mentally ill persons possible. New “methods of treatment and tranquilizers,” doctors expected, would “reduce treatment time to weeks or months,” and “be paid for as any other hospital or medical cost.”¹²⁰ The advent of Thorazine helped forge reformers’ common goals because it allowed reformers to imagine for the first time a mental health system in which patients could be treated from their communities through new medical treatments.

Community Mental Health Reforms in Texas

Local Austin newspaper reports reveal the sense of purpose that federal mental health legislation fostered in communities during the 1960s. In October 1964, one year

¹¹⁸ “Law Assists in Care of Mentally Ill,” *The Austin Statesmen*, December 23, 1963.

¹¹⁹ Chris Whitcraft, “Amendment Holds Health Plan’s Key,” *The Austin American*, August 8, 1964.

¹²⁰ “JFK Asks Funds for Mental Health,” *The Austin American*, February 3, 1963, ProQuest.com; The reference to “tranquilizers” refers to phenothiazine, a horse tranquilizer, that had since the 1950s been used to treat psychosis in patients. Though phenothiazine were more effective than previous treatments for severe mental illnesses, they would not yield the cure to mental illnesses, such as schizophrenia, that many had hoped. For more information on the history of psychotropic medications, see Matthew Hirsch, “‘Calm But Still Alert:’ Marketing Stelazine to a Disturbed America. 1958-1980,” *Pharmacy in History* 50 no. 4 (2008): 140-148.

after Kennedy passed the Mental Retardation and Community Mental Health Centers Act of 1963, the State of Texas began its plans to overhaul its mental health treatment programs. Dr. Moody C. Bettis, a psychiatrist and coordinator for the office of Mental Health Planning, told the Austin chapter of the American Society for Public Administration that, as one reporter put it, “Community mental health centers can wipe out one of man’s cruelest experiences, living under the anti-social stigma of having been in a mental hospital.”¹²¹ Though he was optimistic regarding the ability to cure mental illness, Dr. Bettis was less certain about government support for the project. He warned that state legislators could be fickle, perhaps undermining support for the reforms after construction of community centers began. Reformers like Bettis were well aware that the political and economic contexts could shift at any moment, changing the direction of reform.¹²² Bettis knew the community mental healthcare movement faced significant resistance. For the time being, though, there was a significant level of determination and unity of purpose among reformers as they pursued their efforts to establish a viable alternative to mental hospitals.

Reform of mental health care and the push for community-based care centers in the 1960s rested on the power of expertise to institute change. Like Bettis, many psychiatrists believed that mental illness should be treated as a medical condition without stigma. Bettis encapsulated the common belief amongst psychiatrists that mental illness stemmed from an individual’s “failure to adapt,” and that patient should not be “shipped to a hospital for removal.”¹²³ These professional beliefs reinforced the perception that

¹²¹ Chris Witcraft, “Community Centers Said Best Answer,” *The Austin American*, November 1, 1964.

¹²² Chris Witcraft, “Community Centers Said Best Answer.”

¹²³ Chris Witcraft, “Community Centers Said Best Answer.”

“the community” held the potential to nurse a person back to “good health.” Reformers in the 1960s, like their counterparts in mental hospitals, similarly felt they held the knowledge and authority to “fix” the problem of mental illness, and placed much of the power of community mental health centers in the hands of experts. Expert opinion exerted heavy influence over the trajectory of community mental health reforms and helped rationalize both their shared sense of purpose as well as their power in the community mental health center movement.

The shared purpose of community mental health reform became a statewide mission in 1965 when, under the guidance of Governor John Connolly, Texas created its own community mental health plan to work in conjunction with federal funds. The Texas Plan for Mental Health Services emphasized the need to rely on community resources for the state’s future mental health policy. The plan suggested that communities should receive state and federal funds in order to build their own comprehensive mental health centers.¹²⁴ This latest plan for mental health reform proposed twenty-one community centers to serve areas with populations ranging from 136,000 to 1,650,000 people.¹²⁵ The commitment to reform from state and federal government officials placed the goals of community mental health reform in sight and added to the reformers’ sense of common purpose.

The Role of the ASH in Clearing the Path to Community Mental Health Reform

Austin State Hospital won praise for its forward thinking programs, and thus hospital administrators shared a sense of purpose with reformers. At the outset of the

¹²⁴ “Mental Health Plan Up,” *The Austin Statesman*, January 18, 1965.

¹²⁵ Chris Whitcraft, “TREATMENT: Survey Shows Mental Health Centers Needed in 21 Texas Cities,” *The Austin American*, September 13, 1964.

decade, many in Austin had been proud of the city's mental hospital precisely because it was ahead of its time in moving away from institutionalization. In 1960, *The Austin American* celebrated ASH for its outpatient clinic, which allowed patients to “to meet their everyday problems and continue to work and live in familiar surroundings.”¹²⁶ The basic concept behind the program was to provide treatment for patients without requiring hospitalization.¹²⁷ The BTSHSS praised success of such programs in their 1961 Annual Report. “There should not be any difficulty in appreciating the fact that...patients...seen at these [outpatient] clinics...have continued to adjust their communities,” the report stated, adding that these patients “would have otherwise contributed to increase the already overcrowded population of the mental hospital.” The BTSHSS also noted the programs provided “obvious economic saving for the state.”¹²⁸ The outpatient programs strove to achieve similar goals as community mental health programs and allowed some reformers to see a role for ASH in the new community-based reform movement.

In effect, ASH had already begun to weave a network of relationships that resembled the community-oriented mental health system that reformers sought. ASH served a twenty-six county district with a population of over two million, which stretched from Waco in north-central Texas 185 miles to the southeast in Houston.¹²⁹ Managing the hospital's rated bed capacity of 2,608 and average daily census of 2,979, could only be possible with support from general hospitals, local communities, and private mental

¹²⁶ Al Williams, “Benefits Brought to Many by State's Outpatient Clinic,” *The Austin American*, April 10, 1960.

¹²⁷ Al Williams, “Benefits Brought to Many by State's Outpatient Clinic.”

¹²⁸ The Board for Texas State Hospitals and Special Schools, Annual Report to the State of Texas for Fiscal Year September 1, 1960-August 31, 1961, B-1 and B-2, Austin State Hospital Library.

¹²⁹ Texas Legislative Council, “Care of Court-Committed Mentally Ill Prior to State Hospital Admission,” A Report to the 58th Legislature no. 57-6, Austin, TX, December, 1962, 53.

healthcare institutions.¹³⁰ In Austin, three other hospitals provided care for patients pending admission to state or federal hospitals. Brackenridge Hospital had a rated bed capacity at 271. St. David's Community Hospital had 124 beds. And the private mental hospital, Oak Ridge Sanitarium, could serve 36 patients.¹³¹ Furthermore, the Austin State Hospital District served several more urban counties that generally provided diverse solutions for patient treatment. Residents of Harris County, within ASH's district, had access to seven psychiatric facilities where patients could be treated temporarily. Residents of Waco and Temple could also find psychiatric treatment through federal hospitals via the Veterans Administration.¹³² In total, Austin State Hospital could rely on seventeen other psychiatric facilities to provide temporary treatment or custodial care for court-ordered patients.¹³³ The hospital's relationship with the surrounding communities earned ASH a reputation as a progressive institution that embraced the same goals as community mental health reformers.

ASH's reputation for public transparency also aligned the hospitals' purpose with community mental health reformers. In March 1960, ASH held an open house as a part of its participation in Mental Health Week. The open house displayed a "cross section" of the hospital to visitors between 1:00 and 4:00, when the public could tour select wards, meet hospital staff, and witness "a demonstration of the electroencephalograph, surgical clinics, dentistry department, admission and intensive treatment units, and administration section."¹³⁴ Key aspects of the hospital's cutting-edge medical programs amazed local

¹³⁰ Texas Legislative Council, "Care of Court-Committed Mentally Ill Prior to State Hospital Admission," 53.

¹³¹ *Ibid.*

¹³² *Ibid.*

¹³³ *Ibid.*

¹³⁴ "ASH Holds Open House 1-4 Today," *The Austin American*, May 1, 1960.

visitors. The open house also made an effort to address some of the controversial treatments, like electroshock therapy, by having resident physician Dr. Ferrell Hillman explain the treatments and answer questions.¹³⁵ By providing a degree of transparency through public interactions, ASH staff could portray the hospital as orderly and clean, and as one that operated using the latest technologies with highly professional staff.

Administrators sought to use the open house to reduce the public stigma towards mental hospitals, and they had some success. The press covered the details of the open house and sang the praises of ASH. One reporter noted, “Modern facilities to house patients have appreciably reduced ‘disturbed’ behavior and property damage, especially in ‘chronic’ patients.”¹³⁶ ASH administrators claimed to use the newest technologies alongside the most effective treatments, and to avoid hospitalization whenever possible. “The three-minute cure for mental illness is still quite distant,” one report concluded, “but the public can see what is being done to effect cure.”¹³⁷ The depiction of ASH countered common stereotypes of mental hospitals in the mid-twentieth century. Austinites in the early 1960s saw ASH as a state hospital that was successfully meeting the needs of the growing numbers of patients in its wards, and that was avoiding locking people up at all costs. These perceptions of ASH reinforced the authority of psychiatric experts and the common purpose of mental health reform by providing an example of what a “good” state hospital looked like. To most people in the 1960s, it appeared much like ASH portrayed itself: clean, efficient, transparent, focused on patient release, and to a significant degree even decentralized.

¹³⁵ “Austin State Hospital Open House on Sunday,” *The Austin Statesmen*, April 27, 1960.

¹³⁶ “Attitudes on Mental Hospitals Die Slowly,” *The Austin Statesmen*, May 5, 1960.

¹³⁷ “Attitudes on Mental Hospitals Die Slowly.”

ASH's good relationship with local volunteers illustrates how common purpose of mental health reform existed between the hospital and the community. Paula Womack, Volunteer Coordinator at ASH in the early 1960s, celebrated the positive relationship between the hospital and the community. She conveyed her gratitude and appreciation toward the *Austin American's* coverage of ASH's successful programs in both its education and treatment programs. "Much credit for the public's change of attitude towards mental illness," she wrote, "is due to your paper's interpretation of our treatment and training programs here at Austin State Hospital." Womack revealed a relationship of trust between the public ASH staff that provides another layer to the perceived common purpose of mental health reforms in the 1960s. Womack concluded, "Your willingness to help us acquaint with our needs and our accomplishments is greatly appreciated by our entire staff."¹³⁸ ASH's ability to convince the public of its important role in mental health treatments occurred through the hospital's commitment to continued improvement in care for its patients, which fostered common goals of mental health reform between the public and the hospital.

ASH's efforts to build a positive image continued throughout the 1960s and connected the hospital to the common mission of facilitating mental health reform in the community. In June 1963, ASH superintendent Dr. Sam A. Hoerster used media to provide the public with a glimpse into life within the wards of ASH. In one newspaper report, Betty MacNabb, a reporter from *The Austin American*, depicted patients with severe mental and physical illness, people too ill to care for themselves on their own and described to her readers the necessity of state hospitals. Her story made clear to readers

¹³⁸ Paula Womack, "Change of Attitude," *The Austin American*, January 28, 1962.

that the medical care and personal relationships the hospital offered meant a great deal to those people who likely could not survive without ASH care. One patient, for example, did not know the year or where he was living, and suffered from advanced stages of lung cancer. Dr. Hoerster told MacNabb that the hospital “can do nothing for him” and the patient had but two weeks to live.¹³⁹ Readers also learned of an elderly female patient who had previously been released from ASH into her daughter’s custody, only to return after her mental illness resurfaced. ASH staff suggested that the woman would likely receive better care in a nursing home, which showed an attempt to provide the best care for her as well as reduce the number of patients in need of custodial care. When stories like MacNabb’s surfaced in local newspapers, they likely created sympathy for patients and personalized their lives to public readers. Such patient stories also explained to the public the reasons why mental hospitals were still needed, the importance of the care that they offered, and connected ASH to the shared purpose of mental health reform.

In the early 1960s, a profound sense of shared purpose permeated the community mental health movement. Psychiatrists genuinely felt that their expertise would build a new mental health system that would allow patients to remain in their communities and continue their lives as normal citizens. Government officials supported psychiatrists’ efforts by providing funding and support for reforms, generally through large sums of money supported by the federal government that made psychiatrists’ agenda possible. And many in the public came to believe that mental health reforms were in the best interests of their communities. These shared interests created a common purpose between

¹³⁹ Betty MacNabb, “State Hospital: A Point of Return.” *The Austin American*, June 27, 1963.

these groups that increased the momentum for further improvements in the mental health system.

Dr. Wendell Thrower's Sanity Hearing

Advocates for community mental health reform won support for their vision of the best alternative to mental hospital care. At the same time, however, questions about psychiatric expertise grew. Confidence in psychiatric expertise wore thin as the public became increasingly aware of the subjective nature of psychiatric definitions. The subjective nature of psychiatry created especially intense controversy in debates over court ordered commitments under which a person could be forced into treatment, usually through a local judge or official. In Texas, the commitment process occurred through a sanity hearing, in which a jury determined a person's sanity before deciding whether to commit them to a mental hospital. The commitment process raised public anxiety because of the ambiguous nature of psychiatric definitions and the unchecked power psychiatrists wielded in the commitment process. The subjective nature of psychiatric diagnoses and the lack of individual rights in the commitment process became an increasing public criticism of psychiatry and state institutions. In time, growing public criticism ruptured the shared purpose forged between mental health reformers and the public. One 1963 sanity hearing, in particular, rocked the public's faith in court ordered commitments and thus foreshadowed the persistent tensions that would complicate the reformers' work.

In April 1963, at the height of support for federally funded community-based reform, the sanity hearing of Dr. Wendell Thrower revealed the seeds of tensions that would later help to fracture reform efforts. Thrower's hearing was unusually open to the

public eye through reporting in local newspapers. Indeed, the case had to be moved to the County Court-at-Law room in the Travis County Courthouse in order to accommodate the large crowds that came to witness the trial. Though the six-person jury eventually released Dr. Thrower from the care of ASH, the details of Thrower's attempted forcible commitment, initiated by Dr. Thrower's wife, Joan Thrower, brought to light the difficulties and dangers many people saw as being raised by court commitment.¹⁴⁰ The case turned the tensions over psychiatrists' power and public anxiety into a courtroom spectacle.

Observers wondered how psychiatrists could consider a well-educated, successful person like Dr. Thrower in need of psychiatric commitment. Indeed, much of Thrower's defense relied largely upon appeals to his celebrated career as a thoracic surgeon. Born on July 29, 1926, Dr. Thrower held degrees from Duke University, South Carolina Medical College, and Harvard University.¹⁴¹ He authored several articles in leading medical journals between 1958 and 1966, and was well known and respected in the field.¹⁴² Newspapers described Dr. Thrower as young, handsome, and brilliant; a man who "made the highest mark in the country on his medical board exam," he was depicted

¹⁴⁰ Betty MacNabb, "Sanity Trial Nears Jury," *The Austin American*, April 26, 1963; Betty MacNabb, "Thrower is Freed by Judge Watson: Courtroom is Jubilant," *The Austin Statesman*, May 9, 1963.

¹⁴¹ "Service Set for Reevesville Surgeon," *The News and Courier*, Charleston, South Carolina, May 12, 1987.

¹⁴² See: Irwin M. Arias, Norman Zamcheck, and Wendell B. Thrower, "Recurrence of Hemorrhage from Medically Treated Gastric Ulcers: Four- to Eight-Year Follow-Up of Forty-Seven Patients," *Archives of Internal Medicine* 101 no. 2 (Feb. 1958): 369-376; Warren J. Taylor, Harrison Black, Wendell B. Thrower, and Dwight E. Harken. "Valvuloplasty for Mitral Stenosis during Pregnancy," *Journal of The American Medical Association* 166, no. 9 (1958): 1013-1018; Wendell B. Thrower, Thomas D. Darby, and Early E. Aldinger. "Acid-Base Derangements and Myocardial Contractility: Effects as a Complication of Shock." *Archives Of Surgery* 82, no. 1 (January 1, 1961): 56-65; William C. Birtwell, Harry S. Soroff, Fabio Giron, Wendell B. Thrower, Ulises Ruiz, and Ralph A. Deterling, JR. 1966. "Synchronous Assisted Circulation," *Canadian Medical Association Journal* 95, no. 13 (1966): 652-664.

in local newspapers as an example of a successful and talented person.¹⁴³ Austinites must have been intrigued as a person of such great renown and accomplishment could be committed to a state hospital.

Joan's attempt to commit her husband intensified public anxieties regarding psychiatric power and raised further questions about the legitimacy of court sanity hearings. The trial publicly displayed the disintegration of the Joan and Wendell Thrower's marriage. When Joan Thrower attempted to commit her husband, she revealed the previously hidden conflict in what many of the couple's friends and family members had described as a happy marriage. The Throwers' history together as two well-educated individuals—both had studied at Harvard—who had been married ten years prior to the hearing alarmed many as they watched the events of the trial unfold.¹⁴⁴ While on one hand Joan's testimony reinforced the need for psychiatric leadership in state sponsored mental health, but on the other it seemed that Joan relied on psychiatrists' influence to subvert the authority of her husband.

Though some may have viewed Joan's testimony as an attempt to undermine her husband's power, others, including some of ASH's psychiatric staff, believed her testimony presented clear evidence that Dr. Thrower required psychiatric help. According to Joan, her husband had exhibited strange behavior for the previous several months. The troubles began when Dr. Thrower visited Austin to investigate the prospect of opening a private practice with Dr. Maurice Hood, a fellow thoracic surgeon who had lived and practiced medicine in Austin since 1955. The initial visit went well, and Dr. Hood and

¹⁴³ Betty MacNabb, "Wife Weeps at 'Present'" *The Austin Statesman*, April 25, 1963.

¹⁴⁴ Betty MacNabb, "Wife Weeps at 'Present,'" *The Austin Statesman*, April 25, 1963. Newspaper reports indicate that Joan Thrower had been a doctoral student at Harvard University studying psychology and social anthropology when she met Wendell Thrower.

Dr. Thrower agreed to work together in Austin if Joan Thrower had no objections. But there was more to the story. Dr. Thrower asked Dr. Hood not to contact the University of South Carolina Medical College (USCMC), where he was then employed, because Thrower “was having some difficulty with some of his superiors.”¹⁴⁵ Dr. Hood apparently thought nothing of these difficulties, because he agreed to the arrangement. Yet, according to Joan, Dr. Thrower’s behavior “had become increasingly strange over the past couple of years.” Allegedly, Dr. Smythe, then dean of the USCMC, revealed that “Dr. Thrower’s behavior in the operating room was dangerous to [Thrower’s] patients,” and reinforced her concerns and convinced Joan of the need for psychiatric treatment for her husband.¹⁴⁶ Joan also claimed that Dr. Thrower during a visit to Houston slapped her, forced her to eat bar of soap, and recite a loyalty oath professing her commitment to him.¹⁴⁷ Joan Thrower’s testimony questioned Dr. Thrower’s mental capacity despite his professional background, and provided evidence that supported claims for his need of ASH’s psychiatric services.

