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**THE RISE AND DECLINE OF MENTAL HEALTH HOSPITALS  
IN THE STATE OF MICHIGAN**

**by**

**Gerald H. Smith**

**A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Doctor of Public Administration  
School of Public Affairs  
and Administration**

**Western Michigan University  
Kalamazoo, Michigan  
August 1992**

## THE RISE AND DECLINE OF MENTAL HEALTH HOSPITALS IN THE STATE OF MICHIGAN

Gerald H. Smith, D.P.A.

Western Michigan University, 1992

The State of Michigan has been partially responsible for the treatment of the mentally ill population since 1832, when Wayne County General Hospital opened its doors. The state government made a commitment to care for the afflicted, and at the same time provide an opportunity for other individuals to participate in their treatment. Eventually this commitment led to the establishment of employment for many citizens, and gradually, over the decades, a mental health bureaucracy emerged. It was necessary to hire not only professional staff, but also support staff such as food services, housekeeping, maintenance, and the like. Mental health facilities were built and staffed; they became home for those suffering from mental illness.

As the mental health bureaucracy grew, funding had to be allocated, which accounted for a burgeoning governmental influence. Personnel policies, appropriations, regulatory bodies, and the Michigan Mental Health Code all became intertwined as a complex mental health network came into existence with the objective of positively influencing mental health care.

This research addresses the evolution of the state hospital mental health system in Michigan. The administrative, legislative, judicial, and community perceptions of mental health in Michigan are reviewed and discussed. Surveys of hospital budgets, full-time employment, and annual rates of patient care are analyzed. The conclusion of this research addresses the feasibility of maintaining inpatient treatment programs. A summary and the implications that Michigan mental health faces are then presented. The time frame for this investigation is 1980 through 1989.



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**Smith, Gerald Herschel, D.P.A.**

**Western Michigan University, 1992**

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**To my daughter, Karen.**

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### Acknowledgements--Continued

with her academic endeavors and one day attains a standard of excellence. My love is with her.

Gerald H. Smith



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## CHAPTER I

### INTRODUCTION

#### Background

The State of Michigan has been providing mental health services for the mentally ill since 1835. Delivery of these services has been under the auspices of state government. The mental health system has evolved from a local caretaker role to a highly complex network involving treatment, shelter, and rehabilitation. Research and education have become adjunct specialties. Overseeing this vast organization as it has evolved has been an enormous administrative undertaking. Mental health services now address a variety of pathologies, with different modes of treatment and specialized environments. Adults and children of both genders receive care and treatment. Both the mentally ill and developmentally disabled are now evaluated, placed, and treated according to their need. The Michigan Department of Mental Health (MDMH) eventually became an arm of state government influencing the lives of virtually all Michigan citizens.

The MDMH has undergone many tribulations, as well as experiencing some glorious periods, during its history. Limited financial resources, a defensive administrative approach to problem solving, accusations of insensitivity, and the like, have been major

drawbacks. As noted, though, all has not been negative, as there have been significant milestones in mental health that have benefited the state clinical population. The introduction of psychotropic medications and innovative treatment techniques have continually offered hope for mental health patients and their families. The administrative models used by the MDMH have not, however, varied that much. Certainly, more humane treatment and care exist compared to earlier years, but the MDMH has not promoted any new administrative models regarding mental illness. Studies and investigations have been conducted, but a formal administrative approach has not been utilized. This study concludes that the MDMH has been in a defensive posture, formulating policies based primarily upon exigencies.

### Legislative Milestones

A dramatic change in Michigan mental health service delivery came about in 1963, when the Michigan Legislature passed Public Act 54, the Michigan Community Mental Health Services Act. In essence, each of the state's counties was empowered to establish and administer community mental health services.

Programs or services which were approved for 75% state matching grants included the following: informational and educational services; consultative services to courts and other agencies; inpatient services, outpatient treatment services, rehabilitative services for the mentally ill and mentally retarded, especially former inpatients. (Legislative Service Bureau, Mental Health Statutes, 1968, p. 81)

Perhaps the most fundamental change in mental health service delivery occurred in 1974, when the Michigan Mental Health Code, Public Act 258, was signed into law. Section 330.1134 established the licensing of psychiatric hospitals so as to insure quality care and treatment. It states:

Sec. 134. The director shall establish a comprehensive system of licensing for mental hospitals, psychiatric hospitals, or psychiatric units in the state to protect the public by insuring that these hospitals and units provide the facilities and the ancillary supporting services necessary to maintain a high quality of patient care. The director shall coordinate all functions with state government affecting mental hospitals, and shall cooperate with other state agencies which establish standards or requirements for mental health care institutions to assure necessary, equitable, and consistent state supervision of these institutions without duplication of inspections or services. The director may enter into agreements with other state agencies to accomplish this purpose. (MDMH, 1986b, pp. 5-6)

Civil and other rights of the mentally ill in Michigan were thus fully protected, and these individuals according to law had the opportunity to receive proper care without physical harm, institutionalization, or prolonged and unnecessary hospitalization.

#### Administrative Interventions

Other innovative measures were established as the MDMH sought to improve mental health care. The Staffing Needs Assessment Process (SNAP) was designed for making

recommendations based primarily upon specific individual characteristics or needs of patients served by that facility. In the method, specific patient characteristics are related to standard time values to produce workloads in hours and minutes. Workloads, in turn, are translated into staff required to

perform the work. (MDMH, Office of Management Services, 1988, p. 1)

The Assertive Community Treatment (ACT) program was developed to improve the delivery of mental health services. In essence, ACT is

an innovative mental health program, developed specifically for individuals experiencing problems associated with persistent mental illness. The primary goals of this program are to reduce unnecessary psychiatric hospital admissions and to increase the quality of life for clients living independently. Goals are achieved as a result of intense community-based support. (MDMH, 1988b, pp. 2-3)

Many developments have taken place during the long history of mental health services in Michigan designed to improve treatment of the mentally afflicted. Although the State of Michigan has been progressive, there have been troublesome times in which the MDMH received much criticism. In the past decade, the state has made massive financial cutbacks because of pressing economic conditions. The MDMH, one of the major departments of state government, was ordered to curtail spending. The effect of this dictum on the patient population has been momentous.

#### Statement of the Problem

During the 1980s, the MDMH has pursued a new administrative course--to reduce the inpatient population. In addition, Newberry Regional Mental Health Center has been closed and Traverse City Regional Psychiatric Hospital was scheduled for closing in 1989. The ultimate goal of such actions was to reduce the state mental

hospital budget; however, costs have risen, and even with reductions in the patient population and layoffs of personnel, the patient/staff ratio has increased. Many patients receive immediate intervention and are discharged from a state facility, only to require readmission in the future.

Given a general decline in the overall inpatient population, the time has come to reevaluate the role of Michigan's state mental health institutions. The expectations and responsibilities of this major component of the MDMH are the focus of this research.

### Methodology

This history of mental health in Michigan will hopefully serve to put the vast efforts of the many professionals and citizens alike in perspective so that a new era of mental health services may be enhanced. It is essential to understand mental illness as it applies to this research. Although an elaborate explanation and discussion of this concept is not the purpose of this study, it is important to know that a minority group, specifically the mentally ill, has become a victim of the mental health system in Michigan. As this story unfolds, it will be observed that, even with the best of intentions to serve this population, interested parties could not foresee that certain economic factors would curtail mental health care or that administrative policy limitations would preclude more sophisticated treatment interventions. Furthermore, the early history of mental illness also suggested that little could be done

to intervene with the so-called "insane" for lack of understanding of a most complicated impairment. Given this background, a comprehensive methodology of analyzing historical documents and data provides for a balanced panoramic view of the plight of mental illness in Michigan.

Significant input into the care and treatment of the mentally ill has come from mental health administration, the Michigan Legislature, and the Michigan Judiciary. The community at large also has made a vital contribution, providing an impetus to better serve this population.

Descriptive data were gathered from numerous State of Michigan documents pertaining to institutional cost, the clinical population as a whole, and patient-staff ratios. In addition, the literature was surveyed for models that have contributed to the decision-making process used by the MDMH. Reports of independent task forces and their recommendations also were surveyed.

After the early history of Michigan mental health is presented, an examination of the evolution of the MDMH enables the reader to put in perspective the role of other vital advocates of the mentally ill. This history of mental health required that the perceptions of the Michigan Legislature be examined so as to have a more thorough understanding of the thinking that went into the laws governing the treatment of the afflicted. It also was important to note how the lawmakers over the years recognized and resolved some of the major

problems facing the public administrators of the state institutions. The independent state hospitals eventually came into prominence--a most fascinating period of Michigan history.

The many challenges to commitment procedures and the quality of patient care became a special problem addressed by the judiciary. A review of important cases was undertaken, as well, in an endeavor to have a more enriching understanding of patient rights.

It was not enough to allow for professionals to intercede on behalf of the mentally ill; quite the contrary, the community needed to provide its input. Obviously, having many concerns about the mentally ill was part of a social consciousness. In some respects, the populace became the advocates for a special minority.

A summary of the annual cost for the State of Michigan hospitals from 1980 through 1989 is then reviewed. The purpose of this part of the research is to determine the cost of mental health with respect to inpatient care and the feasibility of scaling down institutions and/or closing them completely so as to develop a more comprehensive and intense treatment environment, such as group homes and community living.

The future of the state mental hospital is finally presented, along with a discussion of a different model for the implementation of a more dynamic treatment intervention. Social equity becomes the primary theme as new public administration is introduced to implement vital changes in mental health. An example of such a grand intervention, along with a conclusion as to the necessity for

change, summarizes a new era in the mental health movement in Michigan.

### The Concept of Mental Illness

Because the present research primarily concerns mental illness, it is important to understand what this term means. For the purpose of this study, mental illness is defined as "a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life" (Davis, 1985, pp. 6-7).

Deinstitutionalization has been one approach to resolving some of the crises in Michigan state mental institutions. Davis (1985) described deinstitutionalization as:

the reduction in the number of patients in state hospitals, and it may involve measures which reduce admissions to, and/or increase discharges from, these hospitals. While in principle deinstitutionalization includes systematic pre-release and community service planning for patients, in practice there has at times been little regard for the disposition of released patients. (p. 5)

### The Concept of Public Administration

The MDMH is administered by a formal organization. Therefore, for purposes of this study, it is important to have a common understanding of the complex concept of public administration of mental health. The following definition of public administration was used as a frame of reference:



The process by which public resources and personnel are organized and coordinated to formulate, implement, and manage public policy decisions. Public administration is characterized by bureaucracies, large-scale activities, and distinctively public administrative responsibilities. (Chandler & Plano, 1988, p. 29)

### Statistical Analysis

One statistical approach will be implemented in this study: a cost-benefit analysis of state mental hospitals. McKenna (1980) noted that:

Decision theory provides a conceptual framework for assisting decision makers in understanding the decision situation. . . . Cost-benefit analysis is another extension of the conceptual framework for systematically investigating certain problems of choice. Specifically, as the name implies, it investigates the costs and benefits of each of a set of alternatives so that the decision maker can better understand the consequences of a decision. (p. 127)

### Rationale for the Research

As noted, this research on the inpatient mental health problem in Michigan is focused on the perceptions of four major parties involved: the MDMH, the Michigan Legislature, the Michigan judicial system, and community concerns. The historical background of mental health institutions is discussed in Chapters II and III. The 1980s are of primary interest because economic factors have influenced the functioning of state mental institutions. In fact, some hospitals have been closed, and others have undergone drastic cutbacks.

### Summary

In this study, an attempt is made to demonstrate that the MDMH has operated primarily to reconcile the economic climate and patient needs. The state mental hospital appears to have outlived its initial function. Conditions have changed, and there may no longer be a need for so many archaic state inpatient facilities.

Confronting such a monumental social-economic problem is certainly not welcomed by anyone. However, unpopular decisions are necessary, and a new approach to mental health treatment and administration is vital. More questions will be asked than can be answered, at least for now. This should not be surprising. The MDMH is faced with a dilemma, and the longer fundamental decisions regarding state institutions are postponed, the more difficult it will be to ease some of the economic and social burdens created along the way. Let us now review, though, the beginning of Michigan mental health as we carefully unravel a most complicated but interesting saga.

## CHAPTER II

### THE ESTABLISHMENT AND EARLY HISTORY OF MENTAL HEALTH ADMINISTRATION IN MICHIGAN

In early American society, horror stories, mysticism, and superstition surrounded the mentally ill, who were thought to be possessed by evil spirits and were treated accordingly; cruel punishments were often inflicted upon them. Several movements were undertaken to treat the mentally ill more humanely, but, for the most part, the afflicted suffered and were often an embarrassment and a burden to their families. Initially, there were no facilities to care for the mentally ill. Families housed their embarrassment, sometimes in ugly and filthy environments--attics, cellars, or some kind of pen. Scientists knew little about mental illness, and professionals at the time did not think much differently from the lay public with respect to these suffering individuals.

When Michigan became a state, there were no facilities in which to care for the mentally ill, and there was no psychological or psychiatric treatment that would provide permanent relief for mental disease. As noted in the Michigan Manual (State of Michigan, 1859), the state established insane asylums. Section 10 states: "Institutions for the benefit of those inhabitants who are deaf, dumb, blind, or insane, shall always be fostered and supported" (p. 102).

In 1834, Wayne County initiated an institutional care program for the mentally ill in Michigan. An ordinance that was passed that year created the Board of Superintendents of the Poor, who converted the "pest house" established in 1832 for cholera victims into the "poor house" and assumed the financial responsibility for treating the mentally ill (MDMH, 1962, p. 2). Technically, then, Michigan's first mental institution was born; it eventually became known as the Wayne County General Hospital at Eloise, Michigan. The first patient legally diagnosed as "insane" was treated at this facility in 1841. However, only a very few of the mentally ill were treated in this facility. It served more as a housing unit for the mentally ill than a hospital since an elaborate treatment program did not exist.

The mentally ill were treated in this manner for the next 20 years. Not until a major facility was established did they receive any kind of intensive treatment.

#### A National Inspiration

Dorothea Dix's crusade for mental health care during the 1840s had a significant impact. In brief, she spearheaded a concerted effort to improve care for a growing clinical population. As the MDMH noted in its historical overview of mental health treatment, many facilities were then established to care for people suffering from mental illness. Dix collected information, visited numerous mental health facilities, and pushed for legislation that would

establish asylums in many states. Michigan was one state that was touched by her monumental influence.

### The Michigan Connection

In 1848, the Michigan Legislature provided for the establishment of a "state asylum for the insane, the deaf, dumb and blind" (MDMH, 1962, p. 4). Initially, individuals with these afflictions were to be placed together in one institution, but this arrangement never reached fruition. Community interest and financial support both were lacking.

Legislation was approved to build a state institution in Kalamazoo, but some nine years later the Kalamazoo "asylum" existed only in the minds of state legislators. Groundbreaking for the Kalamazoo institution was delayed, primarily because of a lack of funding. Eventually, funds were appropriated to support this program, and patients began being admitted on April 23, 1859. Kalamazoo State Hospital was the initial state-supported mental health program to take over the responsibility of caring for the mentally ill from isolated housing locales in Michigan. This facility, in which only those individuals who could possibly be cured were treated, was described in the Michigan Manual (State of Michigan, 1879) as follows:

The Asylum is situated upon an irregular eminence in the western part of Kalamazoo, and has connected with it 200 acres of land. The first building was commenced in 1853, and opened for patients in 1859, under the superintendence of Dr. E. H.

Van Deusen, which position he held till 1878. In 1871 \$280,000 was appropriated for another building. This is situated far enough from the first to render either safe in case of fire in the other. Each building will accommodate about 300 patients. The building first completed is used for female, and the other for male patients.

The buildings, grounds, furniture and appliances of every description, have cost about eight hundred thousand dollars. This includes nearly seventy thousand dollars for reconstruction of a portion of the building destroyed by fire in 1857.

The disbursements of the Asylum on "current expense account" from April 1st, 1859, to April 30th, 1876, were \$1,078,318.98 and the appropriations made for 1877 and 1878 were: for improvements and repairs, \$14,832, and for current expenses, \$35,000.

The average cost of maintenance, including disbursements of every class, is not quite five dollars per week. (p. 415)

Before the State Insane Asylum at Kalamazoo was established, the afflicted who were thought to be incurable were treated in the Wayne County institution. Even after the Kalamazoo facility opened, mentally ill persons from the Wayne County area continued to be housed, if at all possible, in the first facility. Overcrowding soon became a major problem. The two Michigan asylums, having a combined bed capacity of 900, were already serving 1,082 patients. It was estimated that several hundred more individuals needed care, but they did not receive any treatment intervention (MDMH, 1962, p. 8).