Mounting testimony from Dr. Thrower’s colleagues, friends, and family against his sanity raised additional doubts as to the state of Dr. Thrower’s mental capacity. Joan Thrower initially attempted to commit Dr. Thrower for ninety days of observation on April 12. Joan Thrower called the dean of USCMC, who suggested that she have her husband committed for psychiatric observation. Joan Thrower must have alerted the authorities, because the sheriff escorted Dr. Thrower to ASH in handcuffs.¹⁴⁸ His wife’s

¹⁴⁵ “Medics Behavior Related in Court,” *The Austin American*, May 3, 1963.

¹⁴⁶ Betty MacNabb, “Sanity Trial Nears Jury,” *The Austin American*, April 26, 1963.

¹⁴⁷ Betty MacNabb, “Recording Put in Trial,” *The Austin Statesman*, May 7, 1963; Betty MacNabb, “Wife Weeps at ‘Present,’” *The Austin Statesman*, April 25, 1963.

¹⁴⁸ Betty MacNabb, “Dr. Thrower Leaves Free,” *Austin American*, May 10, 1963.

concerns found support from some of Dr. Thrower's colleagues and family. Not only did both the dean of USCMC and Dr. Maurice Hood support the move, but even Dr. Thrower's two brothers, Dr. James Thrower and Troy H. Thrower, came to testify in support of Joan's claims.¹⁴⁹ Her testimony indicated that Dr. Wendell Thrower experienced some type of mental or emotional condition serious enough to require professional help, and supported psychiatric intervention in people's lives.

Dr. Thrower's testimony, his career, along with statements from ASH staff, claimed that he was sane and suggested that psychiatric leadership had grown too powerful. The doctor, who had received a \$250,000 grant from the National Institute of Health, claimed that Dr. Chevis McCord Smythe of USCMC attempted to commandeer the funds for the medical school's use. His claim must have held some validity in court because Dr. Thrower's legal counselors, Percy Foreman and Paul Holt, built their defense around the alleged conspiracy.¹⁵⁰ Furthermore, the chief of male services at ASH did not believe Dr. Thrower required the hospital's help. The six-man jury at the sanity hearing, after listening to the testimony of four different psychiatrists, found Dr. Thrower insane, though not in need of forcible state hospital commitment. On the day of his release, approved by presiding judge J. H. Watson, the spectators in the courtroom reacted with "jubilant" and "spontaneous applause."¹⁵¹ Yet Dr. Thrower did not return to freedom unscathed; leaving the courtroom on May 10, 1963, Dr. Thrower made a final statement to reporters that revealed the emotional toll of the trial. "My wife did this to me," he told reporters, "and now I'm just crossing one bridge at a time."¹⁵² Much of the fascination

¹⁴⁹ Betty MacNabb, "Dr. Thrower Leaves Free," *Austin American*, May 10, 1963.

¹⁵⁰ "Thrower Hearing Enters Second Week," *Austin American*, May 1, 1963.

¹⁵¹ Betty MacNabb, "Dr. Thrower Leaves Free."

¹⁵² *Ibid.*

with the case at the time had been sparked by this peek into the private lives of a prominent couple.

The trial not only brought underlying resistance to mental health reform into light, but also called into question the validity of psychiatry as a whole by opening a discussion about the subjective nature of the psychiatric definitions of sanity. Through Percy Foreman's defense of Dr. Thrower, as well as multiple diagnoses from various psychiatrists that portrayed psychiatry as a pseudoscience, the assertion that psychiatrists could draw a clear line between sanity and mental illness became hazy. For one, Dr. Thrower received three different diagnoses from three different psychiatrists, degrading public faith in psychiatry. During the cross examination of Dr. Clarence Coombs, resident psychiatrist at ASH, Foreman used defense attorney Paul Holt's trademark red tie to demonstrate the subjectivity of definitions. When asked if Dr. Coombs thought two people would define the tie as red, Coombs replied, "I think that everybody who sees Mr. Holt's tie would agree that it's red. But what they would read into his purpose in wearing it is a different matter." Foreman jumped at the opportunity to make his point. "Exactly...what a psychiatrist would read into a simple thing like a man's tie would be different every time."¹⁵³ Foreman's cross examination implied that even the simplest details, let alone complex analyses of mental conditions, were subjective when two or more people were forced to define them. His defense raised the issue that if the definition of sanity differed from one psychiatrist to the next, then it left the possibility for the wrongful commitment of citizens without providing adequate due process. Percy

¹⁵³ Betty MacNabb, "In Thrower Case: His Point Sharp One," *The Austin Statesman*, May 2, 1963.

Foreman's cross-examination of Dr. Coombs laid bare the flaws in mental health reformers' ideology for the court and the public to examine.

Public fears and skepticism regarding psychiatry often remained largely unspecified, though they were real enough for the psychiatrists who sought to defend their field. Psychiatrist Dr. David S. Buell identified the general reaction to psychiatry as a field was "one of anxiety and fear," that originated from "motion pictures, television, and recent books" that portrayed psychiatric practices "as something mysterious, curious, and fearful."¹⁵⁴ While some anxieties stemmed from a fear of the unknown and the relative novelty of psychiatry, as Buell suggested, people's anxieties also originated from a growing awareness of the effects of psychiatric authority on real people's lives, and that caused many to question the validity of its practices. "According to a professor of 'social psychiatry...'" wrote one editorialist for *The Dallas Morning News* sarcastically, "up to 30 percent of the world's population is suffering from mental illness... Then there is at least a 30 percent chance the prof is off his rocker." Notably, the writer connected his attack on psychiatric expertise to his skepticism about the growing number of liberal policies mounting in the 1960s. "The President," he wrote, "said that 32 percent of us were 'living on the outskirts of poverty.' Now all of this is getting out of hand... Things can't really be that bad."¹⁵⁵ The author's criticism, aimed at psychiatry and the government's growing influence over social programs, also reveals underlying tensions regarding the role of experts and government authority at a time when new government-led liberal reform continued to flourish in the 1960s.

¹⁵⁴ David S. Buell, "Fantasy Colors Psychiatry's Image," *The Dallas Morning News*, May 6, 1962.

¹⁵⁵ "Figure-Mad," *The Dallas Morning News*, March 16, 1963.

The defense also played on commonly held anxieties about psychiatry and the conditions in mental hospitals to fight Thrower's commitment. These fears converged in the hearing during Dr. Thrower's testimony as well as the cross examination of ASH staff. Dr. Thrower's testimony reinforced the public's fears, as they read about his experience as a patient at ASH in their daily papers. Dr. Thrower told the jury that he had been held in a seclusion ward, where senile patients would occasionally "wander in and bespoil my bed."¹⁵⁶ He also reported that he received three doses of Thorazine against his will, a drug that was often prescribed for psychotic patients that was also somewhat debilitating, and then stripped by male nurses. "I finally learned that every time I asked for a doctor," claimed Thrower, "I would be given Thorazine." In one of his examples, Thrower claims that he was given the medication after having complained about having contracted a sinus infection. Thrower also described the hospital as filthy, and claimed that the terms of his commitment were never made clear to him after the sheriff brought him to the hospital.¹⁵⁷ Thrower's experience in ASH brought to the fore of the public discussion surrounding the hospital reforms, largely headed by psychiatric experts, the limitations and flaws of experts, the bureaucracies they led, and the potential for abuse and neglect while in their care.

Percy Foreman's cross-examination of hospital employees also played on commonly held fears regarding psychiatric commitments and treatments. Foreman, well known for his dramatic flair in the courtroom, questioned Dr. Clarence Coombs about more dangerous methods of psychiatric treatments while unwrapping and holding up a ten-inch hypodermic needle in "full view of the fascinated jury." "Isn't it true, doctor,"

¹⁵⁶ Betty MacNabb, "Dr. Thrower Tells of Stay as Patient," *The Austin Statesman*, May 6, 1963.

¹⁵⁷ Betty MacNabb, "Dr. Thrower Tells of Stay as Patient."

Foreman asked Coombs, “that an institution such as [ASH], that the physician has two needles in his hands when administering dangerous drugs? One to kill him and one to bring him back to life?” Coombs was then forced to admit that adrenaline was often kept nearby in the hospital for emergency resuscitation purposes. Foreman then asked Coombs about the dangers of Electro Shock Therapy (ETS), a recently developed method of treatment for persons with severe mental illness that was a source of controversy. Coombs reluctantly answered that ETS caused memory loss, but that “barring rare complications,” a person usually regains their full memory after a short time. Foreman persisted in questioning Dr. Coombs until Coombs admitted that “the memory of a man’s entire education, his professional learning, might be erased by the shock,” a possibility that appeared especially threatening to a renowned and highly educated thoracic surgeon such as Dr. Thrower. Coombs also answered that patients receive ETS “at the discretion of doctors and the patient has no choice.” His answer highlighted the fear of being stripped of one’s freedoms and left at the mercy of psychiatrists and doctors whose power over patient treatments went unchecked. That Dr. Thrower never received ETS, experienced memory loss during his temporary commitment, or received an injection by a ten-inch hypodermic was immaterial to the public. Foreman played on existing fears regarding psychiatric treatments that were not well understood by the public. By focusing the jury’s attention away from Thrower’s sanity and towards their skepticism for psychiatry, Foreman forced psychiatrists to defend their field and revealed the many layers of anxiety people had for psychiatry and exposed those fears in the process.

Furthermore, the conclusion of the trial reinforced the ambiguous nature of psychiatric definitions for severe mental illness in which Dr. Thrower was declared

insane but not in need of forcible psychiatric commitment. When Judge J. H. Watson read the jury's decision that freed Thrower, the courtroom "roared with applause" and several female spectators rushed to congratulate the surgeon.¹⁵⁸ Frank Maloney, representing Mrs. Joan Thrower, protested the unusual verdict, claiming, "He's insane; you [the State of Texas] have to confine him," to which Foreman replied "If he's committed, I'll have him out of there in 30 minutes on a writ of habeas corpus." Immediately following the trial, Foreman touted his victory declaring the case "the biggest thing that's [come from] South Carolina since they fired on Fort Sumner," while brandishing a copy of the Texas Mental Health Code stating in front of spectators, "There are about 50 of you here [in the courtroom]... I can prove that at least 20 of you are mentally ill—but which of you is ready for the nuthouse?"¹⁵⁹

Even as hospitals like ASH portrayed themselves as proponents of public health and an important part of the community, the fear of losing one's autonomy and being subjected to torturous medical treatments remained ever present in the minds of the public.¹⁶⁰ Whereas anxieties regarding psychiatric treatments existed before the 1960s,¹⁶¹ never before had the psychiatrists wielded as much power they had in the 1960s, and many believed their power threatened individual freedoms based on ambiguous definitions of insanity. "The practice of institutional psychiatry," wrote behavioral

¹⁵⁸ Betty MacNabb, "Thrower is Freed by Judge Watson: Courtroom is Jubilant," *The Austin Statesman*, May 9, 1963.

¹⁵⁹ Betty MacNabb, "Thrower is Freed by Judge Watson: Courtroom is Jubilant."

¹⁶⁰ Betty MacNabb, "In Thrower Case: His Point is Sharp," *The Austin Statesman*, May 2, 1963.

¹⁶¹ See Michelle M. Nickerson, "The Lunatic Fringe Strikes Back: Conservative Opposition to the Alaska Mental Health Bill of 1956" in *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America*, ed. Robert D. Johnston (New York: Routledge, 2004), 117-130; and Matthew Schneirov and Jonathan David Geczik, in "Beyond the Culture Wars: The Politics of Alternative Health," *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America*, ed. Robert D. Johnston (New York: Routledge, 2004), 245-256.

scientist Carl R. Vann in 1961, “operates to curtail to the freedom of the individual and involves a fundamental redefinition of the role of the psychiatrist.” He argued that large-scale institutions made a psychiatrist “the agent of the government rather than the individual,” and that, “psychiatry, through the guise of professionalism, has become a means in which large numbers of people are deprived of their freedom.”¹⁶² Whereas critics of the mental health system in the 1940s and 1950s had perceived psychiatry as a solution to the inadequacies of the mental health system, by the 1960s many began to view psychiatry as an inherent problem for mental healthcare as institutional psychiatry became closely associated with a loss of individual freedom.

It is unclear as to what degree Foreman’s defense and Thrower’s testimony affected the remarkable decision of the jury during the sanity hearing, but newspaper reports described a public deeply relieved when Thrower is set free, despite the surgeon’s bizarre behavior, the testimony of Joan Thrower and his family and friends, and the jury’s declaration of Dr. Thrower as insane. This reveals a glimpse into the growing skepticism through which psychiatry and mental health reform were viewed; fears regarding the ambiguous nature of sanity, the potential for anyone to have their freedoms and reputations taken away by government agencies led by psychiatric experts, and barbaric treatment of mental patients long implanted in the public’s perception of mental hospitals became a reality in the Dr. Thrower’s sanity hearing. It appeared to the general public that even the best and brightest of people were vulnerable to the ever growing power of the alliance between psychiatrists and the state.

¹⁶² Carl R. Vann, “Psychiatry, Mental Illness, and Civil Liberties,” *The American Behavioral Scientist* 4 no. 10 (Jun. 1, 1961): 28.

Dr. Thrower's sanity hearing exemplified the tensions between reformers and dissenters growing beneath the surface of the community mental health movement in the 1960s. For the time being, psychiatrists, government officials, and the public had supported mental health reform and believed that community centers offered an alternative to mental hospital care. Yet soon enough the movement began to splinter as people questioned the state's ability to implement effective mental health policy and doubted psychiatrists' authority to guide individuals towards mental health. Many became anxious that the "psychiatric state" threatened a person's individual rights on relative definitions of insanity. Though these anxieties seem contradictory to the goal of creating a community-based mental health system, they coincided with the peak of federal, state, and professional commitment to reforms. The tensions between state mental health reform and dissent for professional control over individuals intensified into the late 1960s.

Growing Resistance to Community Mental Health Reform

Even as the community mental health movement gained momentum and found support from much of the public and many professionals, mental health reform also faced greater resistance. One source of resistance arose out of disputes between experts about the direction of the community mental health movement. The rising costs of mental health reform also caused political friction as the state legislature refused to allocate the funding that reformers requested. Furthermore, the public increasingly dissented against mental health reform, as many feared the growing and unchecked power and authority of psychiatric experts to remedy social ills. Resistance grew out of a growing rights consciousness for people who were institutionalized against their will as mounting

skepticism of psychiatric interventions centered increasingly on the lack of civil rights for people in psychiatric institutions.

As reformers in Texas found a common sense of purpose for community mental health reforms, they began to explore the feasibility of reallocating the responsibility for mental healthcare from the state to local communities. They found that, though many perceived the answer to state mental hospital care lay within in local communities, many of those communities were neither prepared for nor readily accepted the changes necessary for reform. The Texas Legislative Council's 1962 meeting reflected the state's expectations for community mental health centers, which focused on the care provided to court-committed patients in their local community prior to admission. The council stated that the "concept of community responsibility for mental health" was "still a long way from acceptance in Texas."¹⁶³ Reformers, empowered under their common purpose, pushed forward with community-based reforms despite evidence of the uphill battle that faced their conception of community mental health centers.

Rural areas in Texas were especially problematic as reformers sought to establish community centers. In addition to the general concern regarding the aging facilities of state hospitals, the Texas Legislative Council reported that deficient local services and lack of state resources remained the largest obstacle in providing care to court-committed mentally ill persons. According to the Council, keeping court-committed patients in jail remained "a widespread practice" in the period between the courtroom and the mental hospital. "A large number" of county officials were unaware that state mental health code expressly forbade confining patients in jails. "Expense to the county," reported the

¹⁶³ Texas Legislative Council, "Care of Court-Committed Mentally Ill Prior to State Hospital Admission," December, 1962, ii.

council “is often the prime consideration, rather than the welfare of the patient.”¹⁶⁴ Local officials often relied on jails to confine persons with mental illness until transport to the nearest mental hospital could be arranged from regions where the nearest mental hospital remained a distant drive for local law enforcement.¹⁶⁵ By waiting to transport patients, law enforcement reduced the number of trips but also left many to wait in facilities least designed to provide adequate care and prioritized local costs over patient care.

Individual counties had few alternatives to jails. Most general hospitals, the Council noted, did not accept mentally ill patients “even on a temporary basis.” Families and other community members could be asked to provide temporary care for patients waiting for transit to a state hospital, which they often did. But responses from county officials indicated that the majority of court-committed persons resided in local jails.¹⁶⁶ Many felt the mentally ill ought to be kept away from communities or that many families could not provide the substantial resources necessary to care for a mentally ill individual. The Council’s findings confirmed that, despite the gaining acceptance of community mental health centers by the state and much of the public, local communities’ actions reflected either an inability or unwillingness to find the resources to provide care at the local level. Much of the friction reformers faced stemmed from problems of implementing changes to the mental health system in local settings.

Since reformers could not rely on county resources, reformers realized that they had to rely to some extent on mental hospitals in order to attain their goals. However, most Texas mental hospitals also required significant funds and renovations. Of state

¹⁶⁴ Texas Legislative Council, “Care of Court-Committed Mentally Ill Prior to State Hospital Admission,” December, 1962, ii.

¹⁶⁵ Ibid.

¹⁶⁶ Ibid.

hospitals, the council reported that “staffing, not facilities, continues to be the greatest problem.”¹⁶⁷ Salary caps for state hospital psychiatrists drove qualified professionals away from mental hospitals and into the private sector. In 1962, only forty top psychiatrists worked in the entire state hospital system, and at least one hundred more were needed. With such a severe shortage of caregivers, acquiring and maintaining qualified staff remained a chief concern for mental hospitals. Texas, according to the report, had the necessary funding to attract more qualified staff, but the inflexibility of state appropriations inhibited the state’s ability to offer competitive salaries.¹⁶⁸ Reformers had to face the reality that they had to rely on mental hospitals’ existing mental health treatments in order to make headway in their reforms. Furthermore, the costs of creating community mental health centers—which they argued would save the state money—required more funding than they had initially suspected. Though many perceived the increasing budget as controversial, most officials and reformers perceived funding as a necessary part of their goals.

Patient populations also posed a formidable problem for state hospitals as reformers who promised that one of the benefits of mental health reform would end long-term commitments in state institutions and the practice of warehousing patients. The number of patients in mental hospitals totaled 15,822 in August 1962, whereas the state estimated total bed capacity at 13,781. By 1964, the council suggested that hospitals would reach their “saturation point,” with a return to “long waiting lists and consequent

¹⁶⁷ Texas Legislative Council, “Care of Court-Committed Mentally Ill Prior to State Hospital Admission,” December, 1962, iii.

¹⁶⁸ *Ibid.*, iv.

delays in admission.”¹⁶⁹ Therefore, even though many were reluctant to rely on state hospitals in the reform process, others turned to community mental health centers as the only viable means to reduce the growing population in state hospitals.

Large patient populations not only caused many to view state hospitals with mistrust, but also to be wary of patients as well. When a patient appeared to abuse the hospital’s resources for their own personal benefit, it opened up debates about what kind of patients deserved the hospital’s care. From the perspective of Dr. Margaret Sedberry, an ASH psychiatrist, some patients abused the hospitality of the mental hospital. One woman in particular, Sedberry reported, “makes me furious.” The woman in question had “psychiatric problems” but she was in ASH “on voluntary commitment,” because she frequently bounced checks and wanted to avoid bill collectors.¹⁷⁰ This particular patient did not receive the same sympathy as others because she appeared capable of lying and scamming the mental welfare system, and therefore not in need of ASH’s care. Though Dr. Sedberry admitted the patient had psychiatric problems, she allegedly stayed in the hospital because she lied about her finances. Even as a common purpose was being forged and facilitated interactions between the state hospital and the public, questions evolved regarding who deserved to benefit from the mental health system. These growing questions provided grounds for fissures in the community mental health movement, as institutions and the public tightened the definitions of the beneficiaries of reforms.

The Texas Legislative Council overwhelmingly supported the establishment of community mental health centers, but generally saw them as alternatives to county jails.

¹⁶⁹ Texas Legislative Council, “Care of Court-Committed Mentally Ill Prior to State Hospital Admission,” December, 1962, iii.

¹⁷⁰ Betty MacNabb, “State Hospital: A Point of Return.” *The Austin American*, June 27, 1963.

“Provision at the local level for at least temporary care and treatment of the mentally ill would be the best way to keep patients from undergoing the traumatic experiences of time spent in jail,” asserted the council. But, local communities appeared to have resisted the policy. The greatest obstacle to community mental health centers was that “local governmental units [were] still reluctant to add to their tax burden by assuming the responsibility of care.”¹⁷¹ Though many professional psychiatrists, state officials, and Texans accepted community centers as the answer to mental health reform, implementation was not always possible at the local level.

Despite reformers’ successes and their shared purpose in providing patient freedoms, resistance to mental health reform grew steadily throughout the late 1960s. Raising and reallocating appropriated funds from state budgets remained a central issue in debates over mental health reform. In 1965 the MHMR appropriated additional funding for educational programs in state hospitals in order to hire more staff. Austin State Hospital alone received an appropriation of \$30,000 with the Central Education Agency for vocational rehabilitation services to patients, and \$2,590 for a special education program with Austin Independent School District. In addition to these added program resources, the MHMR board also provided salary increases for state hospital staff, and it increased the allotment for food expenses from 58 cents per patient to 62 cents. In total, the board allocated a total of \$6,166,070 to ASH for the 1965-1966 fiscal year.¹⁷² These figures do not include the other funds provided for other state hospitals

¹⁷¹ Texas Legislative Council, “Care of Court-Committed Mentally Ill Prior to State Hospital Admission,” December, 1962, 87.

¹⁷² Minutes for the Texas Board of Texas Board for Mental Health and Mental Retardation, September 1, 1965, MHMR Minutes September 1, 1965-August 27, 1967, Box 1998/071-1, Texas State Library and Archives Commission.

and mental health facilities, which also received large sums as a part of the new approach to mental health. For comparison, Kerrville State Hospital's budget was set at \$2,511,918; Big Spring State Hospital at \$1,807,713; Rusk State Hospital received \$3,535,937; and San Antonio State Hospital had a budget of \$4,739,755.¹⁷³ The state of Texas had for many decades spent large sums of money on its mental institutions, and state hospitals had come to rely on those funds. However, reallocating money to community centers had the potential to severely hamper state hospitals' ability to function efficiently, and the push for community centers competed with hospitals for funds, instead of complementing their work towards similar goals.

The MHMR's plan to revolutionize Texas's mental health system, which promised better care at a lower cost to tax payers, required large start-up costs. Federal funding covered the construction of facilities and the procurement of land for community centers, but the costs for salaries and training programs were left to state grants-in-aid.¹⁷⁴ However, the MHMR was not always successful in securing the necessary state funds to create the community centers reformers imagined. Community mental health centers did receive state funds, but they proved to be inadequate. The MHMR reserved \$600,000 for the procurement of salaries, professional fees, general maintenance, and travel expenses. The board also set aside an additional \$450,000 for the construction of community centers, with matching federal funding. Further, the board provided \$600,000 for the care of mental patients in the community centers, and another \$150,000 for training programs

¹⁷³ Minutes for the Texas Board of Texas Board for Mental Health and Mental Retardation, September 1, 1965.

¹⁷⁴ Chris Whitcraft, "Community Plans Shy Funds," *The Austin Statesman*, March 26, 1966.

in mental health institutions.¹⁷⁵ As the community mental health centers gained momentum, even these funds would not be enough to maintain and establish centers that could provide comprehensive mental health care that appealed to the public. “We have no planning funds available except for services,” MHMR Commissioner-Psychiatrist Shervert H. Frazier told news reporters when questioned about the lack of expected funds. “We have no funds for community planners or organizers,” Frazier continued.¹⁷⁶ Though many reformers like Frazier remained optimistic and looked for money from private organizations, like the Hogg Foundation,¹⁷⁷ others such as Dr. Joe Tupin, assistant professor of psychiatry at the University of Texas Medical Branch at Galveston, began to express doubts in the propensity for real change. “How do you plan,” Tupin asked, “When you don’t know what you’re planning for?”¹⁷⁸ Without adequate funding, the growing competition for resources amongst reformers intensified and the common purpose between reformers stretched thin and began to tear.

As it attempted to secure community involvement in mental healthcare the board had to battle the negative perceptions of mental hospitals and state care in order to secure public support. Board Chair, Dr. Horace Cromer, remarked in an October meeting, “The necessity for all units at the local level to give up some of their identity and become part of this joint effort [for community mental health centers] is fundamental.” Dr. Cromer commented on the state hospitals’ role in the reform movement. “We have been using the

¹⁷⁵ Minutes for the Texas Board of Texas Board for Mental Health and Mental Retardation, September 1, 1965.

¹⁷⁶ Chris Whitcraft, “Community Plans Shy Funds.”

¹⁷⁷ The Hogg Foundation for Mental Health was first established as The Hogg Foundation for Mental Hygiene by Miss Ima and Michael Hogg in 1940. The Hogg Foundation continues to advocate for mental health reform in Texas. See The Hogg Foundation of Mental Health, “Hogg Foundation History,” http://www.hogg.utexas.edu/about/Hogg_history.html (accessed November 8, 2015).

¹⁷⁸ Chris Whitcraft, “Community Plans Shy Funds.”

phrase . . . warehousing patients,” he lamented. “This leaves an image in the minds of our patients and their families that nothing is being done for these patients. We all must be keenly aware that State Hospitals and Special Schools . . . must be recognized as part of the program and must be upgraded.”¹⁷⁹ As Dr. Cromer implied, building community mental health centers required not only immense amounts of federal and state funding, but also a two-front war for public opinion. On one front, administrators fought for the legitimacy and validation of community centers, and on the other front they continued previous efforts to convince the public that state hospitals were necessary and helpful institutions. Doing so divided the reformers’ efforts for mental health advocacy.

Securing local support for community centers did not appear to be problematic, especially when the cost of constructing community centers could be paid using federal funds. “Interest in various parts of the State in developing community centers in mental health and mental retardation is developing rapidly,” wrote board member Dr. C. J. Ruilmann. “This is true,” he added “from the north parts of the state to the south and to the east and west.” Dr. Ruilmann also noted, “Local interest appears to be in combining into one center as many as possible of the mental health and mental retardation functions.”¹⁸⁰ Newspaper reports confirmed Dr. Ruilmann’s findings. The *Dallas Morning News* reported that over one hundred community leaders went to Austin in March 1966 to claim portions of the \$80,000 in state funding available for the construction of mental health centers, and that another \$750,000 would be made available

¹⁷⁹ Minutes for the Texas Board of Mental Health and Mental Retardation, October 29-30, 1965, MHMR Minutes September 1, 1965-August 27, 1967, Box 1998/071-1, Texas State Library and Archives Commission.

¹⁸⁰ Minutes for the Texas Department of Mental Health and Mental Retardation, October 29-30, 1965, MHMR Minutes September 1, 1965-August 27, 1967, Box 1998/071-1.

the following year.¹⁸¹ Local community leaders jumped at the opportunity to secure state funds that would appeal to the needs of their constituencies.

Despite the deficit of local funds and resources, the MHMR was fairly successful in using its large state and federal grant funding to encourage communities to organize around mental health issues. One condition for receiving state funds required communities to organize boards of trustees to manage community mental health resources that would work in conjunction with larger state mental health facilities. By 1966, the MHMR had successfully persuaded nineteen of the twenty-one communities deemed necessary for the success of community centers to create and organize functioning boards of trustees eligible for state aid. The MHMR also noted that the hospitals in Austin, Wichita Falls, and San Antonio showed the potential to become promising community centers with comprehensive care available to surrounding communities.¹⁸² The department noted that if the existing services in these areas could be reconstituted for community centers, then Texas would be well on its way to offering a full “continuum of care” to its citizens. “At the same time,” the board concluded, “we will be forging a working partnership between the community and the state.”¹⁸³ In large part, the motive behind community mental health centers was to restore the public’s faith in the state’s ability to provide care and address growing public concerns regarding mental health and mental illness.

¹⁸¹ Carolyn Patrick, “Communities Claim Mental Health Funds,” *The Dallas Morning News*, March 26, 1966.

¹⁸² Minutes for the Texas Department of Mental Health and Mental Retardation January 16, 1967, MHMR Minutes September 1966-December 1967, Box 1998/071-1, Texas State Library and Archives Commission.

¹⁸³ Minutes for the Texas Department of Mental Health and Mental Retardation January 16, 1967.

In Austin, local residents generally supported the drive to create community mental health centers. The Austin-Travis County Mental Health Association held regular fundraisers to support community services. For example, in March 1965 the association sought to raise \$15,800 for mental health services in the area. The Austin-Travis County Association gained support from local high schools, student organizations from the University of Texas, and the North Austin Civilian Club.¹⁸⁴ However, not all residents agreed on what services the center should emphasize, and the community held many diverse expectations for their community center. Citizens backed the vision of a combined center because they believed it would be cheaper and more effective. They were, however, wary of the estimated \$10 million annual cost of creating a diverse center.¹⁸⁵ The Community Council of Austin and Travis Committee made five recommendations for the creation of a combined center for mental health and mental retardation that included an urge to establish a center immediately, to create a nine-member board of trustees comprised of two members from the Austin Independent School District, the University of Texas, and the city respectively, that the center be located near the Brackenridge Hospital complex, and that the center admit both children and adults.¹⁸⁶ The center attracted a broad coalition of support from Austinites, but the public's demands on the community mental health center were diverse and expensive. Such a center required the cooperation of multiple community organizations, the state

¹⁸⁴ "Mental Health Group Will March Tuesday," *Austin Statesman*, May 10, 1965.

¹⁸⁵ "The Steps Leading to a New Community Center Mental Health Center: Special Committee Makes Five Urgent Proposals," *The Austin American Statesman*, December, 18, 1965.

¹⁸⁶ "The Steps Leading to a New Community Center Mental Health Center: Special Committee Makes Five Urgent Proposals," December, 18, 1965.

educations system, and local government, and enough funding to maintain the interests of these various groups.

Woes created by the shortages in state funding hit hard in 1967 when the Texas legislature granted a mere \$25,000 for community centers, one quarter of what community mental health center advocates had sought. The funds provided were established to “support sound plans” but the MHMR had no resources to support community planning. The lack of funds for community centers stemmed from allocations to the State Board of State Hospitals and Special Schools.¹⁸⁷ The funding shortage for community centers created a competition for funds not only with Texas mental hospitals, but the limited resources also forced community centers to compete amongst themselves. Dora Hutson, president of the Texas Association of Retarded Children, worried that the lack of funds would inflict limits on reform. “I hope we can all work together,” said Hutson, “But without more planning and thought, I see the possibility of splintering.”¹⁸⁸ Hutson’s fears of a splintered movement became one of the greatest threats to community mental healthcare reform. In Austin, advocates remained firm on their vision for their center, but the community continued to search for the resources to attract thinning federal and state funds.

The MHMR also began advocating for changes in the state’s approach to mental health. The changes the department introduced were designed to empower community centers, provide greater access to better care for patients, and pressure mental hospitals and other institutions into addressing the growing concerns regarding patients warehoused in older run-down buildings. For one, the department recommended that

¹⁸⁷ Chris Whitcraft, “Community Plans Shy Funds.”

¹⁸⁸ Ibid.

Article IX of the Texas State Constitution be amended to allow “political entities and State supported entities” located in hospital districts to aid in the creation and operation of community mental health centers.¹⁸⁹ The MHMR board made further recommendations to strengthen the ties between the state and private hospitals so as to increase the care facilities for patients. One of the most radical suggestions the board made was to declare a state of emergency in mental hospitals.¹⁹⁰ The proposed bill intended to force a change in mental hospitals, especially in the treatment of patient populations, and force the State of Texas to take a more active role mental health. The MHMR hoped to legally force the state government to provide more funding for hospitals, which would alleviate the tensions between community reformers and mental hospitals. The department sought to ease the tensions that threatened to fracture their efforts to reform Texas’ mental health system.

As the community mental health reform grew and increasingly valued psychiatric expertise, so too did the public’s apprehension regarding the growing alliance between psychiatrists and the state. One expression of this anxiety came from the fear of wrongful incarceration in state hospitals as illustrated in the Thrower case. Nonetheless, patient populations continued to climb from the mid to late 1960s as ASH struggled to plan for its future in a community-based mental health system. Josephine T. Lamb, Chief of Psychiatric Nursing at MHMR who spearheaded the nursing training program at ASH, placed herself at the center of the debate regarding the acquisition of more professional staff for mental health centers and hospitals. Lamb firmly believed that more

¹⁸⁹ Minutes for the Texas Department of Mental Health and Mental Retardation March 3, 1967, MHMR Minutes September 1966-December 1967, Box 1998/071-1, Texas State Library and Archives Commission.

¹⁹⁰ Minutes for the Texas Department of Mental Health and Mental Retardation March 3, 1967.

professionally trained nurses would prove vital to community mental health centers and hoped that the nursing program at ASH could help staff community centers. However, as the MHMR's momentum for community mental health began to sputter, Lamb's understanding of the future of mental healthcare likewise fragmented at its foundation. "As of today," she wrote in a letter to Dr. W.E. Field, Jr., a professor at University of Texas's School of Nursing in Galveston, "it would be pretty hard to state exactly our State program in regard to future planning." Lamb went on to add, "I very much would like to see some program planning for nurses who plan to work in community clinics... so that the nurses role can be updated and they will become more of a member of the treatment team."¹⁹¹ Unfortunately for Lamb, the MHMR continued to struggle for state funding for community center planning until 1968.

The lack of funds available not only threw into question the role of mental hospitals in the future, but also raised questions about how to manage state hospitals during the transition to community mental health centers. The MHMR became increasingly concerned with costs at Texas mental hospitals, and began drafting detailed reports regarding costs and patient populations. One report showed that the population of ASH in 1965 at 3,357 with a budgeted population at 3,300. The estimated daily cost per patient at ASH was \$4.91. The vast majority of patient costs at ASH came from in-patient services, meaning that the state funds remained relegated to "warehousing" patients in hospitals. The average length of stay per patient at ASH was 293 days.¹⁹² While ASH did

¹⁹¹ Correspondence from Josephine T. Lamb to W.E. Field, Jr., October 25, 1965, General Correspondence 1965, Box 2-22/757, Josephine T. Lamb Collection, Texas State Library and Archives Commission, Austin, TX.

¹⁹² The MHMR Biometrical Report of 1965 indicates that the rated bed capacity of ASH fell around 3,108 for 1965 with an overall patient population at 3,360 using in-patient services. However, these estimates also include the bed capacity and population of the Confederate Home for Men. Texas Department of Mental Health and Mental Retardation Biometrical Report, October 1965 in Josephine T.

not have the highest per patient per day cost, the largest in-patient population, nor the longest average stay for patients, the continuing battle for funds made it increasingly important to the MHMR that patient populations and costs be reduced as quickly as possible.

Furthermore, while the MHMR fought hard to wrangle funds for community centers while simultaneously trying to manage mental hospital admissions, leaders of community organizations made it clear that they felt the Austin-Travis County Community Mental Health Center should have nothing to do with ASH. Where the MHMR plan intended to use mental hospitals in cases where patients did not respond to six weeks of out-patient treatment, J. Ed Bridges, president of the Austin-Travis County board of trustees, responded that “[our] neighbors should be treated wherever possible in a community hospital without any worry about having to be put in Austin State Hospital.”¹⁹³ Despite Bridges’ representation of Austinites’ fears of ASH, the MHMR and the local board of trustees agreed to use ASH’s facilities for severe patients in conjunction with the beds provided at Brackenridge and St. Jude’s by the end of April 1967, likely because it was cheaper to use already existing institutions.¹⁹⁴ The differing expectations between the public’s vision for mental health centers and the state’s plan for reform illustrates the growing divide between the public and reformers in the late 1960s. The divide led to growing dissatisfaction from local communities and professionals, and cracked the foundations of the purpose that community center movement once shared.

Lamb General Correspondence 1965, Box 7-22/ 754, 753, 752, Josephine T. Lamb Collection, Texas State Library and Archives Commission, Austin, TX.

¹⁹³ Chris Whitcraft, “State Hospital Use not MHMR ‘Must,’” *The Austin Statesman*, April 17, 1967.

¹⁹⁴ Chris Whitcraft, “MHMR Community Plan is Revised,” *The Austin Statesman*, April 22, 1967.

The compromise between Austinites and the MHMR raised two key overlapping issues. First, could state funds be used to pay for a community center that was partially housed in St. Jude's, a private hospital? And, second, could the facility provide comprehensive care that addressed the needs of the community? As for the bond slowly forming between the MHMR and private hospitals, Chairman Tom McCrummen Jr. of Community Council Central Texas Comprehensive Health Planning Commission indicated that the plan would avoid opening a public service in a privately owned hospital whenever possible. His promise appeared lacking, however, because Brackenridge Hospital administrators were reported as having, "no interest in MHMR psychiatric beds being at the city-owned hospital [Brackenridge]." The failure to find commitment to the community plan from Brackenridge administrators and concerns about relying on privately-owned hospitals for the Austin-Travis County center led some members of the community to wonder whether the idea of a "comprehensive plan" was even possible. Community Program Developer Grover Shaunty grew frustrated. "No single type of inpatient unit can be designed to incorporate everything to meet every patient's individual needs," he complained, adding, "there is no empirical evidence to make a community conclude any one type of hospital facility is in fact the best for all patients." MHMR founder, Chester Snyder worried that competition would lead to fragmentation between hospital and community services. The outcome of community mental health centers could only be determined in the next two years.¹⁹⁵

The shortage looked as if it would prevent local communities from receiving the comprehensive mental health centers they wanted. The board of trustees in Austin and the

¹⁹⁵ Chris Whitcraft, "MHMR Community Plan is Revised."