In 1867, because of overcrowding in the asylums, a number of Detroit physicians were called on to evaluate the living conditions in the "crazy house" (MDMH, 1962, p. 4). As a consequence, a new building was constructed, which opened in 1869. Once again, housing

was provided but little treatment was offered. The mentally ill continued to live under very poor conditions. Thus, after roughly 30 years of professional mental health intervention, all that had been created was barren housing for those suffering from mental illness. Individuals working with the mentally ill attempted to provide treatment, pursuing different approaches to this objective, as they sought additional funding. There was no methodical approach to therapeutic procedures for the mentally ill as this area of medicine was still in its infancy.

#### The National Movement as Impetus

The national movement to help the mentally ill continued to gain momentum. The Michigan Legislature was urged to allocate monies for better care of the patient population. In 1873, the legislature appropriated \$400,000 to construct the Eastern Michigan Asylum (later called Pontiac State Hospital and still later Clinton Valley Center) in Pontiac, Michigan. Two years later, an additional \$67,000 was appropriated for furnishings. This facility opened in 1878. The Michigan Manual (State of Michigan, 1897) described this facility as follows:

The Eastern Michigan Asylum for the Insane, located at the city of Pontiac, Oakland county, was opened August 1, 1878. The first cost was \$467,000 and the present valuation of the property is \$577,908. The total running expense of last year was \$131,518.62. . . . The number of patients in the institution October 1, 1884, was 336 males and 317 females. The number of employees is 143. The institution is controlled by a board of six trustees appointed by the Governor for a term of six years. (p. 242)

The Michigan Manual (State of Michigan, 1879) provides more detail regarding the incidence of mental illness during this period: "The census of 1850 reported 326 insane persons in the State; it being one to 1,190 of the population. In 1874, the number reported was 1,058; or one to 1,261 of the population" (p. 416).

In 1881, Michigan's first medical superintendent was hired, and as a result the mentally ill finally received more than basic care. Their living conditions were greatly improved, and they were treated more humanely. They were given a fresh outlook as they were transferred to better living arrangements. Patients were given some basic responsibilities as well, such as farming, crafts, and caring for their own facility. Wayne County adopted this new attitude toward the mentally ill and began to alter the quarters for its patient population. Building expansion ensued, and a new day dawned in the treatment of mental illness.

In Michigan in the 1880s, a sincere effort was being made to help the mentally ill, and superstitions regarding mental illness were disappearing. Although better services were being provided than in the past, patients were not being cured. Hence, the number of patients continued to increase, and the state could not accommodate all individuals requiring treatment intervention. With no known cure for mental illness, the outcome of treatment procedures fell into one of three categories: continuation of institutionalization, discharge from an asylum, or death while undergoing treatment.



## The Michigan Legislature Continues the Cause

Legislation authorizing the construction of another state institution, the Northern Michigan Asylum (later the Traverse City State Hospital) in Traverse City, was passed in 1881. In 1885, this facility opened its doors to 445 patients (MDMH, 1962, p. 9). The Michigan Manual (State of Michigan, 1897) described the asylum as follows:

The Northern Asylum for the Insane, located at Traverse City, Grand Traverse county, is now in process of construction by virtue of Act No. 225, Public Acts of 1881. The erection of the institution is entrusted to a board of five commissioners appointed by the Governor. . . . The sum of \$400,000 was appropriated by the Legislature to carry out the provisions of the act authorizing the establishment of the asylum. (p. 242)

A perplexing dilemma that plagued state legislators was whether and how to group the mentally ill, epileptics, and those who were criminally insane or guilty of criminal activity. In 1893, the Michigan Legislature attempted to segregate some of these types of patients by erecting another facility, the Michigan Home for the Feeble Minded and Epileptics in Lapeer. The Michigan Manual (State of Michigan, 1895) noted:

Under authority of Act No. 209, Public Acts of 1893, the Michigan Home for the Feeble Minded and Epileptics was located by the board of building commissioners at the city of Lapeer, Lapeer county, on a tract of land containing 160 acres donated by the city. The object of the Home is to "provide, by all proper and feasible means, the intellectual, moral and physical training of that unfortunate portion of the community who have been born or by disease have become imbecile or feeble minded or epileptic, and by a judicious and well adapted course of training and management to ameliorate their condition and to develop as much as possible their intellectual faculties, to

reclaim them from their unhappy condition and fit them as far as possible for future usefulness in society." The sum of \$50,000 was appropriated for construction and \$15,000 for the current expenses in 1894. The Home is to be built on the cottage plan, and contracts have been set for four buildings, amounting to \$44,821.70. The commissioners expect that the Home will be opened sometime in January or February 1895. (p. 645)

The home's bed capacity was 200, and all beds were "filled within a few hours after opening in August, 1895" (MDMH, 1962, p. 9).

Some individuals thought to be more dangerous than others, i.e., the criminally insane, were already being housed elsewhere.

As the Michigan Manual (State of Michigan, 1887) emphasized:

The Michigan Asylum for Insane Criminals, established in 1883, is located in Ionia in connection with the State House of Correction. The institution was completed in September, 1885, at a first cost of \$91,750. The number of patients January 1, 1887, was 102. The institution is under the management of the board of managers of the State House of Correction and Reformatory. (p. 271)

The resources for helping the mentally ill during this era greatly improved. Much was done to help not only the afflicted, but their families as well. However, mental illness was perceived to be shameful, and many of those needing treatment were scorned because of the embarrassment they brought to their families. Demand for facilities in which to provide treatment for the mentally ill in Michigan continued to grow. Thus, in 1893, the Michigan Legislature put its stamp of approval on a facility, to be located in Newberry, Michigan. Demographic studies had suggested that a facility was needed in the Upper Peninsula because mental illness was a growing concern there. The new institution, known as the Upper Peninsula

Asylum for the Insane, opened on November 1, 1895 (MDMH, 1962, p. 9). The Michigan Manual (State of Michigan, 1897) described this much-needed facility:

The upper peninsula hospital for the insane, at Newberry, Luce county, contemplates in the plan, when the institution is completed, in all twenty buildings in the form of a quadrangle, each building to have a capacity for about fifty patients. . . . This is the only institution in the state for the care of the insane built on the cottage plan; this system has the advantage of being able to better classify patients, less danger from fire, better facilities for ventilation, and is more economical. . . . The capacity at present is about 225. The hospital was opened for patients November 4, 1894. There are completed three cottages for patients, one large infirmary, one administration building, one power house, one ice house, one farm house and barn, and a laundry. The value of property June 30, 1896, was \$113,485.48; number of acres of ground, 560; number of patients, male, 99; females, 95; . . . number of attendants, etc., 31. (pp. 727-728)

Although the mentally ill were receiving treatment, it is difficult to determine whether the efforts of professional staff were beneficial. Certainly, the mentally ill were no longer being institutionalized with criminals. In addition, it would appear that the improved living environment of mental patients had a beneficial effect on their health.

#### Treatment at the Turn of the Century

The State Psychopathic Hospital at the University of Michigan in Ann Arbor opened just after 1900 and began to receive patients in 1906. "One of the chief purposes [of the hospital] was to carry on research work in the phenomena and pathology of mental disease" (MDMH, 1962, p. 9).

In the early 1900s, laws were being changed to help the mentally ill in Michigan. For example, in 1906 "mechanical restraint was abolished from Michigan asylums" (MDMH, 1962, p. 10). Furthermore, the Michigan Legislature "passed an act in 1911 which renamed the asylums 'state hospitals,' each to be preceded by the city of location" (MDMH, 1962, p. 10).

#### The Beginning of the State Hospital in Michigan

Although the legislative act of 1911 was responsible for renaming the asylums "state hospitals" (MDMH, 1962, p. 10), local boards of trustees continued to oversee the facilities until 1923. The adoption of a mental hospital concept was also advanced by newer techniques in therapy, which consisted primarily of medications, insulin, and electroshock treatment. The hospital system became compartmentalized as patients were assigned to different wards according to the severity of their illness and the required treatment (MDMH, 1962, p. 10).

It became clear that the state mental hospitals would establish their own identity, as tubercular patients being housed with the mentally ill eventually received treatment in separate medical facilities. As the state mental hospital system began to expand, it became evident that capacity did not satisfy the need. On a more positive note, the state did attempt to provide some incentives to hospital personnel, not only to make the job more attractive, but

also to maintain a professional staff. Financial compensation, room and board, and other so-called benefits were provided.

The process of specialization became even more pronounced as the Michigan Legislature authorized construction of facilities to house epileptics. The legislature was doing all it could to keep up with the escalation of various illnesses. The community at large was demanding treatment intervention on a large scale. The construction of additional buildings for the mentally ill suddenly ceased as other demands became quite pressing. Hence, there was a lull in the expansion of the state hospital system from 1915 until 1930 (MDMH, 1962, p. 11).

With the state hospital system firmly established in Michigan, the Michigan Legislature turned its attention to other social matters. Mental health took on a lower priority for the time being.

Thus the state institution was born. However, even though the facilities were now state hospitals, they were operated by local boards of trustees until 1923 (MDMH, 1962, p. 10). In essence, the state institution was governed by local authority and not by a department of mental health. Considering the reorganization of state facilities, it is remarkable how Michigan progressed in housing the mentally afflicted. The establishment of treatment facilities run by governing boards denoted the recognition and acceptance of a social problem that once had been addressed most unfavorably.

Concern continued to grow as more room was needed to house the mentally ill. Considering that mental patients were now under a more appropriate rubric and that individuals with other kinds of afflictions were also being accommodated elsewhere, construction of additional hospitals was necessary.

### Psychiatric Needs in Detroit

In 1915, it became evident that a facility to treat the mentally ill was needed in Detroit. Receiving Hospital added a "psychopathic ward" in an attempt to alleviate the heavy demands placed on the city to treat residents suffering from mental illness (MDMH, 1962, p. 11). Soon this facility was so taxed by the growing clinical population that care barely existed. Chaos and uncertainty surrounded the care of these patients.

In the early 1900s, more and more people were suffering from mental illness. Social pressures, as well as other catastrophic circumstances, such as the first world war and the economic depression, brought on much mental suffering. Increasing numbers of people could not adjust to industrialization, international strife, and other burgeoning problems in a rapidly changing world. The State of Michigan could not adequately house all of the mentally ill; new institutions were sorely needed.

Even during the very early years of mental health treatment in Michigan, adequate funding was a major concern. Although it had the best of intentions, the Michigan Legislature was not able to

accommodate all the needs of the mentally ill. Inadequate staffing and a limited number of facilities impeded the delivery of treatment. Although the mental health system was much less complex during the early years than it is now, the costs involved were still a primary concern. In addition, the benefits of providing treatment were not readily apparent.

#### Further Evolution of the Michigan Mental Health System

The Michigan mental health system continued to evolve during the early part of the twentieth century. In 1922, a major facility was erected for the treatment of mentally ill children. It was known as the Wayne County Training School for Defective Children, located in Northville, Michigan. The facility had to receive voter approval before it could be authorized as a state mental health facility, so the program did not begin until September 1927. This facility offered more than living accommodations, and mentally ill children were treated more kindly than their adult counterparts (MDMH, 1962, p. 33).

The Michigan Legislature organized the first state hospital commission in 1923. However, instead of making any major policies for the mental health system, this commission served more of an advisory role. The new commission tried to accommodate the patient population, but as the bed capacity of state hospitals increased, so, too, did the number of patients requiring treatment. "In 1926

there was an overcrowding of 2,835 patients above the bed capacity of 6,723 and in 1928 the state hospitals admitted only 213 patients for every 100,000 of the patient population" (MDMH, 1962, p. 13). At the time, no system or model for long-term planning was available.

In 1929, the State of Michigan began to be more assertive in planning for mental health needs. The Hartmann Act was passed, which provided for construction of new hospitals over a four-year period (MDMH, 1962, pp. 13-14). The first facility that was constructed under this act was Ypsilanti State Hospital, which opened in 1931. The new hospital admitted 867 patients, who were transferred from Pontiac State Hospital. In addition, the existing state hospitals were expanded. Attention was given to providing for mentally ill children, and more facilities were established for their care, as well. Nevertheless, the major emphasis continued to be on housing the adult population. When the Hartmann Act was repealed in 1933 due to the economic conditions of the time, further expansion of mental health facilities in Michigan was curtailed (MDMH, 1962, p. 14). The impetus that had seemed so promising was now virtually at a standstill. The focus shifted primarily to caring for those people who were already institutionalized.

This hiatus lasted for about four years. Then came another legislative thrust to improve the mental health program. This administrative structuring was described as follows:



In 1937, the Legislature created the State Hospital Commission consisting of seven members appointed by the Governor with the approval of the Senate. This Commission was given complete authority and responsibility for the operation of the state mental hospitals, and was authorized to employ a Director of State Hospitals and such other staff as required. A director was appointed to this position in November 1937. Other staff were added and for the first time in the state's history a central office on a state level functioned with respect to the matters of mental health. (MDMH, 1962, p. 15)

The State Hospital Commission, which has since become the MDMH, oversaw the patient population and the living conditions in which treatment was provided. The year the Commission was established, the Michigan Legislature provided outside support services and training schools for the "feeble-minded." Establishment of the Mt. Pleasant State Home and Training School facilitated this objective. Two years later, in 1939, the legislature created the Coldwater State Home and Training School, which housed patients who were committed by the courts (MDMH, 1962, p. 16).

Even with the newly established facilities, there were too few beds and far too many patients to be given adequate treatment. Still, the push to develop new programs continued, and as a result of that challenge, the Neuropsychiatric Institute (formerly the State Psychopathic Hospital) was reestablished in 1939 at the University of Michigan in Ann Arbor. This move relieved some of the pressure to treat the afflicted, but the state facilities still had inadequate space to care for the mentally ill.

Unexpectedly, in 1939, the administrative structure that had been established by the Michigan Legislature was abolished; no

longer was there a director of state facilities. The positions of executive secretary and director of mental hygiene were created, but insufficient funds were allocated to support the new positions. Although state legislators had good intentions, they were not realistically addressing the problem of mental illness in Michigan (MDMH, 1962, p. 16).

#### The Creation of the Department of Mental Health and Other Legislative Inputs

Realizing the necessity of organizing the mental health system in Michigan, the legislature created the Department of Mental Health in 1945. This organizational structure was initiated to plan and carry out the state's mental health treatment programs and was the first administrative model to initiate treatment procedures as well as to care for the mentally ill. A variety of interventions were described in the new mental health act of 1945. However, a system to carry out these objectives was not evident. (See Appendix A.) Another important advance came about when the legislature began to describe the afflicted in more favorable terms, i.e., the mentally ill and the mentally handicapped. These respective changes in terminology were made in 1949 and 1952 (MDMH, 1962, p. 18).

The legislated administrative role of the MDMH did much to improve the structuring of the mental health system. The inpatient treatment facilities were more adequately supervised than previously. Centralization of the mental health system also enabled

the formal establishment of policies and procedures. Bed capacity was expanded, and more facilities were opened after the advent of the MDMH. A more detailed description of the Michigan Legislature's role in mental health is discussed in Chapter IV.

### The Mental Health System Is Fully Entrenched

In 1950, the MDMH enlarged its program for the adult inpatient population and allocated funds to augment programs for emotionally disturbed and mentally retarded children, as well.

Expansion of treatment programs continued for the next several years. Funding was provided, not only to treat the mentally ill, but also to develop and carry out research and training. The State of Michigan continued to pursue comprehensive program development as the national mental health movement progressed. Although programs were established, adequate systems and models to oversee them were lacking.

A number of state psychiatric hospitals have been established since 1906; some eventually were closed due to administrative decisions based on economic factors. The first few psychiatric hospitals to treat the mentally ill in Michigan have been discussed in this chapter. Table 1 is a list of the major state facilities that were established between 1906 and 1955.

Table 1  
Chronology of Michigan Mental Hospitals Established  
Between 1900 and 1955

Hospital	Opening Date
Neuropsychiatric Institute, University of Michigan	1906
Caro State Hospital	1914
Detroit Receiving Hospital	1915
Wayne County Training School, Northville	1927
Ypsilanti State Hospital	1931
Coldwater State Home Training School	1935
Mount Pleasant State Home and Training School	1937
Sault Ste. Marie Hospital	1945
Northville State Hospital	1952
Lafayette Clinic, Detroit	1955
Mental Health Research Institute, Ann Arbor	1955

### Summary

The state mental hospital at one time in Michigan's history served a vital function. Caring for the mentally ill was the primary objective, but it is imperative to remember that the communities benefited in that an unwanted segment of the population was removed from the neighborhoods. Gradually it became unnecessary to contain the afflicted for so long. Whereas some patients were

considered chronic, others did demonstrate an improvement in their mental functioning. It became possible to reduce state hospital bed capacities at the various institutions. During the past couple of decades, the mental hospitals began to drain the state economy, creating an enormous liability for Michigan.

This study thus focuses on evaluating those state institutions in operation from 1980 through 1989. These institutions are listed in Table 2. Recently it was announced that Traverse City Regional Psychiatric Hospital would be closing in 1989. Nevertheless, data concerning this facility are included in this study. The Center for Forensic Psychiatry, located in Ann Arbor, and Lafayette Clinic, located in Detroit, are specialty facilities for the mentally ill and therefore are not included in the research.

The MDMH is now a complex arm of state government. The hospital system comprises a large segment of the MDMH, and its presence is probably accepted as a foregone conclusion. The organizational chart of the MDMH (see Appendix B) helps put the hospital program in perspective.

State mental hospitals also must be accredited or certified by the Joint Commission on Accredited Hospitals for third-party reimbursement. Furthermore, they must comply with state laws to remain in operation. There is some leeway in accreditation status, though, as shown in Appendix C. This material establishes the value of treatment at the various institutions.

Table 2

State of Michigan Institutions Serving the  
Adult Mentally Ill, 1980-1988

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Caro Regional Mental Health Center
Clinton Valley Center, Pontiac
Coldwater Regional Mental Health Center
Detroit Psychiatric Institute
Kalamazoo Regional Psychiatric Hospital
Newberry Regional Mental Health Center
Northville Regional Psychiatric Hospital
Traverse City Regional Psychiatric Hospital
Walter Reuther Psychiatric Hospital
Ypsilanti Regional Psychiatric Hospital

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The contemporary administration of the MDMH is discussed in detail in Chapter III for the purpose of bringing the reader up to date with more current mental health policy and procedure. Many interesting milestones have occurred, which have incidentally led to more crystallized perceptions of mental health needs.

### CHAPTER III

#### CONTEMPORARY ADMINISTRATION OF THE MICHIGAN DEPARTMENT OF MENTAL HEALTH

As the mid-twentieth century approached, mental health in Michigan encountered new problems. In 1947, difficulties regarding the MDMH were outlined by the acting director, Charles F. Wagg, in "Problems of the Present and Plans for the Future":

The Department of Mental Health has two important tasks. One is to hospitalize those who are mentally sick and in immediate need of care, and who are in many instances a problem for their relatives and the communities in which they live. The other problem is for the Department to prepare itself to cope with the much wider and greater task that is ahead as the public comes to realize how far behind this state and every state is in the possibilities for more intensive treatment of the mentally sick and for more preventive measures in the field of mental ailments. (p. 1)

Wagg described mental illness and the approach to treatment:

The general patterns for the care of mental illness were established many years ago. At that time mental illness was thought of largely as incurable--something to avoid thinking about, to be afraid of, and to be ashamed of if any member of the immediate family should develop such an illness. During the period that the basic patterns for the care of mental illness were being established, many misconceptions existed. (p. 1)

Wagg (1947) noted many changes that had come about in the care of the mentally ill and acknowledged a rapid increase in the number of individuals needing treatment. Because the care and treatment of mental illness had come under public and governmental scrutiny, more hope existed for those afflicted with mental illness.

During the late 1940s, the primary concern of the MDMH was providing new buildings, better trained attendants, and more trained nurses. Wagg (1947) observed that hydrotherapists, occupational therapists, technicians, psychiatrists, social workers, and psychologists were also needed. More research on mental illness and its treatment was called for, as well.

Although mental health in Michigan has long been a pressing concern, there has been a continued scarcity of resources to meet the needs of the mentally ill. As a result, an alternative to hospitalization treatment--the outpatient clinic--emerged. At Traverse City State Hospital's outpatient clinic, there was a heavy demand for treatment. According to William T. Hyslop (1947), director of outpatient clinics for Traverse City State Hospital, clinical activity was intense. He observed that immediate intervention at the outpatient clinic, rather than hospitalization, was the solution to caring for the mentally ill.

From an administrative perspective, this stance created a major conflict for the MDMH. A controversy arose as to the best approach to treating mental illness--hospitalization versus outpatient treatment. Clearly, there was no easy resolution of the dilemma. However, an even more pressing problem was the tendency for many people to seek relief from individuals claiming to be "miracle workers." Since the community was often unknowledgeable about treatment, it was not uncommon for many prospective patients to "drift from quack to charlatan to cultist" (Hyslop, 1947, p. 5).



The MDMH did attempt to educate the public, but the primary demand was to provide hospitalization or outpatient treatment for all in need.

A review of MDMH policies suggests that two major factors influenced those directives. First, administrative decision making was based on the perceived needs of patients, families, and community. Second, the Michigan economy dictated the funds that would be available. Hence, the MDMH has not always been completely in control of its own destiny. It is important to keep this factor in mind when reviewing administrative models and policy making.

#### Modernization of the MDMH

Contemporary policy formulation by the MDMH began in the 1950s. The years following the Korean War witnessed a healthier peacetime economy. The introduction of psychotropic medication was a spinoff of the new prosperity as funding went into pharmaceutical research. Such medication provided a sedative effect for patients and also enabled behavioral control of the clinical population, thus shortening the overall course of hospitalization.

The MDMH pursued a self-monitoring approach to formulating policy. As issues became of concern, the department diligently pursued research and program development. One important investigation by the MDMH (1955a), conducted in February 1955, focused on patient hospitalization patterns for four years: 1935,

1940, 1945, and 1955. A random sample of patients admitted to a state mental hospital was examined for changes in hospitalization patterns. One problem that arose was how to define termination of patient status; some patients remained on active status even though they were no longer living within the facility. Nevertheless, it was concluded that little change had occurred in hospitalization patterns in the years studied. Length of time in the hospital, death rate, percentage of discharges, and readmission rate were largely unchanged. The success or failure of treatment was not a variable in this study, only the residency pattern.

In another study, the MDMH (1955b) investigated first admissions to selected state mental hospitals. Admission patterns remained a concern. Diagnostic groups and socioeconomic characteristics of the hospital's location were considered to be influential variables affecting placement. It was found that the characteristics of the state hospital and diagnostic groups did influence patients' length of stay. The waiting period for admission was not influential, nor was the mortality rate a factor. Hospitals with a more rapid discharge rate than others usually were selected for first-admission patients. Another characteristic was the quick discharge rate in areas with a low population density. In general, hospital admissions were found to be based on convalescent status, not treatment intervention.

The MDMH continued to attempt to monitor admission trends and to predict future census rates. In 1957, the department conducted a

time-series analysis of the bed population from 1937 through 1956 and then forecasted the bed population to 1961 (MDMH, 1957a). Although a noticeable reduction in the bed population for some other states (Kansas, Ohio, New York) was evident, this decline was thought to be a temporary phenomenon. It was concluded that an increase in the general population would result in an expanding population of mentally ill persons, as had occurred in the past. It was also determined that Michigan's population was growing faster than that of any other east-north-central state. Therefore, the MDMH concluded that population growth should be the primary focus in determining future needs of the mentally ill. Other variables were of secondary importance. Age was considered to be influential only as a correlate of population growth. Thus, the MDMH carried out a population study, but it neglected to hold constant other important variables, such as treatment techniques, intervention approaches, administration of medication, and general care. Nevertheless, the MDMH projected that 900 additional patients would enter the mental health system annually and that by 1975 an additional 6,000 beds would be needed. The possibility of incurring greater error as the forecasting extended further into the future was noted.

In another investigation, the MDMH (1957b) compared the mortality rate in psychiatric hospitals with that of the general population. The investigation covered the years 1950 through 1954. The hospital crude death rate (deaths from all causes in state

mental hospitals) for this period was found to be 6.8 times greater than that of the general population. The overall death rate for hospitalized females was 7.1 times greater than that of females in the general population; for hospitalized males the death rate was 6.6 times greater than that of males in the general population. The MDMH also found that the crude death rate among hospitalized patients declined from 77.7 to 67.5 per 1,000 during the period under study. A greater decrease in the death rate occurred among males compared to females. The greatest decline in the psychiatric hospital death rate was for the younger female group and for the 65-and-over age group without reference to gender. This internal examination is praiseworthy because during this era little self-scrutiny was being initiated.

#### Hospital Expansion During the 1960s

Prosperity continued into the 1960s as the MDMH perceived a growing demand for hospitalization of the mentally ill and the need for more state funding. The latter was forthcoming as economic conditions were conducive to an expanding mental health program, but pressure to provide care and treatment for a growing number of persons continued throughout the decade. Approximately \$96 million was appropriated for constructing new hospitals and for renovating and remodeling existing buildings. An additional 6,600 beds were provided. Allocations for teaching and research also became of primary importance (MDMH, 1960).

The MDMH continued to conduct its own internal investigations. In one such study, the department observed a significant increase in admissions to state mental hospitals in Michigan (MDMH, 1960). From 1948 through 1958, admissions rose 17.9% as the state's population increased by 27%. Concurrently, the discharge rate increased 73%. Thus, considering the death rate and the slight decrease in the clinical population, the total number of patients in all state mental health hospitals had increased by 16.6%.

Staffing problems were of critical concern for the MDMH. In 1960, the American Psychiatric Association (APA) surveyed the Michigan mental health hospitals and found a deficiency in numbers of professional staff members, including nurses, psychiatrists, psychologists, and social workers (MDMH, 1960). The APA recommended that professional staffs be increased 25% by 1965, as the current proportion of professional staff to the patient population was too low to accomplish successful treatment intervention.

The MDMH eventually projected that 2,500 more patients would need to be served between 1960 and 1965 (MDMH, 1960). This figure even took into account the gradual decrease in patients' length of hospitalization.

Even with continued improvements in mental health care, there was still pressure to make more changes. The Joint Commission on the Accreditation of Hospitals recommended more community-based services, an increase in research, and additional revenues for

mental health care. Some of the problems identified in the early 1960s were identical to those of the past. More than 1,000 patients were housed in temporary facilities, which happened to be leased buildings. The patient waiting list increased to 1,500, as well. The hospital system was reported to be overcrowded by an average of 20% to 25%, and the shortage of personnel remained (MDMH, 1960).

During this period, the MDMH was attempting to offer services and treat patients as effectively as possible, given its financial constraints. During 1960-61, 18,827 patients received professional care. At the same time, it was revealed that 90 wards at various state hospitals experienced an absence of employees on certain shifts. Incidentally, this condition was reported to have existed for several years (MDMH, 1960).

The Michigan Legislature eventually approved funds for a new 350-bed unit for females at Kalamazoo State Hospital. By 1962, 120 beds were in place and occupied. Funds for the completion of this project had to be requested in the 1963-64 budget, precluding the timely transfer or admission of patients to fill this unit (MDMH, 1963).

The Howell State Hospital underwent a major renovation between 1961 and 1962, increasing its bed capacity by 375. Essentially, this was the extent of the overhauling of state hospitals for the time being (MDMH, 1963).

The mental health program progressed during the 1960s. Advances in treatment, though, played an important part in reducing

the patient population. In 1960, there were 19,778 patients. The number of patients dropped to 17,053 in 1965 and declined further in 1970 to 11,134. During the same time, the number of state psychiatric employees increased dramatically. In 1960, there were 5,656 employees in state psychiatric facilities; this figure increased to 6,275 in 1965 and rose to 7,698 in 1970 (MDMH, 1987a).

The MDMH budget during the 1960s reflects the state's continuing support for the mentally ill. This support is exemplified by the department's approach to seeking funds, as stated in the Report on Program and Budget (MDMH, 1960):

The Department of Mental Health budget for the year 1961-62 has been prepared in a different manner than in the past. The general principle of the new approach is that all factors of improvement, expansion or new program have been handled separately so that the budget material clearly delineates these separate matters. The Department believes this type of program budgeting is much more meaningful and that it will permit more definitive decisions on the part of the Governor and his staff, as well as the legislative body. (p. 33)

Over the years, there were delays in implementing certain segments of Michigan's mental health program. The MDMH acknowledged this problem in the Report on Program and Budget (MDMH, 1960):

We must emphasize . . . that many of the programs contained in this budget have been delayed for one or more years, and their implementation and further delay only compound the overall problems faced by the citizens of this state in building a comprehensive mental health program to serve the needs of those persons afflicted by mental illness and mental retardation. Certainly this responsibility cannot be denied. We are already far behind the demands for services for mental health. Further delay in putting these programs into effect only increases the future burden which must ultimately be dealt with. The established fact that mental illness and mental retardation are the nation's number one health problems demands the attention

of responsible citizens to cope with these problems in whatever way seems advisable in light of current concepts of care and treatment. (pp. 35-36)

Spiraling costs, increases in the number of people seeking treatment, and antiquated buildings preoccupied the MDMH but also fueled criticism by outside observers. DeLong (1974) asked, "Does the Department of Mental Health really believe that it can provide mental health services for the State of Michigan by itself or does it only appear that way to those of us who are not in the inner circle?" He proposed that "a single unified organization" be created that would "enable the department to interact efficiently and meaningfully with the rest of the mental health system" (p. 4). By creating a stronger community organization to combat and treat mental illness, it was hoped the MDMH could foster the communication necessary in arranging more outpatient treatment and lifting the burden from the state hospitals. DeLong added:

Creation of an organization encouraging continuous interaction among all the elements of the mental health team should not only correct inadvertent perceptions about the Department, it should result in more effective agencies--state and local--and a more effective system as a whole. (p. 4)

#### Patient Decline in the State Hospitals

Between 1965 and 1970, and again between 1970 and 1975, there was a dramatic decline in the number of patients in Michigan's mental health hospitals (see Table 3). Table 3 also illustrates that the number of employees in the state hospital setting gradually



increased until 1970 and declined slightly thereafter as a result of the dramatic decrease in the total patient census.

**Table 3**  
**Numbers of Patients and Employees in Michigan State**  
**Psychiatric Hospitals: 1955-1975**

End of Fiscal Year	Number of Patients	Number of Employees
1955	17,075	4,997
1960	19,059	5,656
1965	17,053	6,275
1970	11,134	7,698
1975	4,925	7,399

Source: Michigan Department of Mental Health. (1987d). Department of Mental Health Fact Sheet. Lansing: Author.

Innovative treatment measures, private hospitals, community mental health services, and private practitioners all impacted the decrease of the inpatient hospital census for state facilities. Table 4 underscores the number of private psychiatric hospitals in Michigan from 1972 through 1975 and the number of patients they accommodated.

**Table 4**  
**Number of Private Psychiatric Hospitals in Michigan,**  
**Patient Census, and Annual Admissions: 1972-1975**

Year	Number of Hospitals	Number of Patients	Annual Admissions
1972	44	1,520	21,145
1973	48	1,527	26,067
1974	48	1,595	30,061
1975	51	1,679	30,940

Source: Michigan Department of Mental Health. (1988a). Department of Mental Health Fact Sheet. Lansing: Author.

#### The New Mental Health Code

The MDMH continued to refine its programs in accordance with the Michigan economy and perceived mental health needs of the time. As the rights of patients became a central issue, the new mental health code of 1974 (MDMH, 1986b) became law; a deep concern about patient abuse was evident. The new mental health code was perhaps the most compelling change of the mental health system in Michigan affecting the care and treatment of the mentally ill. Although many parties contributed to the formulation of this new treatment code, the Michigan Legislature was required to put the comprehensive policies into law. The MDMH was then mandated to formally administer an upgrading of patient care, more effective treatment,

and above all the respecting of patients' rights as citizens of Michigan. (See Appendix H.)

After this dramatic event, the MDMH essentially focused on maintaining the size of the inpatient population and improving the quality of care. The new policies stemming from the 1974 mental health code continued to introduce improvements in treatment. Psychiatric hospitalization remained as the primary mode of care directed by the MDMH. Of course, other treatment programs, such as outpatient centers and private hospitalization, gained importance since the early years of treating mental illness in Michigan.

#### New Directions

An innovative measure known as the Assertive Community Treatment (ACT) program (MDMH, 1987e) was found to reduce hospitalizations by immediate treatment intervention in an outpatient setting. The MDMH was aware of the need to reduce the census for all state mental hospitals by providing outpatient treatment and transferring the care of manageable patients to group homes or to their families. Thus, community placement became an integral part of the Michigan mental health program. The emphasis on reducing the inpatient population continued to be a priority of the MDMH. State hospital facilities now became a fixed adjunct to community mental health programs.