MHMR were left to decide either to mediate between hospitals that were somewhat unwilling participants in the reform, or to rely on existing state hospitals—the very institutions they sought to replace—for services necessary to provide adequate mental health care at the community level.

Conclusion

The 1969 Department of Mental Health and Mental Retardation Report presented to Governor Preston Smith a picture of mental health services in Texas that differed greatly from what reformers envisioned in the early 1960s. Rather than a community-based form of mental health care that would be easily achieved, the 1969 report instead described a year of strife and tension, but also one of success made through the shared efforts of reform. To the MHMR, 1969 was “a year of progress because we served more mentally ill. They received better and faster treatment than ever before.” In particular, the report emphasized that despite setbacks patients had more opportunities for treatment and “return to society as productive citizens.”¹⁹⁶ The report argued that though hospitals generally took on more admissions in 1968, the conversion from the traditional centralized model allowed state hospitals to discharge patients with greater ease because of the working relationship between hospitals and local resources. Patients were “treated in a more home-like environment and returned to their families and jobs faster.” In particular, the report touted the department’s ability to establish planning and program developments for twenty community centers.¹⁹⁷ The department, as they presented their

¹⁹⁶ The Texas Department of Mental Health and Mental Retardation 1969 Annual Report, Folder Mental Health and Mental Retardation, Gov. Preston Smith Records, Box 1994/120-3, Texas State Library and Archives Commission, Austin, TX.

¹⁹⁷ The Texas Department of Mental Health and Mental Retardation 1969 Annual Report.

information to Governor Smith, wanted to ensure that, despite the MHMR's difficulties, could count itself a success.

Of ASH, the MHMR reported great success in diminishing patient populations and returning mentally ill persons back their communities. "For the first time in decades, Austin State Hospital's population dropped below 2,500." The department hailed ASH's treatment, training, and research facilities, and the hospital's focus on outpatient programs, vocational programs, and community acceptance for discharged patients.¹⁹⁸ In spite of the department's failure to set up community centers to replace mental hospitals, it showed through ASH and other state hospitals that progress could be made by reorganizing hospitals towards community involvement and local participation. Furthermore, it asserted that the MHMR restored citizenship to individuals and productivity to communities through the ability to treat and discharge patients faster.

Though the department was unable to establish all of the community centers that it set out to create, the department nonetheless succeeded in establishing twenty-one community boards in some sixteen communities for community centers, and offered optimistic projections for centers in the future.¹⁹⁹ The MHMR Annual Report even claimed "Texas rose to national leadership in 1969 in development of community mental health and community mental retardation services."²⁰⁰ By the end of the fiscal year of 1969, community centers that received state grants-in-aid could be found in San Angelo, Dallas County, Bexar County, Lubbock, Midland, Texarkana, Nueces County, Corpus Christ, Tarrant County, Fort Worth, Waco-McLennin County, Amarillo, Austin, Belton,

¹⁹⁸ The Texas Department of Mental Health and Mental Retardation 1969 Annual Report.

¹⁹⁹ Ibid.

²⁰⁰ Ibid.

El Paso, Harris County, and Jefferson County.²⁰¹ The report projected even more community centers for 1970. For the following year, the MHMR expected to further segment state hospital services by further specializing mental health treatments. The department expected continued state funding and resources, as it projected the construction of an additional six community centers. State hospitals, said the report, would continue outreach programs to local communities.²⁰² Though only partially successful in their goals, reformers did exact a substantial change in mental health services in Texas over the 1960s. However, a growing resistance to mental health reform and the internal disputes regarding a lack of political commitment shown through insubstantial funds and professional infighting limited their success.

By the late 1960s, the process of establishing community mental health centers as longstanding institutions in Texas's network of mental health facilities remained questionable. Mental health centers could not have successfully operated without relying on mental hospitals to continue to provide both outpatient and in-patient care for mentally ill Texans. Furthermore, the issues related to funding for mental health services were ever-present, and though the MHMR presented a report that argued for the relevancy of state mental health reform and state mental health care, many began to challenge the necessity of the state's involvement in mental healthcare. Thus, resistance to mental health reform grew simultaneously from within reformers' ranks as they struggled to define community mental health as an alternative and externally as the state failed to provide adequate funding and as public sentiment towards reformers became increasingly skeptical. At the end of the 1960s, the MHMR believed it had secured progress by

²⁰¹ The Texas Department of Mental Health and Mental Retardation 1969 Annual Report.

²⁰² Ibid.

overcoming many obstacles, but challenges to its existence were many, and more were still to come. In the 1970s, a contraction of social services, a rise in public concern over crime instead of care, and a civil rights movement from ex-patients that would tear down the foundations of public trust in psychiatry came to dominate discussions of mental health reform, and caused the ties that held reformers' unified sense of purpose to unravel. Therefore, by 1969 the MHMR genuinely believed that, despite their struggles, continued progress lay over the next horizon. The 1970s, however, would challenge that optimism, and ruptured their common purpose.

The tensions between the sense of purpose granted through expert perspectives and political authority, and the growing public ambivalence to reforms resembles the apex of other progressive liberal reform movements in the post-World War II United States. Though the timeline for mental health reforms occurred later, it also parallels the trajectory of other progressive liberal reform efforts in the postwar United States. At height these reforms, which were characterized by a faith in state and expert authority to remedy social ills reached a zenith that made reform efforts a target for resistance. The apex of mental health reforms in the 1960s was marked by similar zeal from reformers, who set out confident in their ability to establish new mental health treatments as alternatives to institutionalization. However, reformers' efforts met growing resistance to their expertise, and the basis of their shared sense of purpose faltered as they failed to establish a definitive reform between professionals and the public, and as government funds shrank in the face of an extensive political commitment. The result of this process was one of mixed success, a reform that did create substantial change in Texas mental

health system. But not one capable of living up the original promises of community mental health centers.

IV. THE CAUSES OF FRACTURE IN MENTAL HEALTH REFORM, 1970 TO 1984

In the 1970s, the common sense of purpose that once drove community mental health reform in the 1960s frayed. And by the 1980s mounting internal and external pressures had undermined the movements' shared focus. A growing patient rights movement turned reformers' efforts away from a concern for the collective welfare of mental health patients as clients of the federal government in the 1960s to a concern for individual patients' rights in the 1970s and 1980s. At the same time, state and federal support for mental health reform diminished, which worsened growing tensions between community mental health reformers who began to argue amongst themselves about their goals. Similar dynamics occurred broadly throughout mid-twentieth century. However, the fracturing of mental health reform became a particularly important example of the move from centralized conceptions of power after World War II to the individualistic and decentralized notions of power that dominated political ideology in the 1970s and 1980s. Without this increasingly individuated understanding of mental health care reform, the more well-known crisis of "deinstitutionalization" in the 1980s could not have happened the way it did.

The fragmentation of power of the late twentieth century has been described and analyzed by many scholars. "The social movements of the 1960s," as historian Daniel Rodgers described it, "set new languages and new consciousnesses of power spinning across the political landscape."²⁰³ The 1950s and 1960s emphasized interest-group pluralism where, "the best organized social interests competed ceaselessly for influence.

²⁰³ Daniel T. Rodgers, *Age of Fracture* (Cambridge, MA: The Belknap Press of Harvard University Press, 2011), 79.

Big business, big labor, and big government were the heaviest of the clashing interest groups,”²⁰⁴ However, in the 1970s and 1980s large interest groups and bureaucracies became the targets of criticism from those on the left and the right who viewed centralized power with suspicion. Likewise, “a parallel line of analysis focused on the power of the experts and professionals who increasingly dominated the twentieth-century ‘therapeutic state.’”²⁰⁵ Psychiatrists, along with many other professionals that led social reform movements in the 1960s, faced a growing public distrust of their expertise that undermined reform efforts.

The 1970s led to a splintering of centralized reform movements, and as people focused on “smaller and actor-center dimensions,” of social authority, “power fragmented and diffused.”²⁰⁶ Such fragmentation of power occurred in the mental health reform movement in Texas during the 1970s and 1980s. Community mental health reforms of the 1960s, which had concentrated power under psychiatrists and state leadership, disintegrated in the late 1970s and early 1980s as reformers turned away from the state as an agent of liberation and sought to limit the power of the state to protect the rights of individual patients. Whereas Texas had long sponsored a large network of mental hospitals and endorsed major community-based mental health reforms in the 1960s, the state later withdrew a significant amount of its funding for mental health resources.

The seeds of deinstitutionalization were sown in the early resistance to mental health reforms that emerged even as psychiatry gained in power in the 1950s and 1960s. Skeptics questioned the growing power embedded in the relationship between the

²⁰⁴ Daniel T. Rodgers, 81.

²⁰⁵ *Ibid.*, 82

²⁰⁶ *Ibid.*, 109-110.

psychiatric system and the state. Skepticism regarding institutional care grew as scandals, political infighting, and news of rising costs dominated the public's perceptions of state mental health systems. Simultaneously, tensions intensified as a patient rights movement pushed for greater protection against the perceived oppressions of the institutional system. Yet the protection of patient rights depended upon federal power. Thus, patient advocates called for a more federal regulation in mental health care even as a growing number of Americans question the power of the federal government generally and moved away from the belief that serving the needs of mentally ill persons ought to be understood as a public good worthy of public investment.

In Texas, the fracturing of the mental health movement originated from distinct but overlapping causes. An ascendant political movement seeking to limit the role of government in social welfare, which many history have called the rise of the New Right, actively defunded welfare programs, including mental health treatment centers and mental institutions. At the same time, an emerging patient rights movement that shifted the focus of mental health reform away from community mental health and towards a struggle for a protection of patient rights from the unchecked power of psychiatrists. Both the push to limit government roles in mental health and to protect patients' against abuses intensified the existing ambivalence many felt regarding state-sponsored mental health reform. Moreover, hospital scandals surfaced in local newspapers in the early 1970s, turning public opinion against the state's ability to institute mental health reform. Consequently, by the middle of the 1980s, a reformed mental health system had emerged that, on the one hand, protected patient rights, but on the other hand decentralized treatment and rehabilitation. Austin, and the state's oldest and most famous mental

institutions, Austin State Hospital in particular, became the center of the emerging battles over Texas's mental health reform movement. The Austin State Hospital, once a highly-respected model for effective and decentralizing mental health care, came under attack both as an institution of government inefficiency and as a limit upon individual rights.

The Origins of the New Right and its Effect on Mental Health Reform

The rise of the New Right contributed to a growing rejection of the state-sponsored psychiatric care as an intrusion of the federal government into people's personal affairs. Resistance to mental health reform and psychiatry was broad, and cannot be pinpointed specifically to any one group. However, some of the most vocal resistance to state mental health reform came from people who identified with a movement against the federal government's involvement in mental health. Conservatives, such as conservative activist Dan Smoot in Dallas, often argued against government involvement in psychiatric care by suggesting that the growing federal influence in mental health programs were communistic.²⁰⁷ In addition, they argued that the American people ought to distrust psychiatry, per se, which many believed was nothing less than an attempt to control the public through anti-psychotic medications that had a reputation for pacifying chronically mentally ill patients. "From a conservative perspective deeply suspicious of state power, mental health was a Trojan horse," argued historian Michelle M. Nickerson. For conservatives, mental health was, "a tool of the left, wielding influence under the shroud of medical authority and exerting power with the muscle of federal dollars."²⁰⁸ Though the fears of the spread of communism expressed by far right-wing groups

²⁰⁷ Michelle M. Nickerson, "The Lunatic Fringe Strikes Back: Conservative Opposition to the Alaska Mental Health Bill of 1956", in *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America*, ed. Robert D. Johnston (New Jersey: Routledge, 2004), 119.

²⁰⁸ Michelle M. Nickerson, "The Lunatic Fringe Strikes Back," 119.

generally fell on deaf ears, their fears regarding the nature of psychiatry and mental institutions echoed throughout the 1960s and into the 1970s and 1980s.

Open conflict broke out between supporters of the federal government's involvement in mental health care and extreme conservative groups during a political battle over the Alaska Mental Health Enabling Act of 1957. The bill sparked widespread conservative resistance to mental health reform that proved to be one of the first major barrages against community mental health reform, and mobilized right-wing groups across the nation to resist government sponsored mental health reform. Controversy began when Alaska legislators meant to strengthen the provisions for mental health treatments in the territory of Alaska. The bill created a national controversy by providing for forcible confinement for people having ostensibly extreme political associations and bizarre religious beliefs.²⁰⁹ Resistance to the bill came first from conservative, anti-Communist groups in California, including the America Public Relations Forum and Minute Women of the U.S.A.²¹⁰ By targeting the Alaska Mental Health Enabling Act, these small but vocal groups politicized mental health reform in a new way and paved the way for greater resistance to government sponsored mental health in the 1960s and 1970s.

Though resistance began with small, local groups, their voices gained support from conservative groups across the nation and gained the attention of national politicians. Republican Representative Usher L. Burdick of North Dakota, for one, openly defied the passage of the Alaska bill and national mental health reform. Burdick,

²⁰⁹ Committee on Interior and Insular Affairs, *Alaska Mental Health Enabling Act Report of 1956*, 84th Cong. 2d sess., 1956, S. Rep. 2053, 1-2.

²¹⁰ Michelle M. Nickerson, "The Lunatic Fringe Strikes Back: Conservative Opposition to the Alaska Mental Health Bill of 1956", 123.

like many critics of mental health reform, feared the growing power of psychiatrists, the federal government, and the United Nations, which they perceived as a communist threat. In particular, Burdick identified the lack of protection for civil liberties and vague psychiatric definitions as the basis for conservative fears. “I can be shipped off to Alaska where the one worlders will no longer be bothered by my fight and what they are trying to do...just one doctor stands between me and freedom.”²¹¹ Conservatives like Burdick viewed mental health reforms, like the Alaska Mental Health Enabling Act, as sinister threats to individual liberties.

The right-wing response to mental health reform was not unique to the Alaska Mental Health Enabling Act. In part, the conservative rejection grew out of responses to the growth of the field of psychiatry after World War II. “The progressive undercurrent driving mental health research and policy, and the federal government’s willingness to enforce its findings,” wrote Michelle M. Nickerson, “seemed downright heavy handed” to far-right conservatives.²¹² Psychiatrists believed that their training had the potential to solve the “ills” of society, including everything from marital problems to international relations. “[Psychiatrists] should sit on school boards, take part in town councils and bring our influence to bear on medical education and publication and in industry,” Carl Binger urged his fellow psychiatrists in 1948. “We must use our growing authority, not only in local but in national politics. We may even be able to storm the fastness of the State Department, sit in on deliberations such as the one on tensions recently held by

²¹¹ John Fisher, “Tells Hidden One Worlders’ Weapon in Bill: Could Exile Critics to Alaska as ‘Crazy,’” *Chicago Daily Tribune*, March 15, 1956.

²¹² Michelle M. Nickerson, 122.

UNESCO, or act as trouble shooters at U.N.”²¹³ To conservatives, psychiatry's reach appeared limitless, and their alliance with the federal government allowed the government the power and ability to assert tyrannical authority over individual lives.

Protests against the growing reach of government-sponsored psychiatric care spread across the nation and reached into Texas. The right-wing organization, Texans for America, took the lead, arguing that the growing power of the state, and its alliance with psychiatrists, threatened to destroy individual liberties. In addition to this organized resistance to government-sponsored psychiatric care, there is evidence that individual citizens also argued against the broad scope of public psychiatry. In particular, many objected to the use of psychiatric counselors in schools. Dan Smoot, a Dallas citizen and self-published right-wing journalist, argued that the federal government's support of psychiatric intervention in individual lives threatened liberal constitutional ideals and the basis of American civil liberties. To Smoot and other far-right political activists, mental health reform “sound[ed] like a democratic refinement upon the family spy system which the Soviets use to eliminate individualists.” The government, he believed, sought to stop “rebels or individualists [from] kick[ing] over the traces and resist[ing] such things as a world government presiding over a great one-world socialist state.”²¹⁴ Such fears continued into the early 1960s among those who perceived mental health reform as a government attack on American values. As one activist put it, government-sponsored

²¹³ Carl Binger. "New partnerships for Psychiatry," *American Journal of Orthopsychiatry* 18, no. 3 (July 1948): 545-546.

²¹⁴ Dan Smoot, "Thee and Me" *The Dan Smoot Report* 3 no. 37 (Sept. 16, 1957): 6, in Daniel L. Creson Papers, John P. McGovern Historical Collections and Research Center, Texas Medical Center Library, Houston, Texas.

psychiatry amounted to “an immoral, pernicious inroad into the privacy of every individual.”²¹⁵

For these conservative activists, community mental health programs seemed particularly dangerous. Such community-based, state-sponsored care seemed to threaten to force local communities to forfeit their authority to the federal government for programs that would cost millions of dollars. One such activist, Sarah Potter, aired her concerns in a letter to the *Dallas Morning News*. “It is to be hoped that the people of Dallas will think twice before contributing to the [Community] Mental Health activities under way in this area,” she declared. “This organization...in fact has supported legislation which may make those with emotional problems hesitate to seek help, in that they can be certified and institutionalized by government-appointed health officers without the consent of their families or without a jury trial.”²¹⁶ Eventually, such activists worried the government would create, at public expense, “a gigantic mental health program for the suppression of the individuality of every child...to make him a cog in a socialistic society.” They warned their fellow Texans that government-sponsored mental healthcare was “for the indoctrination of your child...by hand-picked servants of the Super State.”²¹⁷ Right-wing resistance centered on the government’s involvement in mental health treatments and the apparent lack of protection of civil liberties for institutionalized citizens. Such anti-government sentiment and rights-oriented arguments

²¹⁵ J. Evetts Haley to the State Committees of Correspondence and Education of Texans for America, March 6, 1961, Daniel L. Creson Papers, John P. McGovern Historical Collections and Research Center, Texas Medical Center Library, Houston, Texas.

²¹⁶ “Letters from Readers,” *The Dallas Morning News*, May 6, 1964.

²¹⁷ J. Evetts Haley to the State Committees of Correspondence and Education of Texans for America, March 6, 1961.

invigorated critiques of state sponsored mental health systems through the 1970s and 1980s.