Periodically, the MDMH referred to preventive measures as a means of assisting families of the mentally ill, as well as the need

to adopt a general policy to promote mental health. In 1975, the acting director of the MDMH, Donald C. Smith, M.D., addressed these concerns and commissioned a study, whose recommendations were as follows:

1. That a continuing advisory committee on prevention should be established.
2. That the Advisory Committee be kept informed concerning the disposition of funding requests and be requested to advise on such general areas as priorities, criteria for various categories of projects, evaluation plans, and on particular projects where policy issues are involved; that the responsibility for review of funding requests be consistent with the procedure used for other project funding. (MDMH, 1975, p. 5)

As noted, throughout the history of the MDMH, socioeconomic conditions have affected policy and decision making. During more prosperous times, the various directors have formulated mental health policy compatible with the availability of state and federal funds. Philosophical differences arose within the MDMH. Initially, a medical model was utilized. During the last several years, a fiscal approach to operating the state hospitals has come into the forefront. The increasing clinical population, but with briefer treatment techniques, further altered the nature of hospitalization services for the mentally ill. As a result of these changes, administrative policies sometimes lacked continuity from one administration to the next.

### Patient Abuse Contaminates the State Hospitals

In November 1977, Donald C. Smith, M.D., director of the MDMH, selected the Panel on Patient Abuse, which was charged with investigating the concern of patient abuse in state facilities and establishing policies and procedures to eradicate the problem. As stated in the Report of the Select Panel on Abuse in Michigan Mental Health Institutions (MDMH, 1978), the panel's responsibility was

To examine, to evaluate and to make recommendations to the Director on the following matters as they pertain to abuse of patients in programs directed by and funded by the Department of Mental Health:

1. Laws, departmental policies, personnel practices, and procedures designed to prevent incidents of abuse;
2. Reporting requirements, including documentation of evidence of physical abuse;
3. Remedial procedures, including those authorized by the Mental Health Code. (p. 3)

Shortly after this panel was established, the reporting of alleged patient abuse became even more pronounced. Smith was forced to resign the directorship as attention was focused on mistreatment of patients in MDMH facilities, especially the Plymouth State Home and Training School, which provided inpatient programs for children afflicted with mental illness and developmental problems (MDMH, 1978).

Based on data secured by the Panel on Patient Abuse, Governor Milliken outlined a 13-point program designed to eliminate patient mistreatment in all state mental facilities (MDMH, 1978). The panel

worked diligently and set in motion plans to incorporate a highly comprehensive system to identify and rectify situations that violated patients' rights. The ultimate goal was to rid the state mental health system of patient abuse and neglect. (See Appendix D.)

### Contemporary Treatment Offsets Some Problems

At about the same time that these investigations were taking place, it was becoming apparent that contemporary treatment modalities would dramatically accelerate inpatient discharges, reducing the overall state hospital census. This result was a positive outcome of the rapidly changing times. The MDMH (1978) was optimistic about these changes:

Perhaps the most interesting and optimistic statistics . . . are related to length of stay.

Today, half of those admitted to regional psychiatric hospitals will be returned to the community in 30 days or less. Recent studies show nearly 70 percent will be released in 60 days or less; nearly 80 percent in 90 days or less. No longer are ties with family, community and jobs severed by long periods of absence. (p. 4)

Community mental health programs authorized by the Michigan Legislature (Public Act 54) contributed to the dramatic decrease in the inpatient census, as evidenced by the following statistics:

[The community mental health program] expanded from one to eighty-two counties.

State budget for the program has grown from about \$1 million to more than \$70 million.

Persons served on an outpatient basis skyrocketed to more than 150,000 last year versus about 15,000 served by the child guidance and all-purpose clinics in the year prior to adoption of the community mental health legislation.

Community-based agencies serving mentally ill and mentally retarded persons expanded from fewer than 50 to more than 300. (MDMH, 1978, p. 6)

The Staffing Needs Assessment Process (SNAP) was introduced by the MDMH in October 1979. This procedure was designed to:

1. Correlate the needs of the clients (i.e., physical care, intervention measures and intensity of treatment) with the requirements for direct care treatment staff.
2. Have flexibility to meet changing client population loads and evolving methods of treatment.
3. Provide a common data base for consistent and objective interpretation of staffing requirements across all levels of management and treatment within the state mental health system.
4. Be modular in design, so that adjustments can be made to meet new treatment requirements, without having to revise the entire system.
5. Delineate staff by discipline according to program types and treatment modalities.
6. Provide a dynamic instrument for the budgeting and staffing of direct care treatment staff. (MDMH, 1981, p. 1)

The MDMH observed that by budgeting patient time and staff duties, a stronger case could be made for funding needs and that a data base could account for staff members' direct and indirect contact with patients. In addition, a better approach to appropriating the kind of staff interaction with patients could be provided. Accountability for one's own work time was underscored.

### Cost Containment

As the mental health system moved into the 1980s, a dramatic change took place with respect to continued budget decreases and reductions in the patient population. (Descriptive data for all of the state facilities that served inpatients during this decade are addressed later.) Also presented in Appendix E is a contemporary description of the Michigan Department of Mental Health. The changes that took place are discussed when the findings of the cost-benefit analysis are presented. During this period, the MDMH experienced the dramatic effect of budget reductions. In 1983, the department acknowledged the consequences of these budget cuts:

[The department] attempted to maximize collection of additional federal revenues, achieve all efficiencies possible in non-client care areas, and implement reductions intended to maintain services to the most dysfunctional clients.

Despite these steps to minimize the impact of budget cuts, actions required to date have severely limited the ability of agencies to provide services beyond a minimal care level.

Staff capacity in facilities serving adult mentally ill has decreased to less than 80 percent of direct care staffing standards. Indirect staffing was reduced 10 percent during FY 1979-80 with further reductions in FY 1980-81 and FY 1981-82. (MDMH, 1983, p. 11)

To reduce the budget for fiscal year 1983, the MDMH adopted the following six-point plan:

1. Elimination of all department financial reserves.
2. Reductions in facility support accounts for equipment, patient and staff travel, and maintenance.



3. Maintenance of 75 vacancies for state facility indirect staff (housekeeping, food service, skilled trades and other indirect categories).
4. Deferral of some previously scheduled staffing improvements.
5. Reduction of central and facility administrative expenses of \$520,000; attrition and freezing of vacant positions may eliminate need for layoffs.
6. Reduction in special services to that group of clients who are both mentally retarded and emotionally disturbed (referred to as dually-diagnosed clients).

Under terms of a new agreement between the Department, the Executive Office, and the Legislature, certain new funds totaling over \$6 million will be used to offset the full impact of the reduction.

These funds, from federal and private insurance sources, go to the state general fund to pay for services provided by agencies of the Department. The new agreement provides that these funds will be credited to the Department, subsequently eliminating the need for \$6 million in additional cuts.

Given this significant executive and legislative support, the Department can make modest improvements in basic care staff at those hospitals which have the lowest staff-patient ratios instead of ordering further reductions. (MDMH, 1983, pp. 12-13)

Reductions in the mental health inpatient services necessitated a redefinition of the goals set forth by the MDMH. In essence, the emphasis continued to be on community mental health services, ensuring that patients' rights would not be violated and that living arrangements would be minimally disrupted. Decentralization of state mental health services continued as Michigan counties assumed more responsibility for service delivery, except when inpatient treatment was required.

The MDMH again targeted the problem of bed use in 1984. A threefold approach became policy:

1. The reduction of 129 beds for state psychiatric hospitals for mentally ill adults.
2. The elimination of state-operated hospitals and centers for those people requiring nursing care and for developmentally disabled youngsters.
3. The establishment of contracts with hospitals in the community to utilize licensed psychiatric beds with a corresponding reduction of state psychiatric beds. (MDMH, 1984b, p. 8)

Hence, cost containment, soliciting patient reimbursement, and the reduction in bed capacity streamlined the state hospitals. Efforts were also made to improve state hospitals by focusing on coordinated services. Accreditation of these external facilities became a primary objective. Ironically, additional funding was needed. Nevertheless, the MDMH (1984b) attempted to shift much of the responsibility for patient care to the community mental health boards. The department's objective was to operate a more comprehensive hospital network for the mentally ill.

Efforts to reduce the patient census in the state hospitals continued. As a consequence of changing socioeconomic factors, criteria regarding who would be admitted as patients were modified.

SNAP data indicate that a significant number of residents are functioning at a level which is no longer appropriate for state inpatient service provision. Residential services continuum and other data indicate that current community residential settings also may no longer be appropriate. (MDMH, 1987b, p. 14)

Although the MDMH did not elaborate on criteria for admission, it became evident that mentally ill adults seeking hospitalization in 1987 were more severely impaired than those who had been hospitalized in 1980 and that their overall deterioration was more pronounced. It was noted that, for patients to be admitted to state hospitals, the prescribed treatment intervention needed to be more intense than in the past (MDMH, 1987b, p. 17).

Clearly, a major change in policy has evolved. Inpatient treatment is being curtailed; as noted, two state mental hospitals have been closed. The focus of inpatient treatment is now on those individuals who cannot benefit from community placement or outpatient treatment. That is, only the "hard-core" clinical population is being admitted to state mental hospitals. As the MDMH (1987b) Program Policy Guidelines observed: "Community Mental Health Boards shall implement services that will have a direct and measurable impact on minimization of utilization of state facilities" (p. 21).

Even though cost reduction is an underlying concern within the MDMH, the policy has been for the state mental hospitals to serve as a backup to the community mental health system. The Program Policy Guidelines (MDMH, 1987b) established the following policy: "State-operated hospitals and centers shall utilize the physical plant to enhance service delivery to the public mental health system or permit private utilization of space to reduce costs" (p. 21).

The MDMH expressed a deep concern for the lack of consistency in assessment and implementation of programs for the mentally ill.

The MDMH (1987b) Program Policy Guidelines noted:

Neither state assessment of the success of new approaches to service delivery nor the dissemination of information about the models is occurring on a statewide basis. While many innovative and seemingly successful models are being piloted, they are not systematically implemented nor are the associated administrative changes considered. (p. 17)

Two conditions became apparent:

1. Mental health inpatient facilities have been scaled down considerably.

2. Inpatient treatment is furnished for the severely impaired patients, and crisis intervention is provided for short-term patients, usually as a result of court commitment.

#### Remaining Burdens

Even though the above two conditions are now the policy for the MDMH, annual costs continue to increase, many buildings are archaic, and more demands and pressures are being put on staff members. It is difficult for the MDMH to fulfill all of the demands and expectations of the regulatory bodies. Given the current conditions, inpatient treatment is commendable. The 1987 SNAP survey (MDMH, Office of Management Services, 1988), discussed more fully in the chapter on the cost-benefit analysis, demonstrates how state hospitals have desperately tried to respond to patient needs. According to the MDMH (1987b) Program Policy Guidelines, "All

service delivery agents shall maximize reimbursements to offset the cost of providing care" (p. 21). Third-party payment (federal funds and health insurance payments) and private payment have been helpful in reducing the state hospital budget.

ACT programs have continued to expand throughout the state. As of December 1987, 33 programs representing that number of counties were in operation, and the MDMH projected that 42 programs would eventually operate in 40 counties. The department also projected that the 1,300 individuals being served would be increased to 2,000 outpatients by spring 1988. The ACT program budget for 1987 was \$10.5 million, to be increased by the MDMH. ACT then established a staff-client ratio of 1:8 (MDMH, 1987c, pp. 2-3).

The primary objective of these programs has been to reduce the recidivism rate of state mental institutions. The evidence indicates that hospitalizations have been reduced and that, in a majority of cases, treatment stays have been shortened. The MDMH considers the ACT programs to have positive cost benefits. Yet the MDMH has noted that the descriptive data are incomplete (MDMH, 1987c, p. 3).

As a result of community intervention, the state mental hospital is no longer the primary mode of patient treatment. A major facility that was to close in 1989 is the Traverse City Regional Psychiatric Hospital. This hospital was targeted as its bed capacity dwindled from 3,000 to 150. The reasons for this

closing were set forth by State Mental Health Director, Thomas D. Watkins, Jr. (MDMH, 1988a):

1. The interest of local community mental health boards in developing alternative community services.
2. The number of patients at the Traverse City facility who had come from counties within the service district.
3. The availability of other DMH-operated facilities which are certified to receive Medicaid payments.
4. Cost inefficiencies in operation of the hospital's physical plant.
5. Economic forecasts predicting extremely limited growth in state budgets in the coming years. (p. 3)

The Michigan Legislature must authorize the closing of this facility, but this governmental body has not done so since there has not been an adequate administrative plan to conclude the transfer of patients and reassign personnel who will be retained by the MDMH.

#### Summary

The mental health system in Michigan has undergone a tremendous metamorphosis from the time when state hospitals were called insane asylums. Treatment and prevention have become the two mainstays for ongoing mental health care, concomitant with developing humane living arrangements. Community mental health service has evolved to play the dominant mode of treatment intervention. Hospitalization has been relegated to a support role. Even so, many administrative problems remain in treating mental illness. The consolidation of mental health services appears to be of primary importance.

However, this has historically been an elusive goal. Managing a massive mental health network has not succeeded.

The Michigan Legislature has also played a critical role in the field of mental health. Chapter IV addresses their impact, and the state's continued need for overseeing care and treatment.

## CHAPTER IV

### PERCEPTIONS OF MENTAL HEALTH BY THE MICHIGAN LEGISLATURE

The Michigan Legislature has approached mental health from two perspectives: (1) to examine existing conditions of the mentally ill and (2) to pass necessary laws for the care and treatment of this clinical population. Over the years, the legislature has solicited information from professional interest groups, mental health administrators, and the lay public. Committees within the legislature have studied the plight of mental illness in Michigan.

The Michigan Legislature has set the parameters for the care and treatment of the mentally ill. The perceptions of this governmental body can best be understood by a review of the legislative hearings concerning the afflicted. The following six periods are now the focus of this research given other insightful perceptions of the Michigan Legislature, Michigan Judiciary, and community:

1. Independent state asylums: 1861-1911
2. Independent state hospitals: 1911-1923
3. State Hospitals Advisory Commission: 1923-1937
4. State Hospitals Commission as central authority: 1937-1945
5. State Department of Mental Health: 1945-1974
6. Department of Mental Health (new Mental Health Code)  
1974-present



### Independent State Asylums: 1861-1911

Mental health in Michigan has evolved through these major milestones according to the Michigan Department of Mental Health. The review of Michigan Legislature perceptions actually begins before the state asylums were established because significant events preceded the mental health movement in Michigan.

Mental illness was not well understood by the public during the period of the independent state asylum (1861-1911). It was recognized that "lunatics" needed to be contained and that families, indeed society, needed relief from such individuals. The Michigan Legislature recognized the problem, but it was also frugal with tax dollars. The economy was not strongly geared toward resolving social problems. Severely afflicted people, e.g., deaf, mute, and blind citizens, were regarded as needing financial support due to their misfortune. The mentally ill, though, did not receive such sympathy. Although it was generally believed that mental illness was a physical disease, only a lukewarm tolerance for the mentally ill prevailed. With much reluctance on the part of the legislature, the first state asylum was erected and opened for admissions. The scourge of society had a place to live as families sought admission for their loved ones, hoping for a cure, eventually settling for treatment and care, but ultimately being able to rid themselves of a heavy burden:

It appears from the late Census Report, that the State has within its borders two hundred and seventy-six deaf and dumb,

one hundred and seventy-six blind, and four hundred and twenty-six insane and idiotic persons, a large proportion of whom are legitimate objects of State support and charity.

The money heretofore appropriated for the purchase of sites, erection of buildings &c., has been expended by said Board of Trustees, and the work on these Institutions has been arrested for the want of means to press them forward.

Your committee believe the works already commenced, should be continued and completed at the earliest period consistent with the ability of the State finances, and that the School established for the instruction of the deaf, dumb and blind, be liberally provided with the necessary funds to continue its usefulness and extend its benefits. But, your committee express no opinion as to the amount to be appropriated for such purposes, and ask to be discharged from the further consideration of the subject. (State of Michigan, House of Representatives, 1855, p. 2)

The incidence of mental illness was mounting, and treatment for the unfortunate was lacking. Actually, the conditions were horrible. A description of the times follows:

It appears that that most unfortunate class in community, the insane, are already numerous in this State, that many of them are confined in jails, pauper houses and other places equally unadapted to their condition, and which consigns them to an almost hopeless [*sic*] insanity, that many hundred, whose lives might probably have been spared, had there been certain establishments adapted to their peculiar condition, and that friends and families are bearing overwhelming burdens which the State ought either to bear, or for which provide a remedy. (State of Michigan, Senate, 1857, p. 9)

The "insane" were of concern to the Michigan Legislature. There was never any indication that the mentally ill would be abandoned. In 1859, a special committee appointed under a House resolution visited the Asylum for the Insane at Kalamazoo. The primary objective was to examine the facility before authorizing further appropriations as requested by the asylum board of trustees.

The inspection was conducted, with no indication of any major concerns. However, the committee was in a defensive position: "In regard to fitness, your committee are aware that any opinion we may give will be entitled to very little weight with this House, and we have simply to say, the rooms and wards are all airy, cheerful and pleasant" (State of Michigan, House of Representatives, 1859, p. 2).

A detailed report supporting the appropriations is found in Appendix F. The dilemma in funding an asylum was being mitigated. It was inevitable that institutions were going to play an active role in treating and caring for these patients. Concomitant with taxation and the legislature's appropriating the monies for a state mental facility was the establishment of a board of trustees and an asylum administration that would be required to present the need for state support. A new relationship between the Michigan Legislature and the asylum was formed. The institution was now required to justify itself and, given the times, the asylum presented itself well.

#### The Unwanted Population

Mental illness continued to be viewed as an unwanted governmental expenditure but a social problem that was not about to disappear. The Michigan Legislature wrestled with the dilemma of resolving the care of "lunatics." The political atmosphere of the time was elucidated in a report of the Committee on Ways and Means, recommending appropriations for the Michigan Asylum for the Insane:

Early in the session, your committee became convinced of the necessity of avoiding all unnecessary expenses, and of limiting appropriations for all purposes to the absolute necessities of the State. . . .

We feel that this Asylum has already been delayed too long, by years; and though it is unfortunate that the building up of nearly all our State institutions has been thrown upon us at one time, and that the burden is much more pressing on that account, still, we have confidence in the people we represent, that they will bear without complaint, all the obligations imposed by justice and humanity. (State of Michigan, House of Representatives, 1861, pp. 1-2)

It is important to note how some members of the legislature perceived the mentally ill and asylums. Such perceptions and the urgency of treatment were addressed in the Senate as follows:

Insane asylums fulfill a three-fold purpose: First, they are hospitals for the care of insanity, as a physical disease; Secondly, they are prisons to confine maniacs and persons under the influence of delusions, whose personal liberty would be dangerous to the community as well as to their friends; Thirdly, they are asylums or homes for demented persons and harmless lunatics, where they can be made more comfortable and taken care of more cheaply than they can in private families. (State of Michigan, Senate, 1861, p. 3)

A comparison was made with another kind of institution for the less fortunate. The Michigan Legislature was concerned with the families of the residents paying for the cost of treatment and care. If this could be realized, each institution would be self-sustaining. Residents of these institutions could pay for some of their own care by assuming different chores and jobs that would help defray the cost. Patients who were so afflicted were deemed to be helpless and only able to assume very basic learning. Nevertheless, it became the responsibility of the state to provide for their well being:

Their unfortunate condition is obvious to the senses, and the mere sight of them excites the sympathy of every person having the common feelings of humanity. It is not so with the insane.

They are eccentric, excitable, boisterous and turbulent, or they are sullen, obstinate and difficult to manage and control--objects rather of disgust than pity.

Hence insanity excites our sympathy only indirectly, and by long process of reasoning, and not directly by observation. Hence it is the greater charity of the two. (State of Michigan, Senate, 1861, p. 4)

Even though the insane were looked upon somewhat unfavorably, the commitment to fund completion of the first asylum in Kalamazoo was recommended:

Believing that the insane have claims that ought not to be neglected, and that it is the common sentiment of all who are acquainted with their unhappy and miserable condition that the asylum should be completed at the earliest possible period, your committee would recommend that the sum of \$45,000 be appropriated for that purpose for the year 1861, and a like sum for the year 1862. (State of Michigan, Senate, 1861, p. 5)

#### The Boards of Trustees Assume Control

By 1870, asylum trustees were not only the overseers of the facility, but they were also responsible to the Michigan Legislature, reporting on the care of "patients" and the costs involved. Accountability was essential if the Michigan Asylum for the Insane was to remain viable. The legislature became dependent on the trustees' reports. In essence, the legislators' perceptions were influenced by the formal reports presented to them by the trustees. The institutional management of patients was too complex for the lawmakers to be directly involved. The reports were

comprehensive and detailed, even discussing anecdotal occurrences. The legislature, feeling positive about the new institution, endorsed the trustee reports and recommendations, which exhibited cost containment and efficiency.

The Trustees of the Michigan Asylum for the Insane were required by the Michigan Legislature to submit a report of operations, the financial condition of the facility, and the administration of its affairs for the biennial period ending in November 1870. This report cited an increase of 60% in the number of admissions and 70% in the entire number of patients being treated. It was underscored that recovery of patients was increasing, while the mortality rate was being contained. It was imperative, though, to bring to the attention of the legislature that this state facility was in need of an immediate expansion:

Professionally, therefore, the operations of the institution have been very satisfactory. Notwithstanding the unavoidable rejection of nearly forty per cent of those applying for admission, the advantages of treatment have nevertheless been extended to an unusually large number. The proportion of recoveries has increased, and although the halls have at all times been much crowded, and the last summer especially, a very sickly period, sanitary effort has availed to maintain a good degree of health throughout the establishment, and the rate of mortality has been small.

The financial report is fully as favorable. The indebtedness of the preceding biennial period was promptly paid; the receipts from all sources exceed the disbursements by \$1,431.11, and the year closes with no matured debts unpaid. (Michigan Asylum for the Insane Board of Trustees, 1871, pp. 5-6)

The trustees were most diligent in reporting their findings, and every effort was made to adhere to the expectations of the Michigan Legislature. The state asylum was now firmly established as an extension of state government, marking an important period in Michigan history.

The trustees repeatedly pressed for the expansion of facilities. The rate of applications for admission remained intense. Not only did this include new admissions, but chronic cases were also being reviewed on an almost daily basis. There was a sense of urgency on the part of the trustees when they pressed for the legislature to provide for the treatment of the mentally ill.

The trustees did not want to antagonize the legislature, and thus they were cautious in how they presented their findings. It was their intention to provide a request that could be substantiated; they hoped that the legislature would respond swiftly. The trustees, therefore, resorted to using carefully prepared tables and medical data along with anecdotal material. A detailed analysis of financial records was also submitted.

Having performed this duty as perfectly as we are able, we now refer this great interest to your Honorable body, bespeaking for it that careful consideration and judicious action which shall best conserve the public interest and welfare of our unfortunate citizens laboring under this dread affliction.  
. . .

Grateful to the Legislature for liberal support, to our State officers for active co-operation, and to a kind Providence for its signally protecting care, we close with this report another important period in the history of the Institution. (Michigan Asylum for the Insane Board of Trustees, 1871, pp. 28-29)

### Costs Remain as the Major Concern

Costs continued to be a major concern of the legislature and asylum trustees throughout the decade. More people needed help than could be accommodated. The lawmakers did succeed in avoiding the financial burdens for a time:

The trustees are required by law to fix yearly the rate of charge per week for the maintenance of patients. During the two years ending July 1st, 1880, the rate was \$3.92. It should be borne in mind, that up to the beginning of the last fiscal year, an annual appropriation of about \$17,000, intended to meet anticipated deficiencies, was received from the State. But this appropriation was discontinued by the last legislature, and since September 30, 1879, the institution has derived its income solely from the amount charged for the support of patients. The view taken by the legislature was that as the State had assumed the entire support of a large and constantly increasing number of patients, the counties should bear the whole expense of supporting those patients chargeable to them. This withdrawal of the customary appropriation compelled the trustees to advance the rate of charge two cents per day, after making careful estimates based on the disbursements of the previous year. (Eastern Michigan Asylum Board of Trustees, 1880, pp. 5-6)

However, the trustees frequently impressed on the legislature the fact that the number of "insane" patients was increasing. The problem could not be ignored:

The time has therefore come when the legislature will doubtless feel called upon to make provision for those who are still without hospital care. That the insane poor should not be permitted to languish in county receptacles is conceded; shall then such provision be made as now exists in our state hospitals, or shall some substitute be adopted? (Eastern Michigan Asylum Board of Trustees, 1880, p. 16)

Hence, the legislature had to resume an active role in the treatment and care of the mentally ill by appropriating the funds to increase the in-patient bed capacity. The added pressures imposed



by the trustees made it almost impossible for the lawmakers to withdraw from a burgeoning project. Manipulating some guilt did not hurt the cause, either.

The trustees are firmly convinced that the policy already inaugurated in the state, while it is not the cheapest, is the best, and should be closely adhered to--namely, the policy of treating all the insane in hospitals organized on the plan of those now in successful operation. In their opinion, cheap provision means poor care, neglect, suffering; and as guardians of these unfortunate people, realizing their great afflictions and their many necessities, they cannot recommend any provision which will lessen their comforts, or add to their unhappiness.

Again we commend this important subject to your earnest consideration, trusting that you will provide for this unfortunate class as you would provide for your wives, your sons, and your daughters, were they similarly afflicted. (Eastern Michigan Asylum Board of Trustees, 1880, p. 19)

#### Relief of Overcrowding

The Eastern Michigan Asylum for the Insane in Pontiac, Michigan, was erected to provide relief for its sister facility in Kalamazoo, but this respite was of short duration. The counties were providing some of the appropriations; however, costs were escalating, as was a nightmare that was never to disappear.

No sooner did a state facility open its doors to those in need of treatment than its capacity was immediately met. A burgeoning effect ensued as many patients were admitted but could not afford their own care. The families were also limited financially. The counties of residence for these patients were assuming some of the costs, but after two years it was the responsibility of the state to

assume the costs for care and treatment. The Michigan Legislature was aware that they could not transfer the care of these patients back to the counties. Furthermore, they realized that it would be unjust to ask any county office to assume the charges for these patients. Nor was it practical to find any other kind of a facility to care for these individuals. Consequently, there was no other course available to the state; retaining the responsibility for the mentally afflicted could not be avoided.

The trustees continued to exhort the erection of two additional buildings. They did not see any other solution to the clinical-population crisis. They had to contend with the families of the mentally ill and at the same time address the legislature. As the trustees began to realize that there was a state-imposed limit to their facility budget, the only alternative was to limit the number of admissions:

The number of State patients who have been admitted under Section 46 of the Laws of 1877, as being without a legal settlement in any county of the State, is comparatively small. These become at once State charges. Should their number increase materially, it would seem advisable to protect the rights of the State by additional legislation to secure their prompt return to localities where they rightfully belong. Several patients have been admitted here who undoubtedly resided in Canada or adjoining States, but in no instance has a legal settlement been determined or a transfer made. In Massachusetts this work revolves upon the "Board of Health, Charity and Lunacy." The work would seem to belong more properly to such a Board, than to the Secretary of State. . . .

These recommendations were disregarded, and the Trustees are in consequence under the painful necessity of reporting that the Eastern Michigan Asylum is practically closed to the admission of patients. (Eastern Michigan Asylum Board of Trustees, 1880, pp. 6-7)

The report contained another jolt for good measure:

The Asylum belongs to the State. Its usefulness should not be crippled by unjust criticism or adverse legislation.

In conclusion the Trustees desire to say that added experience increases their appreciation of the importance of the interests committed to their charge. Their wise action involves the comfort and well being of hundreds of helpless, irresponsible invalids. Without the aid and support of the Legislature, of the State officers, and of all good citizens, they could not have achieved so large a measure of success. They have labored constantly and conscientiously as faithful servants of the public, and confidently look for your approval of this official action. (Eastern Michigan Asylum Board of Trustees, 1880, pp. 20-21)

#### Mounting Criticism Permeates the System

The trustees eventually came to assume not only the responsibility of the institution with which they were affiliated, but also the brunt of criticism. The Michigan Legislature filled an ancillary role, and then again only in relation to appropriations. Occasionally it was necessary to propose and pass legislation to protect the asylum population. One such instance concerned the sale of poisons. The Board of Trustees made some astute observations on this issue. A female patient, experiencing depression, unfortunately committed suicide. This incident was reported by the Superintendent to the legislature as part of a periodic communication in the summer of 1889. Another episode also occurred, in which a patient almost overdosed on morphine; this was reported as well. It became necessary to change the law regulating the "sale of poisons." Every apothecary, if you will, druggist, and other

individual selling substances was required to keep a record of the sale, date, and the name of the individual receiving the purchase, along with his or her address. These records could easily be reviewed by the police or physician. Any neglect of this procedure was deemed to be a misdemeanor and subject to a \$50 fine.

It was observed at the time of the two cases cited above that the law failed to mention specifically opium and its extractives, morphine, laudanum, and a variety of other substances. "Self-destruction," as suicide attempts were sometimes referred to, was initiated with drugs of this nature. The lawmakers intended to place safeguards on the sale of the alleged dangerous drugs, especially in light of morphine and opium apparently being used in greater frequency at the time. The Board of Trustees, recognizing the possibly alarming increase in substance abuse, recommended to the legislature that laudanum, opium, and morphine specifically be mentioned in the law as controlled substances. The only exception was paregoric, deemed to be a mild opiate. Druggists were also exhorted to exercise diligence when dispensing any medication, so as to prevent not only misuse, but also resale of drugs by unauthorized individuals (Eastern Michigan Asylum Board of Trustees, 1890, pp. 12-13).

### The Beginning of Modern-Day Patient Protection

Laws were passed to protect patients, and there was concern to ensure not only that the appropriations were available, but also that private patients would proceed through legal channels in being admitted to any State of Michigan asylum. The patients and their families were thus not held liable for the costs incurred. The Michigan Legislature was also protecting people against false commitment, although this concern did seem to be secondary.

Commitment procedures in 1885 required two physician certificates to be executed by medical examiners qualified to conduct insanity evaluations. There were instances in which private patients were placed in asylums without a court hearing, resulting in the Michigan Legislature modifying the law so that a medical examiner could not order a commitment without the authority of the court. A probate order became necessary if a patient was to be admitted to an asylum, and it had to accompany the individual. To prevent annoying damage suits against any qualified medical examiner, an exemption clause was also instituted so that frivolous lawsuits could not be filed by family or friends of the patient who had a difference of opinion (Eastern Michigan Asylum Board of Trustees, 1890, p. 15). Fine tuning these court procedures was essential, and even though many more changes in the law with respect to the mentally ill population were to occur in the future, a

foundation to protect patients and even other parties within the system had been firmly entrenched.

The mental institution had become well established by the turn of the twentieth century. The State of Michigan was very progressive and determined to provide care as well as treatment. The legislature did appear to respond to the needs of the people; however, there was considerable delay in appropriating funds for the construction of asylums. A subtle bias existed regarding the mentally ill, but then again the basis for this sentiment had to do with expenditures. Society did not have the perceptions of mental illness that exist today. The understanding was there, as was the recognition of a need to do something about this concern. The unsung heroes were the asylum personnel and the trustees. They were the catalysts in engineering the Michigan mental health movement.

It is evident that the state institution was becoming entrenched in government and as a segment of society. An incidental benefit was the establishment of jobs. Most important, though, was the care for the mentally ill. It is interesting that the perceived concern and care authorized and provided by the state asylums did not differ greatly from that of the 1980s. Although treatment was left to the professional staff, building funds and maintenance along with patient rights were the domain of the Michigan Legislature. It can also be observed that the legislature's approach to the problem of mental illness reflected the attitudes of the citizenry.

The legislative branch adopted an approach to review the budget for each state asylum and to address any other special needs only as they were presented by the trustees of each respective institution. For the next several years, institutional costs were the lawmakers' main concern. The Official Directory and Legislative Manual (State of Michigan, 1901a) reported an expenditure \$24,863 for improvements to the Michigan Asylum for the Insane in 1899. The Eastern Michigan Asylum received \$10,000 for the completion of building projects in 1901. The legislature allocated \$50,650 to the Northern Michigan Asylum for improvements in 1899. That same year, the Upper Peninsula Hospital for the Insane received \$62,910 for improvements and purchases.

Also at this time, the state lawmakers decided to eliminate the recording of documents. Only the passage of laws was to be recorded. The discussion and commentary would no longer be available for public review and assessments. The reasons for this decision are not clear or even acknowledged; however, the Documents of the House of Representatives of the State of Michigan ended with the Biennial Session of 1865. The Journal of the Senate of the State of Michigan also was terminated at the Biennial Session of 1865. Documents Accompanying the Journal of the Senate and House of Representatives were last printed in 1867. The Michigan Joint Documents continued until 1893, when their publication ceased.

The general community was being accommodated insofar as care and treatment of the mentally ill was concerned. The clinical

population requiring such services exceeded the bed population. Hence, some families continued to experience distress. This was to be expected, given the financial constraints placed on the asylums. It is apparent that the Michigan Legislature responded initially to the needs of the community and then to the requests of the board of trustees for each asylum. Then, the legislative body assumed a secondary role--to respond only to major crises or situations that were of economic concern.