Mental health reformers, including the Board of Mental Health and Mental Retardation (MHMR), local non-profits, and individuals involved in the mental health movement had to respond to right-wing resistance to their work. In Texas, for instance, the Hogg Foundation, which was one of the most active non-profit organizations in Texas mental health reform efforts, defended their cause against extreme right-wing views. The anxiety regarding mental health reform, foundation officers argued, “must be shown to be definitely not ‘meddling’ in the community,” and must be shown to be “directed toward getting information about a problem people care about.”²¹⁸ For the Hogg Foundation and other reformers, the remedy to extremist views depended upon the dissemination of information about reformers’ intentions and their potential for success. *My Brother’s Keeper*, a pamphlet written by Bert Kruger Smith and published by the Hogg Foundation, exemplified the attempt to gain public support for mental health reform. “The problem of the mental hospital patient is an urgent one,” Smith began, identifying in particular the extensive costs of reforms. “How to reduce hospital care from years of custodial detention to quick-term, intensive, effective treatment,” he explained, “is the question which economy-minded taxpayers face.” Smith sought to bring “to tens of thousands of persons an awareness of the problems as well as some of the elementary principles of mental health.”²¹⁹ For reformers, the spread of information proved the basis for their

²¹⁸ Hogg Foundation Meeting Minutes, June 27, 1961 from *American Psychologist* 16 no. 5 (May 1961) Daniel L. Creson Papers, John P. McGovern Historical Collections and Research Center, Texas Medical Center Library, Houston, Texas.

²¹⁹ Robert L. Sutherland, forward to *My Brother’s Keeper* by Bert Kruger Smith (Austin: University of Texas, 1953), 3, Daniel L. Creson Papers, John P. McGovern Historical Collections and Research Center, Texas Medical Center Library, Houston, Texas.

rebuttal against what they perceived as outlandish right-wing attacks on mental health reform.

The debate between health care professionals and their allies, on the one hand, and the right's attacks on psychiatry became part of a broader politicization of mental health in the late 1950s and early 1960s. Such reforms became enmeshed in larger ideological debate between left and right regarding the role of the growing federal state in the twentieth century. Though resistance to government involvement in mental health care was a relatively minor issue in the 1950s and 1960s, by the 1970s and 1980s these anxieties had taken on new resonance in both the New Right's attacks on the state and in the patients' civil rights movement that viewed mental hospitals as tyrannical institutions. Historian Daniel T. Rodgers argues that in the late 1960s and 1970s, "Americans asked themselves what sort of moral community the United States was and what sort of moral community it should become. The questions were not new, but, amid the larger shifts in social thought and context, the answers were different from before."²²⁰ These questions permeated the debate over mental health reform. As happened in many arenas of American life, the Right and the Left, for their own reasons, both attacked the growing power of the state, helping to further fragment the key issues of American policymaking. The politicization of mental health reform exacerbated growing anxieties regarding the expanding field of psychiatry and mental health reform.

State Hospital Scandals and Public Skepticism of State Sponsored Mental Health

At the beginning of the 1970s, the State of Texas assumed the care, treatment, and rehabilitation for the majority of people with mental illness and mental retardation.

²²⁰ Daniel T. Rodgers, 181-182.

However, simultaneously—and seemingly in contradiction with their support for public mental health care facilities—many reformers and the public revealed a growing sense of unease with the state’s involvement in mental health treatments. Part of the unease regarding state involvement in mental health grew out of the troubled historical relationship between mental hospitals and the public. Stories of abuse of patients and other scandals marred the history of mental hospitals as early as the nineteenth-century and continued throughout the twentieth-century. When mental hospital scandals arose in the 1970s, they coincided with increased infighting amongst reformers. Scandals made it more difficult to secure already increasingly scarce funds, exacerbating destructive competition between reformers and causing a crisis of faith in reform efforts. This loss of faith coincided with the growth of the patient rights movement that aimed to secure patients' civil liberties in commitment processes and the right to treatment, a process that pitted a new generation of individual rights activists against mental hospitals and identified the state as an obstacle to reform rather than an ally.

On June 6, 1970, *The Austin Statesman* broke the story of an abuse scandal at Austin State Hospital (ASH), contributing to the growing unease the public felt about the state’s ability to lead mental health reform. Democratic State Representative, Don Cavness, accused officials at ASH of “permitting drinking and mistreatment and sexual abuse of teenage patients.”²²¹ Cavness declared that “sexual promiscuity between children and children and attendants” had increased in ASH’s children’s psychiatric children’s unit.²²² Reverend Robert Tate, a mental health reformer on the Board of

²²¹ George Keumpel, “Patient Abuse at Austin State Hospital Charged, MHMR Board Planning Probe,” *The Austin Statesman*, June 6, 1970.

²²² George Keumpel, “Patient Abuse at Austin State Hospital Charged.”

Mental Health and Mental Retardation (MHMR) that oversaw Texas’s state mental health program, echoed Cavness’s claims. “I can well believe [Cavness’s claims] and more, said Tate, “about what is happening at the State Hospital.”²²³ Officials from ASH declined to comment on the accusations, but Cavness insisted that unconfirmed sources told him that two attendants raped a sixteen-year-old patient. He also questioned one of the “treatments” that the hospital used in which patients were allegedly “stripped, placed in a room and encouraged to fight.”²²⁴ Patients who refused to fight were showered with bedpan waste until they became angry enough to fight. Cavness also claimed that a girl had been chained to a basketball hoop for twenty-four hours as punishment. He believed that some patients were held in “quiet rooms where they were stripped and held in padded detention cells for up to three days.”²²⁵ Additionally, Cavness argued that alcoholics in the rehabilitation ward of the hospital were allowed to drink and keep alcohol in their rooms.²²⁶ As Cavness’s allegations unfolded in the Austin newspaper, the public grew increasingly alarmed by the possibility of mistreatment and questioned the validity of psychiatric treatments behind the hospital’s walls.

Despite the severity of Cavness’s claims, the MHMR quickly came out in support of ASH staff, and discounted some of the more serious stories of sexual abuse charges. “I realized I didn’t know what was happening,” Reverend Tate admitted as he reversed his position on the scandals after the MHMR’s stance on the issue became clear. Tate warned that Cavness’s, “story jeopardizes human personalities by innuendo. The board should

²²³ George Keumpel, “Patient Abuse at Austin State Hospital Charged.”

²²⁴ Ibid.

²²⁵ Ibid.

²²⁶ Ibid.

rise up in their defense.” When questioned about his statement that he “wasn’t surprised” about the alleged abuse at ASH, he responded by shifting blame from the institution to the Texas legislature that failed to adequately fund mental health. Reverend Tate had, he said, hoped Cavness’s charges would lead him to fight for more state funds to improve and professionalize ASH staff, and he hoped that Cavness’s claims would solve the MHMR’s problems. When “the legislature [was] in the mood to make decent appropriations,” suggested Tate, “then the problems such as the Austin legislator described would be solved.”²²⁷ Tate continued to emphasize that the legislature’s failure to provide adequate funding and resources for institutional staff caused the loss of control of certain wards.²²⁸ As the Texas legislature withdrew funding from the system, mental health reformers found it increasingly difficult to sustain alliances for reform. Unlike their counterparts in the early 1960s whose sense of a common purpose benefited from a peak in federal support, reformers in the 1970s began infighting as their goals splintered due to a lack of support and funding from Texas legislatures. More importantly, the infighting and lack of state support presented an image of bureaucratic incompetence to the public.

The MHMR reacted defensively to Cavness’s claims, and publicly supported the hospital’s reputation and the department’s leadership in mental healthcare. Dr. William O. Wheeler, psychiatric director for sixteen- to twenty-one-year-old patients at ASH, asserted, “No Austin State Hospital patient has reported any attempt at rape in or out of

²²⁷ Chris Witcraft, “MHMR Voices Backing of State Hospital’s Staff,” *The Austin-American Statesman*, June 7, 1970.

²²⁸ Chris Witcraft, “MHMR Voices Backing of State Hospital’s Staff.”

the hospital in more than a year.”²²⁹ Dr. Wheeler denounced *The Austin-American* and Representative Cavness for their unsubstantiated accusations. Wheeler touted what he described as the many advances made at ASH in the previous two years in psychiatric treatment and housing of adolescents, and argued that the changes made the hospital less prison-like and provided a better therapeutic environment.²³⁰ Additionally, the MHMR reinforced its defense of ASH staff after their investigation of the hospital. Dr. Charles H. Brown, committee chairman, reviewed the security system at ASH and concluded that finding evidence for Rep. Cavness’s claims was “like trying to catch fog in a bucket.”²³¹ Dr. Brown stated that Cavness’s report was filled with “all sorts of stuff,” including a story regarding a girl that Cavness stated “jumped off a cliff,” when in reality the patient—on official leave of absence from the hospital—broke her ankle at a party raided by police.²³² Dr. Brown did assert a need for more security officials to deter “nighttime interlopers, some of whom carry drink or liquor,” and recommended better communication between night and day security shifts, as well as better lighting for the hospital ground at night. However, they found no evidence that could incriminate any ASH staff member on the grounds mentioned in Cavness’s report.²³³ The MHMR clearly needed to denounce Cavness’s allegations in order sustain the public’s support for mental health reform. Mental health reformers no longer enjoyed the generally positive relationship with the public. Increasingly, people eyed the state’s role in mental reform with suspicion and distrusted the authority of mental health experts.

²²⁹ Chris Witcraft, “Hospital Rape Story Discounted,” *The Austin-American Statesman*, June 7, 1970.

²³⁰ Chris Witcraft, “Hospital Rape Story Discounted.”

²³¹ Chris Witcraft, “MHMR Voices Backing of State Hospital’s Staff.”

²³² *Ibid.*

²³³ *Ibid.*

Once the MHMR completed its own investigation of ASH, the department was forced to admit that several instances occurred in the hospitals' wards that had to be addressed. Sexual promiscuity and drug abuse were the most common complaints raised at the hospital, and the report raised alarms about many of the hospitals' practices, many of which were sanctioned psychiatric practices. One complaint raised in the report came from the husband of a female patient who contracted gonorrhea after visiting her, and he insisted that he had not had any extramarital affairs. The woman confessed she had had an affair with a nineteen-year old hospital attendant and was pregnant after "having intercourse 50 to 60 times" with him.²³⁴ The report also revealed the lack of supervision for teenage patients. In one of the clearest examples, three male teens were seen with one female teenager between fifteen and sixteen years old "putting lighter fluid onto tissue paper and holding this to their faces until they would fall over and begin to shake and laugh," which went on for some twenty minutes.²³⁵ Investigators also found instances where adolescents prone to fighting were "taped together at the wrists," at the express orders of an ASH doctor who, "instructed the Child Care Workers to leave the girls together until they were finished arguing," and were "placed on a schedule for arguing every thirty minutes."²³⁶ Of particular concern, the Austin Police Department believed that people voluntarily checked themselves into the hospital after committing crimes in order to avoid being prosecuted, and that twelve patients of ASH were involved in thirty-

²³⁴Mental Health and Mental Retardation, *Report of Investigation of Complaints Concerning Austin State Hospital*, 7, Sara Sitton Collection, Box 1 Folder 4, Austin History Center, Austin Public Library, Texas.

²³⁵ Mental Health and Mental Retardation, *Report of Investigation of Complaints Concerning Austin State Hospital*, 8.

²³⁶ *Ibid.*, 18.

three burglaries and other crimes over the last two years.²³⁷ The content of the report, much of which was published in newspapers across the state, revealed to the public that ASH faculty, despite MHMR's confidence in the hospital, could neither guarantee the safety of their patients inside the hospitals' walls nor could it keep those outside the hospitals' grounds safe from its patients.

The testimonies, printed in the state's newspapers, of two former ASH employees, James Wilson and Rick Laminack, confirmed the grave nature of Caveness's initial allegations. The two described the children's wards as "old, rundown...overrun with rats and cockroaches," and "the closest thing to a ghetto," Wilson had ever worked in. Children often went months without medical care, did not receive the professional attention necessary for treatment. They were denied meals as a form of punishment, and sometimes were locked in isolation for more than a week. Wilson's testimony corroborated one of Caveness's most shocking claims about a teenage patient being chained outside for over twenty-four hours. The girl had been chained to a basketball pole for more than a day because her screams "'bother[ed] other patients and staff.'"²³⁸ The MHMR report on the hospital confirmed not only that the girl had been chained outside to a pole for over a day, but also that hospital staff had done so at the direct orders of a doctor, who explained that occasionally other patients had been "tied to a volleyball net post in such a manner that the patient could free himself. The theory was that when the patient worked himself free he would no longer be angry," and that "the idea of patients being bound was not new and was employed by other mental institutions

²³⁷ Mental Health and Mental Retardation, *Report of Investigation of Complaints Concerning Austin State Hospital*, 10.

²³⁸ George Kuempel, "Pair Support Caveness' Claim," *The Austin Statesman*, June 11, 1970.

throughout the nation.”²³⁹ The testimonies of Wilson and Laminack compounded some of the more shocking practices that were exposed in the MHMR report, and many people began to wonder about the foundations of psychiatric practice. The scandal not only caused greater distrust between the public and mental health facilities, but also caused a rift within the MHMR and hindered the department’s overall ability to secure continued support for mental health reforms throughout the 1970s.

The extent of the report damaged Governor Preston Smith’s reputation and the MHMR’s public standing. Governor Smith, who told reporters that the MHMR and ASH faculty were “doing a good job” and asserted Caveness’s claims were uncorroborated when the allegations first aired, soon found himself a target for public criticism.²⁴⁰ After the MHMR concluded its investigation into faculty conduct at ASH, Governor Smith and the MHMR were forced to admit that all was not well within the hospitals’ wards. Smith backpedaled on his position on ASH as Paul Eggers, the Republican gubernatorial candidate running against Smith, chastised Smith for his “‘premature’ judgment...aimed at ‘placating’ the public.”²⁴¹ “This report does prove that there are some regrettable things wrong at the hospital,” admitted Smith. The governor continued to defend the MHMR for “not attempting to ‘whitewash’ the charges,” assuring Texans that “This board, as do all of our citizens boards...worked hard for our citizens...[and] is one of the strengths of our system.”²⁴² The contradiction between the MHMR’s report and their previous insistence

²³⁹ Mental Health and Mental Retardation, *Report of Investigation of Complaints Concerning Austin State Hospital*, 21.

²⁴⁰ “Patient-Abuse ‘Nil,’ Pair Tell Smith,” *The Austin Statesman*, June 11, 1970.

²⁴¹ Stewart Davis, “Abuse of Patients Confirmed in Report,” *The Dallas Morning News*, July 12, 1970.

²⁴² “Governor Claims Something Wrong at Hospital,” *The Austin Statesman*, July 12, 1970.

that Caveness's claims held no factual basis prompted questions regarding the ability state officials and mental health experts to effectively direct and manage reforms.

Editorials published in local newspapers made clear that the general public invested their trust in the testimony of former hospital employees over the reassurances of Governor Smith and MHMR board members. Despite the MHMR's official investigation into ASH employee conduct, some felt it "unlikely that a report of an investigation by the Board...will settle questions in the public's mind about the Austin State Hospital controversy."²⁴³ The key problem for Austinites, argued reporter Glen Castlebury, was that "the MHMR board continually [was] much too plagued by personalities and politics to secure public confidence on debatable, sensitive and emotional allegations."²⁴⁴ The scandals and infighting showed to the public that MHMR did not have the control over institutional care and mental health reforms that it touted, further weakening the public's trust in state mental health bureaucracies.

MHMR board members gained a reputation for being infected with political problems as infighting within the department aired publicly. The most notable example occurred when Rev. Robert Tate forced Commissioner Dr. John Kinross-Wright to resign after Kinross-Wright fired Deputy Commissioner Gary Miller against the board's wishes in April of 1970.²⁴⁵ Much of the infighting revolved around perceptions amongst the MHMR board members that Dr. Kinross-Wright did not appear committed to establishing community mental health centers in Texas.²⁴⁶ By 1970, MHMR politics chafed state

²⁴³ Glen Castlebury, "CAPITOL," *The Austin Statesman*, June 14, 1970.

²⁴⁴ Glen Castlebury, "CAPITOL."

²⁴⁵ Glen Castlebury, "CAPITOL.," "State MH Director Quits Job," *The Austin Statesman*, April 17, 1970.

²⁴⁶ "State MH Director Quits Job."

officials and board members alike, even to the extent that some members felt that “the whole board should resign” and that having the “slate wiped clean” was likely the easiest way to solve the MHMR’s issues.²⁴⁷ The board that once promised a new and improved mental health system had become identified with inefficiencies, infighting, and scandals. Once the MHMR no longer held a reputation for being a clear leader in Texas’s mental health policy, it became a target for criticism that fueled distrust for the state’s role in mental health reform.

The scandal at ASH and the infighting of the MHMR at the beginning of the 1970s set a tone of distrust and between the public, mental health reformers, and the state government. In contrast to the resistance to psychiatric power in the 1960s that was characterized by an ambivalent attitude toward psychiatrists’ ability to remedy the ills of the mental health system, resistance to psychiatrists’ power in state hospitals intensified throughout the 1970s. The doubts raised by ASH’s patient abuse scandal regarding MHMR’s ability to guide Texas’s mental health reform movement exacerbated the struggles it placed to find support it needed to enact the change it promised. Once the MHMR became entangled in its own squabbling in the face of abuse scandals, the department became a target for criticism. The tensions at the beginning of the decade, therefore, added exacerbated the fissures already forming between the public and mental health reformers.

The Patient Rights Movement, Decline of Expert Authority, and the Rise of the New Right

²⁴⁷ “Letter Asks Chief of MHMR to Quit,” *The Austin Statesman*, April 8, 1970.

By the 1970s, the strongest proponents of mental health reform increasingly framed their argument in terms of individual patient rights. While the advancement of patient rights proved essential for the goal of creating a more just mental health system, this rights-based argument limited the scope of reformers' goals and their potential to win support for increased funding. This shift in ideology proved critical because it coincided with the New Right's concerted attack upon federal funding for state welfare provision that included the increasingly discredited mental health care system. The Right not only criticized state mental health care as inefficient and unnecessarily expensive, but also targeted reformers tactics of using "activist" courts that were often seen as meddling in defining relationships between the state and the individual. Over time, the Right and an increasingly conservative public began to identify the state as the greatest threat to patient rights and progress in mental health care, which was only worsened by the growing cost of Texas's mental health care system.

The momentum against expanded psychiatric care grew in part because professional psychiatrists took up the cause. Psychiatrist Thomas Szasz, for instance, crafted powerful critiques of modern psychiatry in his books *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, first published as an essay in 1960 and republished as a book in 1973, and *Law Liberty, and Psychiatry: An Inquiry into the Social Issues of Mental Health Practices*, published in 1966. Szasz, a libertarian, generally believed that psychiatry was a form of social control often used tyrannically in the name of "good" mental health. Mental illness, according to Szasz, only designated behavior that psychiatrists deemed "abnormal," and Szasz even questioned the existence

of mental illnesses because of the subjective nature in which they were diagnosed.²⁴⁸ Furthermore, Szasz argued that psychiatry served as a means of social engineering for the advantage of the state over its populace by “engag[ing] in attempts to change the behavior and values of individuals, groups, institutions, and sometimes even of nations.”²⁴⁹ His assertions cast doubt on the motivations behind psychiatric treatments that inspired many mental patients and their families to question the authority of psychiatrists in mental health reform.