Legislative Statutes of 1907 Regulating the  
Admission Policy at the State Psychopathic  
Hospital of the University of Michigan

Persons found to be legally insane could be committed to the State Psychopathic Hospital of the University of Michigan by any judge of probate. However, there was an irony in the law--the patient had to obtain approval from the director of this facility. If accommodations could not be provided, the individual was placed in a district asylum for treatment until such time that a room became available. If the patient was benefiting from his or her ongoing treatment, the patient remained where he or she was originally committed.

In 1907, the State Psychopathic Hospital at the University of Michigan became the first short-term asylum in Michigan. Long-term patients were either not to be placed there, or, once admitted, if their pathology was deemed to be chronic, a transfer to a district



facility was initiated by the probate court at the request of the director of the Psychopathic Hospital. It was also not uncommon for treatment and observation to take place on a 35-day commitment order. This was to provide the attending physicians time to conduct their examinations, observe the response to treatment, and file their conclusion with the court. The judge of probate would then designate any legal action to be taken, notifying all parties involved. This would range from dismissal of commitment to placement in either the Psychopathic Hospital or another designated mental hospital.

Voluntary patients were also allowed admission to the State Psychopathic Hospital of the University of Michigan. However, the director had to authorize the admission, and all expenses incurred by the patient were his or her responsibility. A bond had to be secured and approved by the medical director. Incidentally, payment had to be made continually in advance as costs were anticipated. A voluntary patient could be discharged only at the discretion of the director; if warranted, he or she could file a petition for commitment, changing a voluntary admission to involuntary status, to be initiated by probate court proceedings.

It was further possible for the superintendent of an asylum to transfer a patient to the Psychopathic Hospital if the director approved of the admission and the probate court supported this move by the two facilities. The guardian also had to be notified. Henceforth, the same guidelines applied regarding payment and

placement procedures if treatment was going to last an exceptionally long time.

The State Psychopathic Hospital at the University of Michigan was regarded as an innovative facility, the vanguard of mental health during this period in Michigan history. Procedures for admission were clearly outlined, as were many of the other policies that could be of concern. There is no doubt that this format was a foundation for future mental health treatment in the state facilities (State Psychopathic Hospital Board of Trustees, 1919, pp. 7-9).

#### Independent State Hospitals: 1911-1923

The asylums came to be known as hospitals. The legislature continued to receive accountability reports from each institution. The trustees for each facility communicated directly through written reports submitted to the lawmakers. Usually, such communications requested funds for some specific purpose (Kalamazoo State Hospital Board of Trustees, 1919, pp. 12-13). The need for remodeling and a septic system was cited in one report. Barns, machinery, animal pens, and the like were high priorities. Even a dental office was considered important. The hospitals were becoming independent colonies for mentally ill patients. All aspects of the hospitals were accounted for in the trustees' reports, including a detailed description of categories of patients and their movement.

Pontiac State Hospital, formerly the Eastern Michigan Asylum, also had financial concerns. New construction was under way, the funds having been appropriated by the legislature in 1917. The trustees then requested further funding for an additional building to increase the bed capacity. Improvement of farming was of equal concern. The health of the animals and the ability to house them were priorities. These concerns were described in the Report of the Board of Trustees of the Pontiac State Hospital (Pontiac State Hospital Board of Trustees, 1919):

The hospital needs in the matter of special appropriations for the ensuing biennial period may be adequately met, in the opinion of the board, by the granting of a request which the legislature of two years ago turned aside. We believe that the requirements of the valuable hospital herd justify a repetition of this request, and we therefore ask for \$10,000.00 for the addition of a second story to the present dairy herd barn, and for the erection of silos adjoining it. . . .

This involves only the carrying to completion of a project which had assumed full shape when the present dairy herd barn was erected some years ago. (p. 16)

The trustees were actively involved with the concern for total care of patients. Although limited in numbers, they diligently pursued their objectives. Influencing the Michigan Legislature was also a high priority. The desire to help the mentally ill was intense. Certainly, the families and general community had to be pleased with the overall effort. The Report of the Board of Trustees of the Traverse City State Hospital (Traverse City State Hospital Board of Trustees, 1919) underscored the level of involvement:

The general work of the hospital has been well maintained. The medical staff has been from two to four members short, and only the most necessary attention could be given patients. No patient, however, has been neglected. Our interest in the great problems of public health is not less than formerly, and we would urge your Honorable Body to make possible health surveys for the after-care of mental patients, care of delinquent and backward and feeble-minded children, community clinics, school nursing and general mental hygiene work. (p. 8)

The Ionia State Hospital and the Newberry State Hospital also were concerned with the monies available for improvements in their respective facilities. Limited resources were a problem, and the legislature remained adamant about making carte blanche appropriations; there was always the need for more spending. The Report of the Board of Trustees of the Newberry State Hospital (Newberry State Hospital Board of Trustees, 1919) demonstrated some ingenuity with the following special request for funding:

On account of the cost of building material, and by reason of the fact that the tax-payers of the State in these times are heavily burdened, it seems wise to this Board, to do without many improvements that in other times would be considered essential. For these reasons, no requests are being made of this Legislature for new buildings and improvements with the following exception. The last Legislature provided an appropriation of \$8,000, for the purchase of boilers. When bids on these boilers were received, it was found that the amount appropriated was insufficient. Prices have recently been obtained upon such boilers as we need, and we find that the total cost will reach \$13,000. It is therefore, urged, that this Legislature appropriate \$5,000 additional, for this purpose. (p. 9)

The state hospital system for mental health exhibited very little change for many years. The board of trustees eventually was replaced by hospital administrators, who prepared their annual budgets and submitted them to the Executive Offices of the Governor.

Little activity took place with respect to the Michigan Legislature. Funds were appropriated for facility improvements and even the construction of new hospitals, but innovative changes regarding quality of patient care did not change dramatically between 1920 and 1974. In fact, the legislature did not influence mental health care in Michigan until the new mental health code was approved in 1974. An article in the August 8, 1974, issue of Link ("Legislature Approves," 1974) cited the need for the contemporary mental health code:

Michigan has a new mental health code. First envisioned nearly a decade ago, the new code was passed by both houses of the Legislature last month and transmitted to the Governor for his signature.

Every director in the history of the Department of Mental Health has been involved in the statutes revision project as well as hundreds of other professional and lay persons.

This legislation updates and modernizes mental health statutes which were last rewritten more than 50 years ago (in 1923). The new law is consistent with today's knowledge of what can be done for the mentally ill and mentally retarded and recognizes new concepts of what should be done. (p. 1)

With the passage of the Michigan Mental Health Code of 1974, acts and parts of acts that had been amended were repealed. Because of the abundance and complexity of previous laws concerning mental disease, passed from 1901 to 1974, they are not described herein. Nevertheless, they are ordered for reference purposes in Appendix G.

The Michigan Legislature ensured that no patients would have their civil rights undermined by commitment proceedings. This action is described in the Michigan Mental Health Code of 1974 (see

Appendix H). The legislature has taken great pains to secure the rights of the mentally ill. Its focus has been (a) to protect patients' civil rights, (b) to prevent unjustified commitment to a state institution, and (c) to prevent any physical or emotional harm to patients.

### State Legislature Ambivalence

It has been generally accepted that mental illness, while a debilitating disease, underscores shame/guilt-based factors. Family members of the mentally ill are deeply troubled by their loved one who exhibits bizarre thinking and behavior. The mental anguish not only consumes the family unit, but also larger segments of society. Neighborhoods, schools, and places of worship become victims of mental illness as well. Mental health professionals always caution the parties involved by underscoring the need to be understanding, not to condemn. Many individuals, though, have their biases; legislators are no exception.

The Michigan Legislature has had to weigh the merits of inpatient treatment, recognizing that many decisions regarding funding would not be popular. There are necessary limits imposed on funding, and yet human needs prevail. They have consistently made every effort to address the problems of the mentally ill, both human rights and costs. However, other concerns that seem more pressing have detracted from the allocation of monies. This has created quite a dilemma.

### Summary

The Michigan Legislature has been an ally of mental health, contrary to some private opinion and lobbyists. It authorized increased funding even during periods of state financial hardship. Mental health standards have also been upgraded; treatment and the protection of patient rights have received the most attention. The legislature's involvement has also influenced personnel policies and procedures. Over the decades, this governmental body has served the mental health movement with distinction.

The mentally ill have had much support for their care and treatment. Although it is not possible to determine how many people have benefited from legislative involvement, it is fair to say that from a humanistic perspective this branch of government has not acquiesced.

Appendix I contains pictures of the Michigan insane asylums at the turn of the century.

Another vital governmental body to shape the course of mental health in Michigan has been the judiciary. Chapter V expands on this historical impact.

## CHAPTER V

### JUDICIAL PERSPECTIVE

Michigan's judicial system has played a vital role in forging the kind of involvement offered by the state mental health facility. Since the latter part of the nineteenth century, the courts have had an influence in defining insanity, establishing the legalities of contracts, and formulating proceedings for commitment to an institution. In this chapter, the researcher describes the decisions of the judicial system during the various mental health eras outlined at the beginning of Chapter IV. Pertinent cases are cited, and in those instances in which further elaboration is required, a detailed description of the mental health issue is provided.

Even though court decisions have affected many areas of mental health, the primary discussion in this chapter centers on institutional care. These decisions are especially noteworthy because the main arena for treatment has been state-operated facilities. The cases discussed in this chapter pertain primarily to "insanity" issues, court proceedings, and some noteworthy individual situations.



### Independent State Asylums: 1861 to 1911

The Michigan Judiciary reviewed a relatively narrow range of cases before the turn of this century. Mental illness and the consequent commitment to "asylums" affected certain members of our society and thus resulted, on occasion, in court intervention. As institutions became a way of life for mentally afflicted individuals, the citizenry had to contend with such issues as guardianships, financial support, and legal contracts. The majority of judicial decisions in the late 1800s addressed these issues. However, the courts were periodically called upon to hear cases calling for the definition or interpretation of "mental functioning" and related behaviors of those committed to state institutions.

Before 1900, there was concern that people not be committed to an asylum without ample justification. The courts first established that "incompetent" meant only "incapable," without fully defining the psychological significance of this term. The Michigan Digest (1985) cited the following legal reference:

Mich. 1893. The word "incompetent," as used in How. Ann. St. sec. 6314, in reference to insane or incompetent persons, is synonymous with "incapable," as used in section 6315 in reference to the same persons. In re Leonard's Estate, 54 N.W. 1082, 95 Mich. 295. (p. 432)

A more precise definition did not emerge until 1938.

Another important judicial decision concerned business transactions involving mentally ill persons and the possibility of fraud. The courts were cautious about the interpretation of mental

illness and guardianship. Whether elderly or exhibiting a diminished mental capacity, a patient's integrity and personal estate had to be preserved, a probate court ruled in 1887. "Mental incapacity must be alleged and proved in order that the court may acquire jurisdiction." Only then could a jury find the individual to be insane, and for the petition of commitment. A general verdict was not deemed to be acceptable by the courts. It was necessary for the jury to rule specifically on all issues cited in the petition. The courts observed that one could not afford to be nonchalant about such grave matters (In re Sturick, 31 N.W. 582, 64 Mich. 685) (Michigan Digest, 1985, p. 462).

The law regarding such matters was further strengthened in 1891: Appointed guardianship for an individual judged to be mentally incompetent is for the purpose of "charge and management of his property and person," and once directed by the court this action sufficiently adjudges the individual as mentally incompetent, preventing the mismanagement of the person's self or property (Munger v. Kalamazoo Probate Judge, 49 N.W. 47, 86 Mich. 363) (Michigan Digest, 1985, p. 464).

It is evident that the courts were cautious when addressing the mental capacity of the party involved so that they would be protected, if necessary, from either themselves or not-so-well-intentioned people. The management of the estate of a person suspected of mental incompetence was also ruled to be of extreme value by the judicial bench.

Much leeway was also given to an individual's idiosyncrasies and a patient's state of mind, as cited in the Michigan Digest (1985):

**Mich. 1882.** The weakness of mind, shown by vacillation, shiftlessness, improvidence, occasional despondency, and a religious hobby does not, in itself, render one incompetent in any such sense as to make business dealings with him prima facie fraudulent. West v. Russell, 11 N.W. 812, 48 Mich. 74. (p. 432)

Attempting suicide was a primary factor in determining insanity, but not the only criterion. The courts adopted a strong position on this issue, as cited in the Michigan Digest (1985):

**C.C.Mich. 1879.** Suicide, or an attempt or threat to commit suicide, may be considered, in connection with the previous demeanor and conduct of the party, as evidence of insanity. Wolff v. Connecticut Mut. Life Ins. Co., Fed.Cas.No.17,979, 2 Flip. 355, 8 Ins.Law J. 97, 7 Reporter 357. (p. 433)

However, it was not enough to establish insanity on the basis of suicidal ideation or behavior without other supporting evidence.

**C.C.Mich. 1879.** Neither an act of suicide, nor an attempt or threat to commit suicide, would of itself justify a jury in finding a person insane. Wolff v. Connecticut Mut. Life Ins. Co., Fed.Cas.No.17,929, 2 Flip. 355, 8 Ins.Law J. 97, 7 Reporter 357. (p. 434)

"Insane asylums" did not come under court scrutiny until the turn of this century, and few cases have been cited regarding treatment facilities during this era. With regard to asylum care, financial restitution became a concern. The Michigan Digest (1985) noted:

**Mich. 1899.** Under the statute making an insane person supported in an asylum liable for his maintenance, and providing that, if he comes into any property, it shall be

liable to the state or county for his support, the superintendents of the poor can maintain an action at law in the circuit court against an indigent insane person, on her acquisition of property by inheritance to recover the amount paid by the county for her support. Simons v. Van Benthuisen, 80 N.W. 790, 121 Mich. 697, 6 Detroit Leg.N. 28. (p. 503)

With respect to the appeals process regarding commitment of an individual to the "insane asylum," the Michigan Digest (1985) quoted the following decision:

Mich. 1896. How. Ann. St. sec. 6779, providing that, in all cases not otherwise provided for, any person aggrieved by an order of the judge of probate may appeal to the circuit court, does not apply to an order entered by the judge of probate on application for the commitment of a person to the insane asylum as a private patient, under Pub. Acts 1895, No. 204. Sparrow v. Ingham Circuit Judge, 67 N.W. 112, 109 Mich. 272. (p. 448)

Court decisions reflected the public mood. It was clear that, concomitant with placing individuals in asylums, citizens' rights had to be guaranteed. Precedents were being established as the courts were faced with difficult situations. Like the state legislature, the judiciary was challenged to protect property and financial contracts. In some respects, mental illness was not so much the concern of the courts as was the state of mind of individuals entering an agreement or having a financial contract declared null and void. Criminal acts conducted under the influence of alcohol also called for legal interpretation.

More than a century later, society is still contending with many of the same issues regarding mental illness and its consequences. Examining the progression of court decisions throughout the early to mid-1900s, it becomes evident that the

judiciary assumed a passive role regarding the patient population; a more aggressive approach came later. Not for decades would the legal rights of the mentally ill receive a high priority.

#### Further Interpretation of Mental Imcompetence

Courts sought to establish a frame of reference for interpreting mental incompetence, a difficult task because even mental health professionals were challenged to define the enigmas of the mind. Only the law could decide what constituted insanity (In re Phillips, 122 N.W. 554, 158 Mich. 155. 1909) (Michigan Digest, 1985, p. 434). Therefore, a "preponderance of the evidence" was deemed necessary to declare an individual insane (Grand Lodge, A.O.U.W. of Michigan, v. Brown, 125 N.W. 400, 160 Mich. 437. 1910) (Michigan Digest, 1985, p. 434).

In 1900, a Michigan circuit court took a more aggressive approach, defining the mental conditions that must be lacking in order to exempt an individual from legal responsibility:

**Mich.Cir.Ct. 1900.** To exempt a person from legal responsibility on the ground of a derangement of the mental faculties, such derangement must be such as to prevent intelligent volition in respect to the act with which he is charged. He should have, as necessary to liability, so much memory and power of perception and reflection as will enable him to identify his acquaintances, to recognize his relations to them, to understand as ordinary minds do the nature and uses of material objects around him, and to appreciate the obvious and universal obligation to abstain from violence and bloodshed in the peaceable intercourse of his neighbors with him. People v. Smith, 1 Mich.N.P. 81. (Michigan Digest, 1985, p. 482)

Even though this decision was made in 1900, the courts were still in a quandary about how to define mental incapacitation. Perhaps People v. Smith, although definitive, was not always referred to because (a) the protection of property was of primary importance, and (b) the stigma of insanity precluded a more unrestrained approach by the courts in establishing insanity. It must be underscored that the judicial system was forging virgin territory. The consequences could have been severe if the courts had not taken a conservative approach toward the insanity issue and commitment procedures.

Initially, individuals could not be placed in an "insane asylum" unless they were actually found to be insane. The courts were determined to prevent unnecessary detainment. However, any person found to be "dangerously insane" did require confinement, and this was "always" justifiable (Van Deusen v. Newcomer, 40 Mich. 90. 1879) (Michigan Digest, 1985, p. 440). Commitment procedures were not formalized until the beginning of the twentieth century. Before that time, procedures were required by the courts, but as can be observed, challenges to the legal system did occur.

Mich. 1894. The failure of the probate judge to enter an order in the journal of the probate court, as required by Comp.Laws 1871, sec. 1934, does not invalidate the original certificate, under seal of the probate court, by which an insane person is admitted to an asylum, and supported at county expense. State v. Dunbar's Estate, 57 N.W. 1103, 99 Mich. 99. (Michigan Digest, 1985, p. 448)

The judicial system was called upon to interpret events and how they applied to individual rights. It is noteworthy that the courts

also established legal precedent that, in many respects, has not been redefined in succeeding years. The wisdom of the judicial system prevailed, even though there were challenges on technicalities. Procedural decisions by the courts were not intended, however, to establish policy.

Mich. 1896. How. Ann. St. sec. 6779, providing that, in all cases not otherwise provided for, any person aggrieved by an order of the judge of probate may appeal to the circuit court, does not apply to an order entered by the judge of probate on application for the commitment of a person to the insane asylum as a private patient, under Pub. Acts 1895, No. 204. Sparrow v. Ingham Circuit Judge, 67 N.W. 112, 109 Mich. 272. (Michigan Digest, 1985, p. 448)

The judiciary in 1904 more clearly outlined commitment procedures in an endeavor to avoid unwarranted cases being admitted to "insane asylums." The stigma of these facilities was apparent.

Mich. 1904. Pub. Acts 1903, p. 329, No. 217, sec. 16, provides that the probate judge, on the filing of a petition for an order admitting one to an insane asylum, shall fix a date for a hearing thereof, and appoint two reputable physicians to make an examination of the alleged lunatic, whose certificate shall be filed with the court on or before the hearing. Section 14 (page 328) declares that no person shall be held in any asylum except on certificates of insanity for admission as provided in the statute; and section 15 provides that certificates of insanity must be made by two reputable physicians, under oath, appointed by the probate court. Held that, where the physicians appointed by the probate court certify to sanity, the probate judge has no authority to proceed and himself determine the question of sanity. Grinky v. Durfee, 100 N.W. 171, 137 Mich. 49, 11 Detroit Leg. N. 177. (Michigan Digest, 1985, p. 447)

### Crimes of Intoxication and Passion

Cases involving criminal behavior and intoxication were also relevant if the defined behaviors justified commitment to an asylum.

The ability to take responsibility for one's own actions was underscored.

These decisions established a foundation for interpreting deliberate acts of aggression that were not the result of insanity. The courts, then, distinguished between an individual's mental incompetence and other tendencies and/or intentions that would influence acts of aggression. Furthermore, the courts did not ignore acts of defiance, even when alleged insanity did exist. The following four important decisions addressed behavioral intent:

**Mich. 1868.** Temporary insanity produced immediately by intoxication does not destroy responsibility where the accused, when sane and responsible, made himself voluntarily drunk. People v. Garbutt, 17 Mich. 9, 97 Am.Dec. 162. (Michigan Digest, 1985, pp. 481-482)

This legal decision was extremely important in terms of culpability for behaviors that were not directly related to mental illness, but rather to errors in judgment. The courts, though, attempted to elucidate further the decision rendered in 1868:

**Mich. 1870.** If a person be subject to a tendency to insanity which is liable to be excited by intoxication, of which he is ignorant, having no reason from his past experience, or from information derived from others, to believe that such extraordinary effects are likely to result from intoxication, he ought not to be held responsible for such extraordinary effects; and so far as the jury believe that his actions resulted from these, and not from the natural effects of drunkenness, or from previously formed intentions, the same degree of competency should be required to render him incapable of entertaining, or responsible for the intent, as when the question is one of insanity alone. Roberts v. People, 19 Mich. 401. (Michigan Digest, 1985, p. 481)



Evidently, during this era, allowances were made for intoxication, but the court was not so lenient with crimes of passion.

**Mich. 1878.** That form of emotional insanity which is substantially an unbridled passion, and lasts just long enough to enable an act of violence to be committed, and then subsides, does not relieve a criminal from the responsibility for his acts committed while under its influence. People v. Finley, 38 Mich. 482. (Michigan Digest, 1985, p. 481)

### Property and Contracts

Concern for property and binding financial contracts has long been deemed of monumental importance. Many such cases were brought to litigation during the period under consideration. The mood of court decisions in such matters is discussed in the following paragraphs.

In 1882, a Michigan court ruled that even though people are under guardianship due to insanity, this does not preclude their being sued (Ingersoll v. Harrison, 12 N.W. 179, 48 Mich. 234). Having set such a precedent, the court was then able to pave the way for any Michigan county to sue even an "indigent insane person" upon that individual's acquisition of properties through an inheritance (Simons v. Van Benthuyzen, 80 N.W. 790, 121 Mich. 697, 6 Detroit Leg.N. 28. 1899) (Michigan Digest, 1985, p. 503).

The courts carefully ruled on cases involving the need for commitment, but not allowing those judged insane to avoid financial obligations. The bench was diligent in addressing many cases

presented. The legal challenges continued, and mental health laws evolved. These decisions may appear to be straightforward, but this, alas, is not the case. For example, in 1888, a complicated situation arose:

**Mich. 1888.** A widow, in the absence of an express agreement, is not chargeable to her daughter for the board of her imbecile son. Howe v. North, 37 N.W. 213, 69 Mich. 272. (Michigan Digest, 1985, p. 453)

Insofar as mortgages were concerned, the court's decision was as follows:

**Mich. 1882.** Mortgages in good faith under the grantee of an insane person cannot be considered bona fide purchasers in order to uphold the deed. Rogers v. Blackwell, 13 N.W. 512, 49 Mich. 192. (Michigan Digest, 1985, p. 479)

During this initial era, independent state asylums witnessed the beginning of judicial intervention. Without this important support, functioning of the asylum would have been chaotic. The courts provided a semblance of order and assisted in developing the foundation for commitment.

Entirely independent systems were merging as mental health treatment became more prevalent in Michigan. As independent state asylums evolved into state hospitals, the judiciary was called upon to intervene much less frequently.

#### Independent State Hospitals: 1911 to 1923

This period of mental health treatment was one of relative quietude in terms of court involvement. The majority of cases that came before the bench concerned guardianship and related issues.

Contractual agreements also called for legal intervention. Otherwise, the role of state hospitals (as the former insane asylums were now termed) was clear. The same was true for commitment proceedings. Major decisions in these matters are reviewed in the following paragraphs.

Guardianship was a delicate matter when the allegedly insane person possessed money or property. Contractual arrangements in the form of mortgages, deeds, and business relationships involving an individual declared mentally incompetent required court intervention.

The majority of cases cited at the beginning of this period in Michigan history were related to guardianship. These cases were not simply about who would care for mentally incompetent individuals or even oversee their financial assets, but rather they concerned the difficult situations that arose regarding custody and property. Some of the important decisions in these cases are examined below. Although the cases had many other ramifications, the focus of this discussion is on the patient.

#### The Importance of Wardship

In 1911 and 1913, two important decisions guaranteed protection of a ward's rights:

**Mich. 1911.** Where the court acquires jurisdiction over the person of an insane defendant, who has a general guardian, it should appoint a guardian ad litem to defend the suit, and should appoint the general guardian or some person who would

actively protect defendant's interests. Love v. Merrill, 130 N.W. 1123, 165 Mich. 503. (Michigan Digest, 1985, p. 505)

**Mich. 1913.** Under the statute which provides for the appointment of a guardian for any person who by extreme old age or other cause is mentally incompetent, etc., a petition for appointment need not state the cause of the ward's incompetency. In re Miller's Estate, 139 N.W. 17, 173 Mich. 467. (Michigan Digest, 1985, p. 472)

Six years later, the courts refined the law with regard to old age and competency:

**Mich. 1919.** In ward's action for discharge of guardian, appointed in proceedings under Comp.Laws 1915, sec. 13950, providing for appointment of guardians for persons who are mentally incompetent because of old age or disease, sanity or insanity, was not an issue, the single inquiry being whether the ward was mentally incompetent, because of old age or disease, to properly manage his estate. Henderson v. Henderson, 172 N.W. 623, 206 Mich. 36. (Michigan Digest, 1985, p. 464)

Appointed guardians were required to abide by certain stipulations established in probate court. For example, real estate could be disposed of only during a court proceeding; this was to protect an incompetent ward from deception and fraud. These ground rules were established in 1911 (King v. Sipley, 131 N.W. 572, 166 Mich. 258, 34 L.R.A., N.S., 1058, Ann.Cas. 1911 D, 702) (Michigan Digest, 1985, p. 472).

Just as the mental health administration and Michigan Legislature attended to the needs of the mentally ill, so did the judicial branch of government. A mental health movement continued to be forged to help not only the unfortunate victims of "insanity," but also the families and greater community. This social

undertaking was a tremendous achievement that may not be fully recognized even today.

### Perceptions of Fraud

Additional concerns about the perception of fraud called for legal opinion. In a precedent-setting case, an attorney rendered services to a mentally incompetent individual, obtaining his release from an asylum. As a consequence, the courts ruled, in 1913, that the estate became liable for the attorney's fee as long as services were provided in good faith, regardless of the outcome (Lyon v. Freshour's Estate, 140 N.W. 517, 174 Mich. 114, 45 L.R.A., N.S., 67, Ann.Cas. 1915A, 726) (Michigan Digest, 1985, pp. 477-478). However, a probate court had to authorize the attorney's fee. Otherwise, the contract between a guardian and an "insane" individual and the attorney was null and void; as well, the contract could not be enforced against the estate of the afflicted--even after his/her death (Nelson v. Sackett's Estate, 160 N.W. 539, 194 Mich. 450. 1917) (Michigan Digest, 1985, p. 468).

Just as the law was establishing protection against illegal commitment, so it became necessary to monitor a ward's state of affairs financially and management of property:

**Mich. 1922.** Where a guardian has been appointed to manage the property of a person adjudicated incompetent to manage his own affairs under Comp.Laws 1915, sec. 13950, the guardian cannot be required to turn the property back to the ward, before there has been an adjudication that the ward was competent to manage his property, though there had been an adjudication that he was

again sane. In re Minock's Estate, 187 N.W. 345, 218 Mich. 97. (Michigan Digest, 1985, p. 464)

Many novel situations were coming before the judicial system. Occasionally, a set of unusual circumstances called for legal intervention or even established precedent. Yet insanity was well defined as far as the law was concerned.

#### Court Cases From 1923 to 1937

Compensation for legal services was again brought before the bench in 1929. The court was not impressed by the uncontradicted testimony of the attorney representing an "incompetent's" guardian, who had authorized the requested fee. The court concluded that it was not bound to authorize such a fee in this matter (In re Bender's Estate, 224 N.W. 381, 246 Mich. 405) (Michigan Digest, 1985, p. 476).

Lawyers were not the only individuals seeking payment for their involvement; guardians were also seeking remuneration. The Bender estate continued to generate legal issues requiring opinions from the court:

Mich. 1929. Probate court, in determining compensation of guardian, should consider extent and manner of services. In re Bender's Estate, 224 N.W. 381, 246 Mich. 405.

\$295 to guardian of mentally incompetent for services during one year in making five loans and for use of automobile and services at funeral, held sufficient. In re Bender's Estate, 224 N.W. 381, 246 Mich. 405. (Michigan Digest, 1985, p. 466)

Occasionally, it was necessary to protect the "mentally incompetent" from their own "friend" or guardian:

**Mich. 1929.** Mentally incompetent's guardian may not loan trust fund to himself or use it to pay personal obligation to another, or to finance personal affairs. In re Bender's Estate, 224 N.W. 381, 246 Mich. 405.

Where mentally incompetent's guardian purchased mortgage on his own land with ward's money, court properly charged him with amount of mortgage, even if mortgage was ample security. In re Bender's Estate, 224 N.W. 381, 246 Mich. 405.

Probate court could not authorize mentally incompetent's guardian to purchase mortgage on his own land with ward's money. In re Bender's Estate, 224 N.W. 381, 246 Mich. 405. (Michigan Digest, 1985, p. 469-470)

The courts continued to require that petitions for commitment to a state mental hospital be specific and that having "strange fancies" was not sufficient to have one admitted:

**Mich. 1927.** Petition merely alleging strange fancies as basis for claim of insanity of person sought to be admitted to hospital held insufficient. Pub. Acts 1925, No. 283, sec. 11. Ex parte O'Neil, 214 N.W. 411, 239 Mich. 450.

Requirement that petition for order directing admission to hospital state facts upon which allegation of insanity is based is jurisdictional. Pub. Acts 1925, No. 283, sec. 11. Ex parte O'Neil, 214 N.W. 411, 239 Mich. 450. (Michigan Digest, 1985, p. 442)

### Sterilization of the Mentally Ill

Sterilization of the "mentally defective" was of primary concern in 1925, requiring interpretation of and adherence to the law. Two court hearings on this subject were held in 1925. Because of the length of these proceedings, they are not discussed here but are presented in Appendix J. In brief, sterilization was held to be

legal and not in violation of a "mental defective's" rights. Certain proceedings needed to be followed, and if they were deemed to be in compliance as outlined by policy and held within abeyance of the law, then the patient was sterilized.

#### Refinement of Commitment Procedures

A case illustrating the thoroughness of commitment proceedings was heard in 1930. Before hospitalization, a patient had to be declared "insane." Within 35 days thereafter, a preliminary hearing, adjudging the person to be mentally incompetent and serving him/her with notice of that judgment, was mandatory. If these criteria were not met, such a hearing was declared void (Ex parte Martin, 227 N.W. 754, 248 Mich. 512) (Michigan Digest, 1985, p. 461).

#### A Return to the Problem of Defining Insanity

It has never been fully clear according to legal interpretation as to what constitutes insanity. Mental health professionals have attempted to establish a precise definition, but they have not always been in full agreement. Certainly, if this is the reality, then it is understandable why the courts have needed to rule on the merits of each case. Procedural matters have been refined so as to protect the rights of all parties involved.



Even with formal procedures for court commitment in place, there were still challenges to what constituted a lucid mind versus mental incompetence, and even the legal proceedings to determine such a critical issue. Individuals were not always detained, as evidenced by a 1936 decision by an appeals court reviewing a former proceeding.

**Mich. 1936.** Where sole testimony in proceedings for adjudication of insanity as to insanity was that alleged insane person was "insane" and record was silent as to court having complied with statute requiring full investigation before adjudication of insanity, proceeding held nullity, and person committed could not be detained thereby. Comp.Laws 1929, sec. 6888. In re Davis, 268 N.W. 822, 277 Mich. 88. (Michigan Digest, 1985, p. 435)

A precarious balance existed in applying the law to delicate and even controversial cases. Not always was a court opinion so straightforward:

**Mich. 1937.** An insane or incompetent person who is under actual and subsisting guardianship of estate is conclusively presumed incompetent to make a valid contract, notwithstanding it was made during a lucid interval. Acacia Mut. Life Ins. Co. v. Jago, 273 N.W. 499, 280 Mich. 360. (Michigan Digest, 1985, p. 471)

#### A Case of Conflict of Interest

Mental incompetency cases have always been serious matters. Many situations have required legal intervention to ascertain the degree of "insanity" being questioned, but guardianship and financial matters of a ward have also been brought before the bench. Conflict of interest arose in the case of Baxter v. Union Industrial

Trust and Savings Bank, 263 N.W. 762, 273 Mich. 642 (1936) (Michigan Digest, 1985, p. 468).

Years before this case was brought to court, Baxter was legally declared mentally incompetent. The Union Industrial Trust and Savings Bank was appointed by the court as Baxter's legal guardian. Large financial holdings were at stake, of which purchases before the Great Depression were held in question. Baxter's legal guardian also carried out financial undertakings after assuming the court appointment. Confusion arose as a result of these financial dealings. The courts rendered opinions in the following order: six decisions in the matter of Baxter v. Union Industrial Trust and Savings Bank, 263 N.W. 762, 273 Mich. 642 (Michigan Digest, 1985, pp. 468, 469, 476).

The assigned guardian initially was held liable for purchasing improper trust investments and for the interest that would normally have accrued. In addition, all income received was credited to the Baxter estate. The exact nature of these investments was not the concern; rather, the procedures for securing them violated federal law.