Szasz also helped popularize the concept of patient rights and strengthened the notion that patient civil liberties ought to be protected. Szasz likened the struggles of mental patients to other oppressed groups and encouraged mentally ill persons to fight for their own civil rights. “Like the Jews of Nazi Germany or, until recently, the Negroes in the South, mental patients have been afraid to stand up and fight for their liberty.”²⁵⁰ His answer for how mental patients ought to improve their lives was highly influenced by his perception of the Civil Rights movement. Szasz suggested that, “Perhaps the most effective method for securing the mental patient’s liberty—not to become mentally well, but, if need be, to remain as he is and yet enjoy the right of an American—lies in legal action against his oppressors.”²⁵¹ Szasz’s analogy between the African American Civil Rights movement and the patient movement reflected the growing links between

²⁴⁸ Thomas Szasz, *The Myth of Mental Illness Foundations of a Theory of Personal Conduct* (New York: Harper Perennial, 1974), 101.

²⁴⁹ Thomas Szasz, *Law, Liberty, and Psychiatry: An Inquiry into the Social Issues of Mental Health Practices* (New York: The Macmillan Company, 1963), vii.

²⁵⁰ Thomas Szasz, *Law, Liberty, and Psychiatry*, 253.

²⁵¹ *Ibid.*

resistance to psychiatric power amongst the public and an idea of rights-based liberalism, one that “proved inadequate to the immense social problems that lay before it.”²⁵²

Individuals like Szasz encouraged a growing movement that focused on defining the civil liberties of institutionalized individuals. The efforts to establish rights for persons with mental illness had a broad, grassroots base that is often hard to identify. However, in Austin, activists began to raise awareness for mental patient rights. Activist Marj Wightman editorialized her views on mental patient rights in August of 1964 in the *Austin American*. “Don’t give anyone the idea you’re a nut,” she warned Austinites, “You may wind up in a legal jungle fighting for your civil rights.” Wightman went on to tell Austin readers that mental patients “comprise one of the largest oppressed minorities in the nation.”²⁵³ Wightman cited Professor Ralph Slovenko as the inspiration for her activism. Slovenko, professor of Law at Tulane University, spoke at the American Psychiatric Association (APA) in 1964 with Thomas Szasz, and wrote extensively on the limited rights of mentally ill persons in the 1960s.²⁵⁴ In 1961, Slovenko criticized commitment procedures across the nation for their ignorance of patient rights. “The jail cell is no more abominable than the closed ward of some hospitals,”²⁵⁵ he charged. Worse, he claimed, “as recently reported in Texas, seventy per cent of its patients do not need to be in a mental hospital.”²⁵⁶ As professionals aired their criticisms of the mental health movement of the 1960s, they gained traction with members of the public. Though

²⁵² Robert Korstad, “Civil Rights Unionism and the Black Freedom Struggle,” *American Communist History* 7, No. 2 (December 2008): 257.

²⁵³ Marj Whightman, “Law of the Jungle,” *The Austin American*, August 3, 1963.

²⁵⁴ Emma Harrison, “Psychiatrists Air Rights Attack: Mental Health Movement is Debated at Meeting,” *The New York Times*, May 6, 1964.

²⁵⁵ Ralph Slovenko and William C. Super, “The Mentally Disabled, the Law, and the Report of the American Bar Foundation,” *Virginia Law Review* 47, no. 8 (Dec., 1961): 1372.

²⁵⁶ Ralph Slovenko and William C. Super, 1374.

such resistance to reform had not yet gained the traction it would during the 1970s, Szasz and Slovenko helped lay the groundwork for later political action and created increasing political pressures for a movement for patient rights.

Congress, swayed by the growing momentum of patient rights activists across the nation, also raised doubts about forced commitments in state hospitals throughout the 1960s and launched numerous investigations to assess the status of the constitutional rights of institutionalized persons. In November 1969 the Subcommittee on Constitutional Rights led by Democratic South Carolina Representative John Lanneau McMillan held a congressional investigation on the constitutional rights of the mentally ill. The purpose of the McMillan's report was to establish the effectiveness of the District of Columbia Hospitalization for the Mentally Ill Act of 1964 that intended to protect the rights of mentally ill persons in Washington D.C.²⁵⁷ McMillan told the House that he hoped that law would start the process of "fashioning...a strong chain of constitutional protections for a long-neglected group in our society."²⁵⁸

McMillan's call for protection of civil rights indicated a rising bottom-up demand for the protection of patient civil liberties. The Senate received "hundreds of letters of complaint and injury concerning the treatment of mentally ill," who "saw grave constitutional problems arising if the law assumed a governmental right to involuntary hospitalization."²⁵⁹ As state-based psychiatrist-led mental health reform received growing criticism, reformers' focus shifted away from an exploration in community mental health

²⁵⁷ House Committee on the District of Columbia, *Protect the Constitutional Rights of Persons Who are Mentally Ill*, 88th Cong., 2d sess., 1964, H. Rep. 1833, 1.

²⁵⁸ House Committee on the District of Columbia, *Protect the Constitutional Rights of Persons Who are Mentally Ill*, 2.

²⁵⁹ Senate Committee on the Judiciary of the United States Senate, *Constitutional Rights*, 91st Cong. 2d sess., 1970, S. Rep. 91-1205, 2-3.

to a patient rights movement that focused on protecting the individual patient against the potential abuses of the psychiatric state. The growing emphasis on individual patient rights, while necessary, fractured the common sense of purpose that had once tied reformers' efforts together.

Growing conservative attacks upon the welfare state also shaped the politics of mental healthcare reform by further undercutting the support for funding hospitals and mental health programs. Resentment against government spending grew and “focused on soaring federal spending and climbing tax rates,” as many Americans expressed frustration that “Criminals, the mentally ill, American Indians, immigrants, youth, prisoners, and homosexuals, demanded ‘special privileges’ while hard-working Americans were overlooked and overtaxed.”²⁶⁰ Such frustrations arose early in the 1970s and were reflected in conversations surrounding state budgets. *The Dallas Morning News* described the Texas budget drafted by legislators in June 1972—which provided for only \$15.8 million of the requested \$300 million—as a “financial time bomb.” Representative Jake Johnson from San Antonio “complained of ‘the high price of poverty’” as the budget committee denied a \$3.5 million request from the MHMR “for federal certification that allow[ed] welfare patients to receive their checks.”²⁶¹ Mental health reformers found themselves struggling for political support as MHMR programs associated with the “high price of poverty” that became increasingly controversial through the 1970s. The growing political skepticism for welfare programs also brought mental health reforms under fire, and contributed to a retraction in political support for state sponsored mental health.

²⁶⁰ Michael Schaller, *Right Turn: The American Life in the Reagan-Bush Era, 1980-1992* (New York: Oxford University Press, 2007), 41.

²⁶¹ “Budget Requests Slashed,” *The Dallas Morning News*, June 22, 1972.

Mental health programs not only faced pressures from shrinking budgets and increasing political resistance, but also contended with dramatic changes in the federal government's leadership role in mental health reform. Federal officials sought to decentralize services by fracturing the National Institute of Mental Health's influence over reform movements and redistributing its authority to politically appointed regional directors in the Department of Health, Education, and Welfare (HEW). Federal policy makers hoped that the shift from NIHM to HEW would "bring decisions closer to the people," but its effect was to shift the responsibility of mental health reform from a central federal agency to regional directors at HEW.²⁶² Furthermore, many questioned HEW's ability to manage the community mental health centers and continued reforms. When NIMH Director Stanley Nolls resigned in response to the decentralization of federal mental health care oversight, he attacked HEW as lacking qualified personnel to run national mental health programs. Likewise, many of NIMH's healthcare professionals feared that that decentralization "seriously jeopardized" community based health centers and thus would disproportionately hurt racially segregated or underprivileged communities.²⁶³ Community centers, once the answer to the many problems of state mental hospitals, faced the increasing threats of shrinking financial support and political attack. What had once been a broad national reform movement in the 1960s splintered in the 1970s.

While it appeared to some that decentralization might crack the foundations of the community mental health movement, some reformers found the prospect of

²⁶² "Politicizing Mental Health," *Public Information Center News* 1 no. 3 (August 1970): 3 in Gov. Preston Smith Papers, Mental Health and Mental Retardation Folder, Box 1994/120-3, Texas State Library and Archives Commission.

²⁶³ "Politicizing Mental Health," *Public Information Center News* 1 no. 3 (August 1970): 3.

decentralization liberating for patients and mental health professionals alike. Public perceptions of progressive mental health policies shifted from the 1960s to the 1970s, as increased patient liberty became a major goal for reformers. Both Travis County and Central Brazos Valley units, two wards at ASH, enacted open-door policies that allowed patients to come and go from the hospital as they pleased, and allowed a greater amount of patient autonomy than had ever been seen before at the hospital. Though many people expressed serious security concerns about allowing patients to leave and return at their own will, the open-door policy allowed patients to create their own communities within hospital units.²⁶⁴ Dr. Margaret Sedberry, then director and psychiatrist of the Travis County Unit, summarized the change, “The philosophy used to be that the psychiatrist played God...but with decentralization, each unit is like a small hospital in itself. The doctor is no longer God.”²⁶⁵ Whereas the previous structure of state hospitals focused on instituting tighter security, the new “open door” model of hospital care helped reduce the association between the hospital and confinement. ASH thus had to project an identity to the community that was both therapeutic and liberating. Though for a time ASH managed to find a middle ground between patient rights and providing effective services, such compromises would become harder to find as state budgetary constraints limited mental health program funding.

Texas’s struggle to find alternative funding for mental health care, and for welfare programs as a whole, became part of a national crisis in welfare provision. States had relied largely on federal funds to support social and welfare services, but as the cost of these programs grew, sympathy for welfare programs shrank. The State of Texas faced a

²⁶⁴ “At State Hospital: Open Wards Symbolize Freedom,” *The Austin Statesman*, March 11, 1973.

²⁶⁵ “At State Hospital: Open Wards Symbolize Freedom.”

\$400 million year deficit for 1972. Texas residents watched as their representatives “inflict[ed] new fiscal pain” through new taxes to pay for welfare programs. The “booming welfare and education costs...suffocate[ed] the states,” and ensured that “while people in Washington talk, those back home are going to pay—big.”²⁶⁶ As attention shifted toward costs of services, many began to view state services as being stretched thin at the expense of the individual taxpayer. The community services that had been the answer to mental health reform and the key to the transition from hospital to community center became increasingly seen as an additional burden on the individual taxpayer.

As discussions about treatments focused increasingly on patient liberty, funding for mental health centers faced increasing scrutiny by a state legislature that had become more concerned with costs than quality of services. In 1975, the state legislature slashed the MHMR’s budget and accused community mental health and mental retardation centers of being wasteful and grossly inefficient. Two members of the House Appropriations Committee claimed community centers amounted to “little more than ‘porkbarrel’ [sic] operations which pay inflated salaries to persons of questionable competence,” and believed community services’ budgets required additional state oversight and regulation.²⁶⁷ Demands for increased funding in the mental health system coincided with the increase in overall resistance to welfare spending, thus weakening the MHMR’s political allies in the Texas House and Senate. The Texas Senate Human Resources Committee, for example, delayed passing a bill to increase funding for state community mental health and mental retardation services after Senator Bill Braecklein—

²⁶⁶ Bruce Boissat, “Fiscal Pinch of the States,” *The Austin Statesman*, March 8, 1971.

²⁶⁷ Dave Mayes, “MHMR Officials Grilled by House Panel,” *The Austin Statesman*, March 7, 1975.

a key supporter of MHMR activities in the legislature—learned of the \$70 million required to implement the changes outlined in the bill. Even though reformers promised a substantial boost to the quality and types of services available, the cost of the services appeared far too high for the committee.²⁶⁸ The lack of support for additional spending on community mental health center reform not only led to doubts in the communities that mental health professionals sought to help, but it also undercut the political support necessary to maintain mental health as a priority.

More and more observers, from a wide range of political backgrounds, began to argue for the rights of mentally ill persons as citizens in the 1970s. In doing so, they created an ambiguous political environment. Once momentum for mental health reform sputtered, the anxieties about court-ordered commitments, psychiatric control over individuals, and the legitimacy of psychiatry as a medical profession all converged around the notion of the mental patient as citizen in the 1970s. This broad coalition of groups concerned with patients' civil rights created what became known as the ex-patient movement. The goal of the patient rights movement sought to protect the civil liberties of mentally ill persons by restricting the power of state institutions to hold people in state hospitals for lengthy periods and by securing a patient's right to refuse treatment. Litigation sought to establish clearer definitions of mental illness and to secure a constitutional right to treatment that included an individual's ability to refuse therapy. In the midst of these debates, several court cases arose regarding patient rights, which limited mental hospitals' abilities to provide treatments and refocused mental health reform on mental hospitals instead of community mental health care. As reformers used

²⁶⁸ "Panel Delays MHMR Bill: Mentally Retarded Rights Act Cost 'Frightening,'" March 11, 1975.

federal courts to intervene on their behalf, it exacerbated the conflicts between state legislatures, the state, and the MHMR surrounding funding that led to the eventual fracturing of mental health reform efforts.

At the same time that funding for mental health programs declined, mental health reformers faced growing criticism from advocates of patient civil rights. Patients, as well as hospital attendants, began speaking out regarding their experiences of abuse and neglect within state psychiatric hospitals. Together, they sought to change the state's legal framework to secure the rights of mental patients and the rights of mentally disabled persons. Free the Slow, a local civil rights group in Austin, fought for the rights of mentally disabled persons by criticizing treatment in mental hospitals and state schools. The former state hospital and state school employees joined Free the Slow to protest the forceful use of experimental drugs without consent from patients.²⁶⁹ The group focused on concerns regarding the lack of patient choice in treatment programs and indefinite confinement in institutions.

The Mental Health Law Project (MHLP), founded in 1972, sought to push for mental health reform through litigation. In particular, they set out “to use the systematic involvement of lawyers and mental health professionals in order to eliminate the disparity between professional ideals and performance in the field of mental health and mental retardation.”²⁷⁰ The organization sought to rectify a discrepancy between psychiatric practices that emphasized patient autonomy and state hospital treatment that remained

²⁶⁹ “State Hospitals Criticized Here” *The Austin American*, August 25, 1973.

²⁷⁰ Lawrence Schwartz, “The Issue of Litigation,” (Speech given at Mental Health Symposium Sponsored by Texas Department of Mental Health and Mental Retardation and the Texas Foundation for Mental Health and Mental Retardation, Austin, TX, April 3–4, 1974), Daniel L. Creson Papers, John P. McGovern Historical Collections and Research Center, Texas Medical Center Library, Houston, Texas.

centered on control. The MHLP sought regulations for state institutional care that legally defined the basis for psychiatric commitment and protected patient civil liberties in state institutions. They wanted the federal government to force every institution “to provide a humane physical and psychological environment for its residents.” The group also aimed for new standards for the hospital facilities, and they crafted the notion of a patient’s right to due process that established that facilities had to treat patients or release them. Finally the MHLP sought “a least restrictive alternative,” meaning that state hospitals should find the least restrictive means to providing treatments, minimizing long-term forced commitments as much as possible.²⁷¹ The MHLP and its allies, profoundly shaped the developing patient rights movement, bringing a focus on legal protections for mental patients within existing institutions instead of exploring alternatives to mental hospital care.

Local newspapers often reported on the dilemma the mental health system faced and focused the public’s attention on the effectiveness of state mental health systems and raised questions about the state’s respect for patient’s civil liberties. For instance, the *Austin Statesman*’s Larry Wright reported on the travails of one twenty-three-year-old woman who suffered from epileptic seizures and exhibited signs of excessive drinking, promiscuous sexual behavior, and rebellious activities throughout her life.²⁷² Wright witnessed a discussion between social workers as they debated the best course of action. For such a troublesome patient, the social workers suggested, neither institutional nor community resources would offer the woman much help. “What is her sin that she be sent

²⁷¹ Lawrence Schwartz, “The Issue of Litigation,” (Speech), Austin, TX, April 3–4, 1974.

²⁷² Larry Wright, “She’s a Mental Patient Beyond Help—Or is She?” *The Austin Statesman*, June 17, 1974.

to the hospital?” they asked. “People don’t like when a retarded girl” is promiscuous, “but what about patient’s rights?” they continued, as the group discussed patient autonomy in treatment programs. “I begin to question what we have really done for her.”²⁷³ Stories like Wright’s raised questions about the state’s ability to effect change through psychiatric intervention. These questions kindled public doubts about state intuitions’ ability to help individual patients recover their livelihoods after a mental illness.

In 1970 Alabama reformers, Charles Halperin and the Center for Law and Social Policy, brought a class action lawsuit seeking to establish a constitutional right to adequate care. The case arose when Alabama’s state hospital fired a large portion of its staff due to budget constraints, which negatively affected the patient-to-staff ratio. In *Wyatt v. Stickney*, Halperin argued that states had a legal obligation to staff adequate numbers of professionally trained personnel in order to fulfill patients’ constitutional right to treatment.²⁷⁴ By reducing its staff, Halperin argued, the hospital had violated its patients’ right to treatment.²⁷⁵ Indeed, Alabama’s state institutions faced many of the same struggles as their counterparts in Texas, rooted in the combination of increasing need for funds, diminishing political support, and evaporating state and federal funds. Alabama’s institutions adapted by decreasing the quality of their services and firing staff.²⁷⁶ In *Wyatt v. Stickney* former patients and attendants sought to force Alabama to rehire staff and refund their state hospital programs. The U.S. District Court ruled in

²⁷³ Larry Wright, “She’s a Mental Patient Beyond Help—Or is She?”

²⁷⁴ David Pharis, “History of Mental Health Legal Issues,” in *State Hospital Reform: Why was it So Hard to Accomplish?* Ed. David Pharis, (Durham, North Carolina: Carolina Academic Press, 1998), 53.

²⁷⁵ David Pharis, “History of Mental Health Legal Issues,” 53.

²⁷⁶ David Pharis, “History of Mental Health Legal Issues,” 55.

favor of the patients and found “that patient treatment did not meet any minimum standards of treatment of the mentally ill.”²⁷⁷ The results of the case, which came to affect all mental institutions across the nation in 1971, helped establish staffing ratios, standards of care, physical standards for patient facilities, and rehabilitation care after release.²⁷⁸ *Wyatt v. Stickney* helped reformers develop a clear definition of what constituted treatment, and to establish boundaries surrounding the treatments provided by the state.

But the boundaries and stipulations of the court case proved counterproductive because of the additional funding requirements the case placed on institutions at the same moment that state and the federal governments reduced money for mental health programs. The State of Alabama appealed the court ruling and “argued that the cost of implementing the minimum standards set forth...would require capital expenditures of sixty-five to seventy million dollars, a sum equal to more than half of the State's present general fund,” and that the outcome of the case “failed to give sufficient consideration or recognition to other equally important demands on the State's revenue.”²⁷⁹ The case ultimately placed larger requirements on state institutions while ignoring a major underlying cause of state institutions’ inability to provide adequate treatment.

Though many rights-based reformers involved in mental health care supported the intent of the court case to secure a stronger commitment from the state, some advocates also viewed the “emergence of rights of the mentally handicapped” as a major “dilemma

²⁷⁷ David Pharis, “History of Mental Health Legal Issues,” 55.

²⁷⁸ Department of Health, Education, and Welfare, *Mental Retardation and the Law: A Report on Status of Current Court Cases: A Report on Status of Current Court Cases* (Apr. 1973) by Paul Friedman, Report, Office of Mental Retardation Coordination, Washington D.C., 3.

²⁷⁹ Department of Health, Education, and Welfare, *Mental Retardation and the Law: A Report on Status of Current Court Cases: A Report on Status of Current Court Cases*, 9.

for state mental health systems.”²⁸⁰ Dr. Kenneth Gaver, commissioner of the MHMR, suggested that the court ruling might force facilities to choose between “the right...to receive adequate treatment or rehabilitation, and his right to receive that help in the environment that has the least restrictions on his personal freedom.”²⁸¹ This dilemma, as Dr. Gaver outlined it, occurred because generally the best care was found in state hospitals, institutions that were also seen as providing the least amount of freedom for patients. Though community centers could provide an alternative, reformers now recognized that they required “a massive commitment of funding and talent.”²⁸² The MHMR estimated that the state commitment to mental health facilities would have to triple to approximately \$1 billion in order to comply with the *Wyatt v. Stickney* federal mandate.²⁸³ Though the litigation sought to establish clearer rights for patients and care, it also had the unintended effect of intensifying the problem of state funding, and further damaging the efforts of state sponsored mental health advocates.

Wyatt vs. Stickney did more than increase financial pressures for mental health reform; the suit also created a crisis for mental health advocates regarding the future of the federal government’s role in regulating local institutions. For instance, the court established mandatory patient-to-staff ratios that many mental health practitioners felt were nearly impossible to meet.²⁸⁴ The staffing ratios defined by the court set the stage for the large-scale removal of patients from mental institutions. Robert Humphries,

²⁸⁰ Dave Mayes, “Mental Health Systems Face Major Delima,” *The Austin American Statesman*, Evening ed., September 13, 1974.

²⁸¹ Dave Mayes, “Mental Health Systems Face Major Delima.”

²⁸² Ibid.

²⁸³ Dave Mayes, “Under Court Ruling: Mental Cost to Triple?”

²⁸⁴ Robert Humphries, “The Issue of Confrontation,” (Speech given at Mental Health Symposium Sponsored by Texas Department of Mental Health and Mental Retardation and the Texas Foundation for Mental Health and Mental Retardation, Austin, TX, April 3–4, 1974) Daniel L. Creson Papers, John P. McGovern Historical Collections and Research Center, Texas Medical Center Library, Houston, Texas.

Assistant Attorney General for the State of Alabama, expressed this concern during a speech at a mental health symposium in 1974. “The near impossibility of complying with [the] staffing ratio standard” suggested that there was “no way that we can ever comply unless we are able to reduce our patient population to a reasonable level.”²⁸⁵ Though Humphries did not know it at the time, the reduction of patient population would become the most common answer to the federal mandate beginning in the mid-1970s. A by the early 1980s, reduction in patient populations would define the deinstitutionalization of mental hospitals.

In addition to shaping the size of patient populations through federal mandates, early 1970s litigation also redefined the boundaries of a patient’s rights to decide on whether to be treated or not. In 1975, the U.S. Supreme Court Case heard *O’Connor v. Donaldson*, a suit originating in Florida that distinguished a patient’s right to liberty from their right to treatment. *O’Connor v. Donaldson* raised the issues of indefinite confinements and forcible commitments of patients. The court sided with the patient, Kenneth Donaldson, who claimed he was sane during his fifteen years of confinement. The Court established that patients who did not pose a danger to themselves or others could not be held indefinitely in mental hospitals and had to receive treatment or be released from care.²⁸⁶ Whereas previously psychiatrists determined the length of a patient’s confinement, *Donaldson* sought to prevent lengthy forced commitments to state hospitals. The case limited the state’s power of commitment by affirming that “a finding of mental illness alone does not justify a state’s indefinite custodial confinement of an

²⁸⁵ Robert Humphries, “The Issue of Confrontation,” (Speech) Austin, TX, April 3–4, 1974.

²⁸⁶ J. B. O’Connor vs. Kenneth Donaldson, 74-8 US 2486 (1975), WestLaw.com.

individual...if the individual is dangerous to no one and can live safely in freedom.”²⁸⁷

The Court’s decision in the *Donaldson* case addressed the longstanding fear regarding vague commitment standards and subjective definitions of mental illness. The Court intended to force state laws to define the rationale behind forcible commitments, strengthening the patient rights movement by acknowledging institutionalization as a threat to patient civil liberties.

Though *Donaldson* redefined the stipulations for involuntary commitments, the effects of the case were limited because the circumstances surrounding O’Connor’s grievances were so specific that it was unclear to what extent the court’s ruling would affect other mental patients in other hospitals. Benjamin Heinman, a spokesperson and lawyer from the Mental Health Law Project, described the case as ““significant but limited,”” and added that the decision did not clearly “establish a constitutional right to treatment,” as many patient rights activists had hoped to accomplish.²⁸⁸ The limitations of *Donaldson* created increasing tension between state mental health professionals and patient rights activists because the patient rights movement was only partially successful in securing a definition of involuntary confinement.

In the late 1970s, mental health facilities faced greater challenges to providing care as costs continued to balloon and patients pushed for expanded rights. The Austin-Travis County Mental Health and Mental Retardation Center, for example, faced much more demand than they could handle for the social services they offered. By June 1976, the center reported that it had served seventy-five percent of the patients it expected to

²⁸⁷ *O’Connor v. Donaldson*, 95 US Supreme Court no. 74-8 422 U.S. 563, 45 L. Ed. 2d 396, 1975, 4.

²⁸⁸ Dave Mayes, “Ruling Won’t Affect Texas Patients,” *The Austin American*, July 1, 1975.

serve for the entire year.²⁸⁹ And the increased demand created problems because, as the center's deputy director stated, "When demand is way up, there are problems with providing adequate care."²⁹⁰ Financial matters only grew worse when the MHMR was forced to reorganize itself and cut services in order save money because they did not receive adequate funding.²⁹¹ After *Wyatt vs. Stickney* and *O'Connor vs. Donaldson*, mental health reforms had to proceed with caution in order to continue operating, despite the clear need from the public for more mental health and mental retardation services within the community and a lack of financial commitment.

ASH provides insight into how the regulations instituted by *Wyatt vs Stickney* and *O'Connor vs Donaldson* proved challenging for the hospital as state finances shrank. As ASH faced an additional crisis of diminishing funds, coupled by a simultaneous increase in federal stipulations, the institution struggled to provide care to its diverse patient population. In 1979, the hospital only reported a population of 855, a significant reduction from its population in 1976 of 1,009 patients.²⁹² Though the patient population had been significantly reduced, so had staff salaries and the hospital had come rely on student interns and volunteers from the University of Texas who typically worked for one semester.²⁹³ The Travis County Unit at ASH cited issues of staffing, morale, and a lack of funding in the hospital's annual report to the MHMR. The unit stated it was "constantly

²⁸⁹ "MHMR Services Use Exceeds Forecast," *Austin American Statesman*, June 17, 1976.

²⁹⁰ "MHMR Services Use Exceeds Forecast."

²⁹¹ Mark Kilpatrick, "MHMR Board gets Blast," *Austin American Statesman*, October 5, 1977.

²⁹² Austin State Hospital, *Annual Report to the Texas State Board for Mental Health and Mental Retardation, 1979-80*, Prepared by Superintendent Louis N. Laosa, 55, Austin State Hospital Library, Austin Texas; and Austin State Hospital, *Annual Report to the Texas State Board for Mental Health and Mental Retardation, 1979-80*, Prepared by MHMR Commissioner Kenneth D. Gaver and Superintendent Luis H. Laosa, 56. Austin State Hospital Library.

²⁹³ Linda Anthony and Allen Turner, "Risks 'Inevitable at Austin State Hospital,'" *The Austin American Statesman*, July 1, 1978.

[in] a crisis situation...TDMHMR and ASH rules make treatment more difficult.” The report further cited that “As...funding decreased, admissions and readmissions rate and need for service...increases without any increased financing for the Unit.”²⁹⁴ Heavy regulations and lack of funding made it difficult for units at ASH to implement effective treatments. ASH therefore struggled to comply with greater regulations while facing limited financial commitment from the state.

Even compliance with the “least restrictive alternative” brought public scorn as newspaper reports criticized the hospital’s inability to effectively treat patients. Some patients—allowed to leave the hospital of their own accord under the new standard—committed suicide or were arrested.²⁹⁵ One patient who had been hospitalized eighteen times survived his release by operating as a male prostitute until he earned enough money to pay for a motel room. The patient called ASH “a joke. They just dump you on the sidewalk when they’re through with you.”²⁹⁶ Restrictions on hospital commitments and adherence to the least restrictive alternative policy, while liberating for some patients, unintentionally made it more difficult for others to receive the long-term treatment their illnesses required. Some persons with mental illness left the hospital feeling uncared for and abandoned. Moreover, as one report put it, “a lot of relatively unstable people are back on the street—perhaps before they should be.” In fact, ASH reported that 1,791 admitted persons in 1977 were returning patients.²⁹⁷ Unlicensed halfway houses or boarding homes often awaited mental ill persons released from hospital care, many of

²⁹⁴ Austin State Hospital, *Annual Report to the Texas State Board for Mental Health and Mental Retardation, 1978-79*, Prepared by MHMR Commissioner John J. Kavanagh and Superintendent Louis H. Losa, 5.

²⁹⁵ Linda Anthony and Allen Turner, “Risks ‘Inevitable at Austin State Hospital.’”

²⁹⁶ Linda Anthony and Allen Turner, “Mental Patients Eased onto the Road Back,” *The Austin American Statesman*, July 5, 1978.

²⁹⁷ Linda Anthony and Allen Turner, “Mental Patients Eased onto the Road Back.”

which exploited mental patients' instability. As one MHMR psychiatrist assessed the situation, "People are being dumped out of hospitals so that they can say they're not warehousing [patients]...so they're still being warehoused, but in deficient facilities with no medical care."²⁹⁸ Though the patient rights movement managed to regulate some state hospitals' treatment practices, the results did not lead to better care for all patients. Activists focused their attentions on further legally defining the right to treatment. In the wake of the court ruling on *Wyatt v. Stickney* and in the midst of the *O'Connor v. Donaldson* case, another legal battle for patients' civil rights gained traction in Austin. *R.A.J v. TXMHMR*, as it became known, targeted the conditions and treatments in Texas's eight state psychiatric hospitals. The case involved a male patient, referred to by his initials "R.A.J.," housed in Terrell State Hospital. The suit, initially filed in 1974 at a time when the court system of the United States generally upheld and expanded rights, continued until 1997, long into the era when courts became more skeptical about patient rights.²⁹⁹ The case's first settlement in 1981 forced state hospitals to make many institutional changes including, hiring more staff, renovating aging facilities, meeting safety standards, and creating clear procedures for issuing psychotropic medications. In addition, hospitals had to win accreditation of state hospitals through the Joint Commission on Accreditation of Hospitals (JCAH), create specialized treatment programs for adult and geriatric patients, and provide greater commitment to aftercare facilities. Additionally, it was the responsibility of state hospitals to seek appropriate funding from the legislature.³⁰⁰ These demands for more treatment programs, staff,

²⁹⁸ Jane Daugherty, "Halfway Houses Exploiting Discharged Mental Patients," *The Austin American Statesman*, December 18, 1977.

²⁹⁹ David Pharis, "The History of the R.A.J Lawsuit in Texas," 63.

³⁰⁰ *Ibid.*

improved facilities, and aftercare, however, did not guarantee funding and occurred at a time that the federal government shifted its priorities sharply by defunding mental health facilities.

Ronald Reagan and the Intentional Fracturing of Mental Health Care

The federal government in the early 1980s under President Ronald Reagan intentionally accelerated the processes of deinstitutionalization that had begun as unintended consequences of *Wyatt v. Stickney* and *O'Connor v. Donaldson*. Right-wing attacks on welfare programs increased in the 1980s while the left simultaneously demanded larger government intervention on behalf of patients in state hospitals. The collision of these two forces in the arena of mental health reform weakened the infrastructure of the state mental health system, increased per-patient costs within hospitals, restricted state hospitals' ability to provide long-term care for patients, and ultimately encouraged deinstitutionalization.

The United States Congress enacted the Civil Rights of Institutionalized Persons Act (CRIPA) and became federal law under President Carter on May 23, 1980. The act was intended to strengthen the federal government's ability to force state governments to correct state institutions that violated the rights of institutionalized persons, including psychiatric patients and prisoners.³⁰¹ Carter hoped that the bill would "promote the protection of human rights" and expand civil rights.³⁰² Though CRIPA appeared to reformers as if it would strengthen their ability to enact change within institutions;

³⁰¹ "Civil Rights of Institutionalized Persons Act Statement on Signing H.R. 10 Into Law. May 23, 1980," *American Reference Library - Primary Source Documents* (January 2001): 1. *MAS Ultra - School Edition*, EBSCOhost (accessed October 16, 2015).

³⁰² "Civil Rights of Institutionalized Persons Act Statement on Signing H.R. 10 Into Law. May 23, 1980."

however, the act received “less than enthusiastic enforcement” under the Reagan.³⁰³ “In the eight years since its passage, CRIPA has not fulfilled Congress' expectations.” criticized law professor John Kip Cornwell in 1988.³⁰⁴ He added, “The federal government...has a responsibility to defend those citizens who are unable to seek redress of constitutional rights denied them. The government's performance over the past seven years has been far from exemplary.”³⁰⁵ Instead of relying on federal authority to enforce and protect patient rights, the federal government relied on conciliation between states and reformers.³⁰⁶ Mental health advocates thus found themselves in lengthy negotiations with state officials, which slowed the pace of reform considerably and made it difficult to enact sweeping changes to the state mental health system.

Increased tensions regarding MHMR funds were compounded by the federal retraction of monies to social services in 1981 after the political climate shifted firmly toward conservatism. “In this present crisis, government is not the solution to our problem; government is the problem,” declared Ronald Reagan in his first inaugural address as president. “From time to time we've been tempted to believe...that government by an elite group is superior to government for, by, and of the people.”³⁰⁷ His address affirmed a shift to the right in American politics that represented views that directly opposed the New Deal and the Great Society. The perception of the government as the “problem” instead of the answer to society’s problem would have far reaching

³⁰³ David Pharis, “The History of the R.A.J Lawsuit in Texas,” 57.

³⁰⁴ John Kip Cornwell, “The Failure of Federal Intervention for Mentally Retarded People,” *The Yale Law Journal*, 97 no. 5 (Apr., 1988): 845.

³⁰⁵ John Kip Cornwell, “The Failure of Federal Intervention for Mentally Retarded People,” 862.

³⁰⁶ *Ibid.*, 849.

³⁰⁷ Ronald Reagan, "Inaugural Address," January 20, 1981. Online by Gerhard Peters and John T. Woolley, *The American Presidency Project*. <http://www.presidency.ucsb.edu/ws/?pid=43130>.

consequences for mental health reformers who were unable mount a substantial resistance to right-wing attacks on government-sponsored mental health programs.

President Reagan, living up to his promise to “get government back within its means, and to lighten our punitive tax burden,” proposed large-scale budget cuts to social welfare programs, many mental health professionals expressed their discontent.³⁰⁸ John Wolfe, executive director of the National Council of Community Mental Health Centers, believed that President Reagan’s budget proposal—which cut federal funding for state mental health programs by 25 percent—would push back mental health reform twenty years. Wolfe likened Reagan’s budget cuts to a reversion to “Social Darwinism” that marked a complete reversal of the federal government’s previously supportive stance toward the mentally ill.³⁰⁹ Wolfe protested Reagan’s cuts and feared that mental health services would be altogether forgotten with the new block tax grants to states, which did not require that funds be spent in any one area.³¹⁰ As *R.A.J.* required more funding for mental hospitals, the result of the litigation took funds away from community centers as the federal government—the chief proponent of mental health legislation since the end of World War II—retracted its support and leadership from mental health reform.

Patient rights activists hoped that *R.A.J.* would force the state to reform its eight psychiatric hospitals. The first complaint filed in 1974 claimed that Terrell State Hospital violated patients’ constitutional rights to a safe environment and immediate treatment, as well as their right to refuse medications. They complained that hospitals were dangerous,

³⁰⁸ Ronald Reagan, "Inaugural Address," January 20, 1981. Online by Gerhard Peters and John T. Woolley, *The American Presidency Project*. <http://www.presidency.ucsb.edu/ws/?pid=43130>.

³⁰⁹ Linda Little, “Reagan Budget Threatens Mental-Health Care,” *The Dallas Morning News*, March 11, 1981.

³¹⁰ John C. Wolfe, “Dangers Facing Mental Health,” *The Dallas Morning News*, April 23, 1981.

treatment often came too late, and when it did come that psychiatrists tended to overmedicate patients in order to keep them calm.³¹¹ The state did nothing to address these concerns until 1980 when federal experts reviewed Texas state hospitals on behalf of the Civil Rights Division of the U.S. Department of Justice [DOJ]. The DOJ's investigation prompted an amended complaint filed by the Plaintiff, which added several specific cases of overuse of psychotropic medications, inappropriate use of electroshock therapy, misdiagnosis of patients, systemic lack of care, instances where treatment was not pursued, and inadequate living conditions within hospitals.³¹² According to Garry E. Miller, director of the MHMR during the first settlement of *R.A.J.*, these findings largely supported the public's existing perceptions of state hospital conditions, which he claimed were "unsubstantiated" and based on "naïve pop psychological analysis" that received additional media attention on the most extreme or violent incidences within hospitals.³¹³ The complaints filed in *R.A.J.*, though legitimate, also served to reinforce a negative perception of state hospital care that had long existed in the public's memory and intensified throughout the patient rights movement.

The suit was settled out of court in 1981. The MHMR agreed to provide more facilities and greater protection for patients, to provide adequate staffing to meet patient ratios, and to develop clear standards for the use of psychotropic medication. They also agreed to allow court-committed patients to refuse medications and to separate patients according to their respective diagnoses and functionality.³¹⁴ In this way, the MHMR

³¹¹ David Pharis, "The History of the R.A.J Lawsuit in Texas," 63.

³¹² *Ibid.*, 63-64.

³¹³ Gary E. Miller, "Reform through Litigation: A Commissioner's perspective," *State Hospital Reform: Why Was It So Hard to Accomplish?* ed. David Pharis (North Carolina: Carolina Academic Press, 1998), 102-103.

³¹⁴ David Pharis, "The History of the R.A.J Lawsuit in Texas," 65.

seemed to address the concerns of patient liberty. Don Gilbert of Terrell State Hospital during *R.A.J.*, recalled the positive change he saw as superintendent. “State hospitals underwent facelifts and staffing levels began to approach reasonable levels,” Gilbert asserted, and saw that “the news value of state hospital life dissipated as the sensational stories became harder to find.”³¹⁵ Gilbert expressed “a collective feeling of accomplishment” for many working for a better mental health system because of the ability to make hospital life better for patients.³¹⁶ The pervasive sense of accomplishment during the early successes of *R.A.J.* allowed the MHMR and patient activists to breathe a sigh of relief as they witnessed conditions improving in mental health facilities. However, many of these achievements were short lived as debates surfaced around defining appropriate staffing ratios and state funding caused the tensions surrounding patient rights in state hospitals to resurface.

Even though reformers initially perceived the 1981 settlement as a victory, implementing those changes proved daunting, and tensions increased as administrators sought to meet the standard staffing ratios in state hospitals. Though most agreed the patient-to-staff ratio had to be increased, few mental health professionals “agree[d] on the appropriate levels of staffing and no objective data existed to instruct either the plaintiffs or the defendants.”³¹⁷ Eventually, both parties agreed on a ratio of one doctor to every five patients, but instituting the ratios became, according to Don Gilbert, superintendent at Terrell State Hospital a “nightmare.” Hospitals sought a loose interpretation of staffing regulations that applied to hospital units comprising of several wards that would allow

³¹⁵ Don Gilbert, “The Postive Impact of R.A.J.,” in *State Hospital Reform: Why Was It So Hard to Accomplish?* Ed. David Pharis (Durham, North Carolina: Carolina Academic Press, 1998), 126.

³¹⁶ Don Gilbert, “The Postive Impact of R.A.J.,” 126.

³¹⁷ *Ibid.*, 126.

institutions to reallocate staff from unit to specific wards as necessary. In contrast, patient activists sought a narrow definition that set the ratio based on the ward level, which required that every ward meet staffing regulations at all times.³¹⁸ The stricter interpretation, which won in court, required hospitals to hire a greater amount of staff. Furthermore, the stricter definition meant that a hospital would not meet regulations even if, for example, an employee did not show up for work on a ward. Narrower definitions of staffing ratios then intensified debates over funding, because the initial appropriation the legislature provided was not enough to hire the personnel necessary to meet the court's stipulations.³¹⁹ The MHMR had to return to the legislature for more funding, adding to frustrations about the expanding costs of mental health that became a major cause of the fracturing of the mental health system.

The initial settlement required the MHMR to spend more money on state hospitals, which the legislature reluctantly allocated, "believing this to signal the end of the additional resource issue."³²⁰ Much to legislators' dismay, however, the MHMR would continue to ask for more funding in order to meet the conditions of the settlement. David Pharis, the federal court monitor in the case, described some of the political tensions surrounding funding. The "TXMHMR was very reluctant to...advocate for increased operating budgets," he wrote, "they were concerned that drawing attention to the needs of the lawsuit could cause negative reactions on the part of the legislature."³²¹

³¹⁸ Don Gilbert, "The Postive Impact of R.A.J.," 127.

³¹⁹ Ibid.

³²⁰ Ibid.

³²¹ David Pharis, "Politics and Costs," in *State Hospital Reform: Why Was It So Hard to Accomplish?* Ed. David Pharis (Durham, North Carolina: Carolina Academic Press, 1998), 193.

Concerns about the adequacy of the MHMR budget, administrative costs of the lawsuit, and fears of federal interference remained a constant tension throughout *R.A.J.*³²²

Additional federal court cases filed against the Texas Department of Criminal Justice, the Texas Youth Commission, and additional suits against the MHMR for problems raised in other state hospitals and state schools raised “philosophical questions[s] about activists courts intervening in the legislative business...[that] intensified in Texas,” during the 1970s.³²³ The financial commitment required by *R.A.J.* was substantial and grew continually through the years that the case made its way through appeal after appeal. In 1981, the overall state hospital budget totaled \$128.3 million and that of community services was \$48.5 million, and by order of the federal court, the MHMR would have seek out more funds in order meet the confines of the settlement.³²⁴ But in 1981 the legislature also slashed MHMR budgets, which caused the MHMR to close seven community centers in 1981.³²⁵ By 1982 the *R.A.J.* agreement expanded to require the MHMR to increase its financial commitment to aftercare programs such as halfway houses for “improved patients beginning their return to the community.”³²⁶ Though this demand for alternative to hospitalization brought the discussion of community centers back in to debates over mental health reform, the new regulations also shifted community-based care facilities’ purpose from an alternative to mental hospitals to a key step in the path towards deinstitutionalization.

³²² David Pharis, “Politics and Costs,” 193.

³²³ *Ibid.*, 195.

³²⁴ *Ibid.*, 197.

³²⁵ Christy Hope, “Mental-Health Care Funds Sought,” *Dallas Morning News*, March 1, 1982.

³²⁶ Bill Lodge, “State Institutions Due Overhaul: Mental Health Officials to Meet Demands in Class Action Suit,” *The Dallas Morning News*, March 7, 1981.

When the MHMR requested additional funding from the state legislature for community resources in 1983, the request shocked the Texas legislature. The MHMR asked for an additional \$15 million from the state for community programs.³²⁷ The increase in funding came to be seen as essential support for residential programs that would facilitate the process of decentralizing Texas's mental health system. "Dollars must follow patients," one political editorialist in Dallas wrote, "if the state is serious about decentralizing treatment, it must also decentralize its spending."³²⁸ MHMR budgets shifted toward individual patients and the decentralization of mental health. Whereas previous reforms had focused on creating a public good for the entire community, reformers in the 1980s increasingly saw mental health care as benefiting individuals along their path in the mental health system.

The conflicts over funding, federal commitment, and continued regulation of mental health services explains why *R.A.J.* did not affect state hospitals as much as it intended. Mary Dees, former patient at ASH, provided her perspective of hospital life in 1982 when the state forced her to seek treatment in a state hospital after a severe drug overdose. During her admission and six-month commitment she "[had] no memory of being informed of her rights or of the process to report rights violations or abuse and neglect allegations." Her fourth day in treatment led to the realization of her loss of freedom, "I was in prison. The judge had sentenced me to thirty days, which was later extended to ninety. None of the staff explained to me that I could be released pending improvement." She was "discouraged from attending the court proceedings. [She was told she] would lose despite the fact that [she] was doing really well and starting to act

³²⁷ Phillip Seib, "Setting Mental Health Agenda," *The Dallas Morning News*, January 12, 1983.

³²⁸ Phillip Seib, "Setting Mental Health Agenda."

like a human being.”³²⁹ Dees’ testimony not only described a lack of recognition of patients’ legal rights, but also told of violations of her personal liberty:

Four out of six months my treatment consisted of being tied down in a four-point restraining bed in the day room. This left me helpless to ward off male patients, who would touch and stroke me... The staff were no more hospitable: on one occasion I was subjected to a large heavy staff member sitting on me; on another occasion, I was tied to a chair tied to a cement support column... with staff threatening to photograph me.³³⁰

Conditions in the hospital had not improved regardless of the *R.A.J.* litigation. Despite all the efforts of reformers, mental hospital conditions remained dysfunctional, and by 1982 the many members of the public and the federal government had forgotten the shared purpose that reformers once believed in.

The MHMR had not complied with many of the stipulations of the agreement reached in 1981 and MHMR commissioner Gary Miller resisted the agreement by refusing to abide by an involuntarily-committed patient right to refuse medications. As a result the court issued a Memorandum Opinion and Order in 1984.³³¹ Unlike previous mental health rulings which expanded the rights of the patient, the Court’s 1984 memorandum upheld the right of physicians to force treatment on involuntarily committed patients, so long as they “afford[ed] the involuntarily committed patient the right to have the treatment decision reviewed, and would provide an extra step in the review process if the patient is able to appreciate the nature and consequences of his decision.”³³² Though the purpose of the memorandum was to “establish therapeutic

³²⁹ David Bell, Patsy Cheyney, Mary Dees, Susan Medlin, and Anonymous, “Reminiscences,” in *State Hospital Reform: Why Was It So Hard to Accomplish?* Ed. David Pharis (Durham, North Carolina: Carolina Academic Press, 1998) 13-14.

³³⁰ *Ibid.*, 14.

³³¹ David Pharis, “The History of the R.A.J Lawsuit in Texas,” 68.

³³² *R.A.J., et al. v. Gary E. Miller* 590 F.Supp. 1319 U.S. District Court, 3-74-0394-H (1984). WestLawNext.com.

alliances between the patients and their treating physicians,” it only served to further complicate the interactions necessary for humane and effective treatments.³³³

Federal intervention in state hospitals unintentionally created a complex legal framework that prevented hospital staff from providing effective treatments, and incurred friction between the federal government and state legislators that stagnated momentum for reform. “In a broader sense the lawsuit was the concern of the governor, state legislators, mental health advocates, and a variety of people...concerned about public policy,” wrote David Pharis reflecting upon the implications of RAJ and mental health litigation. “Governmental leaders were acutely concerned about the interventions of a federal judge,” because “such interventions would interfere with their responsibilities and capacity to perform their functions as legislators.”³³⁴ The continued use of federal courts to define the relationship between individual patients and state institutions, therefore, not only reduced state hospitals’ ability to provide care to a large population of patients, but also pitted local and federal governments against one another as local politicians increasingly viewed the federal government as an impediment to effective state governance.

The collision of the rise of the New Right in the late 1970s and early 80s and the increasingly rights-based platform of mental health reforms shifted the reformers’ focus away from exploring community-based alternatives, and towards institutional changes that protected and empowered patient choice inside state hospitals. The dismantling of the mental health reforms envisioned in the 1950s and crafted in the 1960s led to a mental

³³³ R.A.J., et al. v. Gary E. Miller 590 F.Supp. 1319 U.S. District Court, 3–74–0394–H (1984). WestLawNext.com.

³³⁴ David Pharis, “Politics and Costs,” 193.

health system that yielded mixed results. On the one hand, patients succeeded in securing the civil rights they sought to protect them against the psychiatric power of state institutions. On the other hand, mental health advocates found themselves less able to forge the types of alliance that would allow them to create a large-scale movement. Once the power of mental health reform shifted away from institutions and onto the individual patient, reformers found it more difficult to generate the momentum to enact major change in the mental health system and by the mid-1980s resulted in a weaker and less effective mental health system.

Conclusion

The history of the mental health reform movement in the 1970s is one of greater legal regulation coupled by decreasing federal support and guidance for mental health institutions. It is also a story of a growing demand from the public and civil rights advocates for a fairer mental health system for individual patients. Increased federal regulation coupled with diminishing funds and declining political support caused greater federal control over treatment and conditions inside mental institutions without providing the resources and guidance necessary to affect the change reformers once sought. Mental health reformers continued their work, but in a much more fragmented way. Without the resources the federal and state governments once provided, the only way state hospitals like ASH could comply with federal regulations was to drastically reduce the number of patients it treated as well as significantly limit the care the institution provided. Those individuals who turned to the community as an alternative to mental hospitals were denied the protection they believed existed, and many were left to fend for themselves without access to adequate treatment.

“The era’s key intellectual shifts cannot be pinned to any single part of the political spectrum,” wrote Daniel T. Rodgers on the 1970s and 1980s. “The fracture,” he asserted, “was in the end as much a product of left-leaning intellectuals as it was of the new intellectual right.”³³⁵ Rodgers’ assertion regarding the broader intellectual and political changes in American life can also be found in the narrative of late twentieth-century mental health reform. The causes of fracture for mental health reform cannot be assigned solely to the left or the right, nor can the atomization of reform that resulted from increasing costs of mental health care and penny-pinching state legislatures. Instead, the simultaneous critiques from the left’s increasingly rights-based push and the right’s disdain for big-government and welfare programs signify a shift in mental health advocacy. This shift strengthened individual patients’ rights over the power of large state institutions, but weakened the mental health reform movement’s ability to build coalitions between psychiatrists, citizens, patients, state legislatures, and federal policy to create an effective mental health system. As the atomization of mental health reform ensued, mental health reformers shifted their focus away from creating new forms of mental health care and towards the relationship between individual patients and the state, and ultimately created a weaker position to push for change.

³³⁵ Daniel T. Rodgers, 8.

V. CONCLUSION

Texas's mental health system remains fragmented, and ultimately ineffective, and the once shared sense of purpose that united reformers is all but forgotten. David Pharis, a mental health reformer during the *RAJ* patient rights lawsuit in Texas, reflected on the needs for future mental health reform. To be successful, Pharis said, reformers must “seek the way that involved groups can get together more harmoniously and productively in the promotion of a shared agenda.”³³⁶ Despite Pharis's call for the need for mental health advocates to re-forge a common sense of purpose, reformers have yet to unify behind a singular vision of a new mental health system. As the patient rights movement created a more just system for patients, advocates focused mental health reformers' efforts on ensuring patient autonomy and dignity in an institutionalized setting. The movement forced states to improve state hospitals instead of building the more effective community-based mental health system envisioned by reformers in the 1960s. Mental health reforms that began two generations ago have produced mixed results. On the one hand, patients need no longer fear being incarcerated without due process or receiving treatments without providing consent. On the other hand, mental health reform did not create alternatives to state hospitals, which continue to struggle to maintain adequate staffing ratios, to provide adequate care to an increasing patient population, and to provide access to effective treatments.

Austin State Hospital remains mired in the struggles that many state hospitals face. Recently, ASH received a citation from Centers for Medicare and Medicaid Services investigation for having too few nurses on staff and improperly restraining

³³⁶ David Pharis, forward to *State Hospital Reform: Why Was It So Hard to Accomplish?* ed. David Pharis (Durham, North Carolina: Carolina Academic Press), x.

patients. In some cases, investigators observed a ratio of one nurse to every forty-three patients. More alarming, the report cited instances where patients were restrained without their consent.³³⁷ If the hospital is unable to correct the grievances cited in the investigator's report, the hospital may lose \$7.1 million in federal funding.³³⁸ ASH's struggle to improve facilities, meet staffing ratios, and ensure patient safety echoes the grievances of the 1940s and 1950s that community mental health reformers set out to fix.

The situation at ASH is, unfortunately, not unique. Terrell State Hospital has been at the center of a public controversy as well. In 2012, a scandal emerged through a report in the *Austin-American Statesman* of a patient's death after being restrained for fifty-five hours straight.³³⁹ Terrell State Hospital then faced a similar ultimatum as ASH—improve hospital facilities and staff, or risk losing federal funding.³⁴⁰ Despite the reformers' previous efforts, state hospitals struggle to maintain safe environments for patients as well as to meet federal and state regulations. Such reports raise a question as to what degree current state hospitals resemble the snake pit institutions reformers balked at in the 1940s.

That is not to say that reformers stopped trying to build a better system. In fact, in Texas a broad coalition of reformers proposed a new mental health bill that hoped to reinvigorate community services in Texas. In San Antonio, law enforcement and mental health services began to work together through the guidance of Leon Evans, the director

³³⁷ Andrea Ball, "Austin State Hospital Could Lose \$7.1 Million in Federal Funding," *Austin American Statesman* September 16, 2015. <http://www.mystatesman.com/news/news/local/austin-state-hospital-could-lose-71-million-in-fed/nngdW/> (accessed October 20, 2015).

³³⁸ Andrea Ball, "Austin State Hospital Could Lose \$7.1 Million in Federal Funding."

³³⁹ Emily DePrang, "A Careless Solution," *TexasObserver.org*, November 28, 2014. <http://www.texasobserver.org/terrell-state-hospital-geo-care-privatize/> (accessed October 20, 2014)

³⁴⁰ Andrea Ball, "Federal Investigation: State Hospital Cause Patient's Death," *The Austin American Statesman*, June 6, 2013, <http://www.mystatesman.com/news/news/federal-investigation-state-hospital-caused-patien/nYD33/> (accessed October 20, 2015).

for the Center for Health Care Services, to construct a local center known as the Restoration Center for people with severe mental illness to divert people with mental illness away from prisons and into treatment.³⁴¹ The center required the collaboration and funds from various offices of the city's services and infrastructure that did so because they recognized that fractured services led to ineffective treatments, which cost each department more money.³⁴² This re-envisioned community mental health system has not only saved the city \$50 million over the past five years, but it has also led to the creation of the Restoration Center, which is capable of meeting a wide array of mental health needs across Bexar County.³⁴³ Local efforts are not only visible in the respective budgets, but also in the county jail, where "Overcrowding...has not only been reduced," but also created "a surplus of approximately 800 beds."³⁴⁴ The efforts of all of those involved in creating alternative treatment methods for people with mental illness in San Antonio reveals the potential effectiveness for community centers in Texas cities as well as the growing need for community mental health reform.

Historians have a key role to play for reformers looking to put the fractured pieces of the mental health system back together again. By examining the successes of early reformers who forged a shared sense of purpose, as well as the causes of fracture that led to the disaggregation mental health services, historians can help reformers by reminding

³⁴¹ Denis Grantham, "Right Place, Right Time, Right Approach," *Behavioral Healthcare* 31 no. 8 (Nov/Dec 2011): 16. http://www.mhtransformation.org/jdtr/documents/leonevans_rightplacerrighttime.pdf (accessed October 21, 2015)

³⁴² Jenny Gold, "Wrestling With A Texas County's Mental Health System," *KaiserHealthNews.com*, August 20, 2014. <http://khn.org/news/san-antonio-model-mental-health-system/>. (accessed October 21, 2015).

³⁴³ Jenny Gold, "Mental Health Cops Help Reweave Social Safety Net In San Antonio," *NPR.org*, August 19, 2014. <http://www.npr.org/sections/health-shots/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio>. (accessed October 21, 2015).

³⁴⁴ Denis Grantham, "Right Place, Right Time, Right Approach," 19.

them of the alternative mental health system envisioned by their predecessors nearly sixty years ago. As the population and economy of Texas continue to grow, the state will require a more effective and less costly mental healthcare. Community mental health centers offer a great deal of potential benefits, but in order to be built and maintained, they must be created in a sustainable manner that caters to the needs of the community in a way that convinces state legislatures of their need and feasibility as alternatives. The history of the community mental health center as a product of experimentation and collaboration on the part of mental health practitioners, government officials, and average citizens must be brought to light so that reforms in the present benefit from reforms of the past. Without the contributions of historians and their expertise, the avenues for additional mental reform remain fragmented.

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