When it came to the guardian's purchase of mortgage bonds, the courts determined that there were no illegalities. Because of the economic depression of this period, although the Baxter estate suffered a major financial loss, the guardian was not deemed accountable for the loss. An additional opinion rendered the guardian harmless in the purchase of guaranteed bonds that were

bought in 1928 but became worthless after the economic collapse. The Baxter estate attempted to prove that the securities used were inadequate; however, the courts did not accept this argument.

The trust company also bought bonds from an affiliate having the same stockholders. Consequently, a conflict of interest arose. As a result, the courts allowed Baxter to declare this sale void, but only after he had been deemed restored to "sanity."

In 1930, Union Industrial Trust sold itself mortgage bonds. This was accomplished by serving in a dual capacity--as a guardian and as a savings bank. The trust company knew of depressed real estate values, and there was no evidence supporting the contention that this was an attempt to secure the mortgage bonds. In essence, the trust company purchased these bonds at far below their market value. However, the courts again ruled that the guardian, the trust company in this case, was liable to Baxter, who was declared incompetent at the time.

The court record suggests that Baxter regained his sanity and petitioned the courts to release his guardian. No court appearances followed, and Baxter v. Union Industrial Trust and Savings Bank ended on this note. This chain of events illustrates the courts' determination to follow the letter of the law, without regard to the realities involved.

In the next period of mental health history, known as "The State Hospitals Commission as Central Authority," significant court

decisions continued to affect the patient population and the community at large.

The State Hospitals Commission as Central  
Authority: 1937 to 1945

During this period, court proceedings continued to refine issues as they related to the mentally ill. For the most part, cases that came before the bench related to personal situations. Several challenges to legal technicalities arose and are discussed in this section.

Further legal interpretation of insanity was required to safeguard those alleged to be mentally incompetent and the public. In 1959, an important interpretation of insanity addressed this need:

**Mich. 1939.** "Insanity" is broad, comprehensive and generic term of ambiguous import for all unsound and deranged conditions of mind and includes every species of organic mental derangement from whatever source or cause, whether congenital or result of arrested mental development, act of Providence, victim's own imprudence, religious excitement, physical disease, dissipation, old age, or unknown causes, and whether personal or hereditary. Beattie v. Bower, 287 N.W. 900, 290 Mich. 517. (Michigan Digest, 1985, p. 432)

Probate court did not stop at this juncture in defining "insanity." A more descriptive characterization of this kind of disorder was acknowledged by judiciary proceedings in Beattie v. Bower.

"Insanity" is more or less permanent disorder of mental faculties, without loss of consciousness and will, and marked by delusions, illusions and hallucinations, changes in character and habits, and unreasonable and purposeless actions

and language. Beattie v. Bower, 287 N.W. 900, 290 Mich. 517. (Michigan Digest, 1985, p. 432)

As a consequence of this redefinition of insanity, the courts lowered the requirements necessary to begin commitment proceedings:

Mich. 1939. Insanity need not be established by medical experts' testimony, but condition of mental unsoundness distinguished by common observers is adequate to justify equitable investigation. Beattie v. Bower, 287 N.W. 900, 290 Mich. 517. (Michigan Digest, 1985, p. 435)

### Protection of Human Rights

It was sometimes difficult to declare people "insane" and at the same time protect their individual rights. The courts heard many insanity cases presented by lay persons who could testify and establish a foundation for committing an individual to a state hospital. Two significant judicial opinions were set forth at this time:

Mich. 1940. All persons are presumed to be sane, and in every proceeding the burden of proving insanity rests upon the one alleging it. Comp.Laws 1929, sec. 6888. In re Ryan, 289 N.W. 291, 291 Mich. 673. (Michigan Digest, 1985, p. 433)

Probate court judiciously protected all concerned parties involved with insanity hearings.

Mich. 1940. The "proceeding leading to an adjudication of insanity" is not an "advisory proceeding," but is a "proceeding in the interest of the public" to protect deficient citizens, and hence is not a proceeding wherein any act or admission of respondent could prejudice an adverse party. Comp.Laws 1929, sec. 6888. In re Ryan, 289 N.W. 291, 291 Mich. 673. (Michigan Digest, 1985, p. 433)

Three years later, it became necessary to further limit the procedure for commitment:

Mich. 1943. The statutory requirement that certificates of insanity must be made by two reputable physicians, under oath, appointed by probate court of county where such person resides, is "jurisdictional," and, unless there is strict compliance with the statute, probate proceedings for commitment to hospital are a nullity. Comp.Laws 1929, sec. 6887. Freedman v. Freedman, 6 N.W.2d 924, 303 Mich. 647. (Michigan Digest, 1985, p. 447)

### Due Process

Mental health laws were enacted to prevent committing an individual to a state hospital without due process. It was considered essential that any party being certified "mentally diseased" be permitted to attend his/her own hearing, unless his/her presence was deemed improper or unsafe. In 1945, the probate court was required to nullify a commitment because the patient in question was not present at his own hearing (Ex parte Roberts, 17 N.W.2d 752, 310 Mich. 560) (Michigan Digest, 1985, p. 446). The court determined that no evidence had been presented supporting the contention that the patient was not able to attend his own hearing or that his attendance would have negative consequences. The court could only void the patient's commitment.

Private parties could provide evidence for committing someone, but physicians had to perform their own evaluation. Failure to have a physician's evaluation would result in the cancellation of a patient's admission to a state facility. The courts reinforced this expectation, as cited in two decisions in 1946:

**Mich. 1946.** Commitment as an insane person was illegal in absence of evidence of insanity other than certificates of physicians appointed by court to examine allegedly insane person. In re Haines, 24 N.W.2d 526, 315 Mich. 657. (Michigan Digest, 1985, p. 447)

It became necessary to hold an examining physician accountable for his testimony. Probate court would not tolerate a nonchalant approach in committing an individual to a state facility.

**Mich. 1946.** Reports of physicians showing that their conclusions were based on the findings of others and not on their own personal examination of allegedly feeble minded person were insufficient to warrant commitment of such person as feeble minded. Comp.Laws 1929, sec. 6888. In re Payette, 24 N.W.2d, 427, 315 Mich. 790. (Michigan Digest, 1985, p. 447)

Formal procedures were also required to discharge a patient from the State Hospital Commission's custody. Recovery from illness had to be firmly substantiated:

**Mich. 1944.** The statutory provision for hearing on petition for discharge and for jury trial of issue whether person committed to State Hospital Commission's Custody as a psychopathic person has fully recovered from such psychopathy, if such trial is demanded within specified time, is mandatory, but the statute requires that the petition for discharge must show a factual basis for the claim of full recovery. Comp.Laws Supp.1940, sec. 6991-1 et seq. Passerman v. Judge of Recorder's Court of City of Detroit, 12 N.W.2d 437, 307 Mich. 755. (Michigan Digest, 1985, p. 501-502)

#### The State Department of Mental Health: 1945 to 1974

The definition of "insanity" seemed to require continuous elaboration and refinement. In 1949, courts continued to contend with this issue. It also appears that the bench modified its interpretation according to need:

**Mich. 1949.** A "mentally incompetent person" is one who is so affected mentally as to be deprived of sane and normal action, and person incapable of conducting his business successfully may still be mentally competent. Pub.Acts 1939, No. 288, c. 3, sec. 1, as amended by Pub.Acts 1947, No. 358. In re Swisher's Estate, 37 N.W.2d 657, 324 Mich. 643. (Michigan Digest, 1985, p. 432)

In 1952, the judiciary more specifically interpreted "insanity":

**Mich. 1952.** An insane delusion exists when a person persistently believes supposed facts which have no real existence, and so believes such supposed facts against all evidence and probabilities and without any foundation or reason for the belief, and conducts himself as if such facts actually existed. In re Solomon's Estate, 53 N.W.2d 597, 334 Mich. 17. (Michigan Digest, 1985, p. 432)

#### Social Stigma Raises Concerns

It was a social stigma to be admitted to a state hospital. Thus, the courts had to make it clear that admission to a state facility did not presume an individual was mentally ill. It was necessary to hold a separate hearing on the declaration of mental incompetence and still another hearing to appoint a legal guardian:

**Mich. 1955.** Admission to state hospital pursuant to statutory provisions is not an adjudication of mental incompetence and is separate proceeding from that of appointment of guardian for one adjudged to be mentally incompetent. Comp.Laws 1948, sec. 703.1; Comp.Laws Supp.1952, secs. 330-21-330.23. Norris v. Norris, 69 N.W.2d 208, 342 Mich. 83, certiorari denied 76 S.Ct. 182, 350 U.S. 903, 100 L.Ed. 793. (Michigan Digest, 1985, p. 441)

An easy solution to the question of what constitutes sanity did not present itself at this time. Witness a 1956 court ruling referring to the opinion of 1940, p. 88:

**Mich. 1956.** All persons are presumed to be sane, and in every proceeding burden of proving insanity rests upon one



challenging the sanity of the individual. Comp.Laws Supp. 1954, sec. 780.505. In re Mahon, 73 N.W.2d 854, 344 Mich. 212. (Michigan Digest, 1985, p. 433)

### Admission to the State Hospital

Admission to a state hospital presented equally disturbing problems. Again, interpretation of exact procedures required judicial intervention in 1960.

Mich. 1960. Under statutory provisions that petition to commit individual to hospital by reason of mental illness shall contain statement giving facts, not conclusions, upon which allegation of mental disease is based, and that medical affidavits of physicians, to authorize admission, shall contain facts and circumstances upon which opinion of physician that individual is actually mentally ill, feeble-minded, or epileptic. . . . Comp.Laws Supp.1956, secs. 330.20, 330.21. In re Opal, 104 N.W.2d 802, 360 Mich. 696. (Michigan Digest, 1985, p. 441)

The 1949 definition of "mental incompetence" continued to be used in later court cases declaring an individual not sane. Minor modification did occur, but it was in the wording of the court opinion regarding the specifics of each case.

### Additional Problems Prevailed

In 1971, concern about temporary commitment and the rendering of treatment was brought before the bench. The ruling observed that authorized physicians were to exercise restraint in performing treatment, with the exception of maintaining the patient on the premises, preventing harm to himself/herself, and preventing another

patient from being injured (Stowers v. Wolodzko, 191 N.W.2d 355, 386 Mich. 119) (Michigan Digest, 1985, p. 449).

The court also ruled that an individual had the right to communicate with relatives and an attorney to obtain release from a state facility. Numerous telephone calls did not have to be allowed, but open communication could not be denied (Michigan Digest, 1985, pp. 449-450).

The court further declared that these statutes applied to private hospitals as well as to state facilities when providing treatment that could be deemed a nonemergency. Only after a court hearing committing a patient to the institution could formal treatment procedures be applied. Physical or emotional violation of a patient, then, was viewed as a "liability for assault or for trespass" (Stowers v. Wolodzko, 191 N.W.2d 355, 386 Mich. 119) (Michigan Digest, 1985, p. 480).

Trial courts occasionally erred. In 1974, a judicial review concluded that the lack of a diagnostic report or judicial hearing regarding a patient's mental competence violated his/her rights. In essence, a formal examination of the party was mandatory (People v. McShan, 219 N.W.2d 792, 53 Mich.App. 407) (Michigan Digest, 1985, p. 482).

Department of Mental Health (New Mental  
Health Code): 1974 to Present

Even by 1980, several years after implementation of the Mental Health Code of 1974, there was essentially no change in judicial interpretation of "mental incompetence":

**Mich.App. 1980.** A "mentally incompetent person" is one who is so affected mentally as to be deprived of sane and normal action or who lacks sufficient capacity to understand in reasonable manner the nature and effect of the act he is performing. May v. Leneair, 297 N.W.2d 882, 99 Mich.App. 209. (Michigan Digest, 1985, p. 43)

In comparing this definition with that of the 1949 court opinion in regard to the Swisher estate (see p. 90), it was apparent that the struggle to define mental incompetence remained as addressed earlier. The judiciary, though, did modify the definition of an incompetent person according to the facts in the case being heard. Hence, a precise definition of "insanity" has never been determined by probate court.

Commitment proceedings have continued to require legal interpretation. Courts have found it necessary to distinguish between criminal cases and civil hearings. In 1982, the court ruled that commitment of an individual to a state mental hospital on an involuntary basis did not call for evidence beyond a reasonable doubt, but rather "clear and convincing evidence" was needed for a hearing of this nature. The court further upheld that the allegedly incompetent individual had the legal right to respond to questioning and that a "finder of fact" could only form a judgment regarding the

"mental or psychological disablement," if any, through this procedure (Matter of Baker, 324 N.W.2d 91, 117 Mich.App. 591) (Michigan Digest, 1985, p. 445).

#### Protection of the Patient's Record

Patients' access to records was another dominant concern during the mental health reforms of the 1970s. Contrary to expectations, the courts concluded on two occasions, in 1978 and 1979, that in revealing case records to a patient, discretion had to be used so as to prevent the patient or another significant party from reading material that could be detrimental. The court also ruled that representatives of a state mental health facility could not capriciously determine that it was in the patient's best interest to conceal material. There had to be substantiated conclusions to that effect (Op. Atty. Gen. 1978, No. 5125, p. 454; Op. Atty. Gen. 1979, No. 5500) (Michigan Digest, 1985, p. 437).

As mental health organizations and other advocates of the mentally ill exhorted patient rights, individual cases came before the judicial bench. Invasion of privacy was a major concern. The Mental Health Code of 1974 was underscored by a 1980 court decision stating that any individual who was involuntarily confined in a state mental hospital because of mental illness was not subject to unconstitutional invasion of privacy (Op. Atty. Gen. 1980, No. 5653) (Michigan Digest, 1985, p. 438).

### The Never-Ending Problem of Defining Mental Illness

If the reader has concluded that mental illness is now adequately defined by the courts, this is not the case. The need to redefine mental illness has continued to surface, requiring court intervention. As late as 1984 and again in 1985, legal opinions regarding this issue were rendered. In 1984, the courts upheld that a person is "legally insane" according to the law in the following circumstances:

**Mich.App. 1984.** Person is "legally insane" if person lacks substantial capacity to appreciate wrongfulness of her conduct or substantial capacity to conform her conduct to requirements of law.--People v. Foster, 367 N.W.2d 349, 138 Mich.App. 734. (Michigan Digest, 1985, Addendum, p. 20)

In 1985, two separate court hearings among several ruled on the definition of mental illness, with subsequent appeals being denied:

**Mich.App. 1985.** Definition of "mental illness" contained in M.C.L.A. sec. 330.1400a is not limited to psychosis.--Matter of Portus, 371 N.W.2d 871, 142 Mich.App. 799, appeal denied. (Michigan Digest, 1985, Addendum, p. 20)

**Mich.App. 1985.** Mental impairment due to any cause, physical or purely psychological, may form basis for a finding of "mental illness." M.C.L.A. secs. 330.1400a, 330.1500(g), 768.21a(1).--People v. Doan, 366 N.W.2d 593, 141 Mich.App. 209, appeal denied. (Michigan Digest, 1985, Addendum, p. 20)

It is apparent that the definition of insanity will continue to be challenged periodically in court. The specifics of each case will require judicial review, based on the law, expert testimony, the mental characteristics of the party involved, and societal concerns.

Another major concern that was brought to the attention of the courts was criteria for discharging a patient from a mental health facility. The case in point was a landmark decision of 1984. (The case and opinion are presented in Appendix K.)

### Protection of the Patient

Patient abuse has plagued mental health treatment in Michigan since its inception. Certain legal protections do exist for hospital personnel when there are altercations between patients. Immunity for staff does not apply when a patient is harmed by any employee. (The pertinent case and conclusion by the court are noted in Appendix L.) State hospital facilities are held accountable for maintaining safety and security for all parties on the premises, including patients who are vulnerable (Michigan Digest, Addendum, 1985, pp. 24-25).

In the 1987 matter of Hinkelman v. Borgess Medical Center, 403 N.W.2d 547, 157 Mich.App. 314 (Michigan Digest, 1985, Addendum, pp. 24-25), the courts ruled that a special relationship exists between psychiatrist and patient, just as it does between facility and patient. However, a therapeutic alliance must be established because the law does not always apply with respect to protecting a third party who might be endangered. In this case, the court ruled that even though the victim of a murderous assault by a psychiatric patient occurred without the medical center personnel notifying the intended victim of a dangerous situation, there was not a unique

relationship between the threatening patient and the staff member because the patient had been admitted on a voluntary basis on two previous occasions and for only a brief period during each admission.

The psychiatric hospital was not regarded as an "agent by estoppel" (Michigan Digest, 1985, Addendum, p. 26) (power of judicial offices to stop or discontinue a legal proceeding) of the independent psychiatrist, although a physician-patient relationship existed. Furthermore, the hospital was regarded as the treatment environment; there was no other expectation of immediate or intense treatment being provided by the hospital. Therefore, the court concluded that the "psychiatric hospital had no duty to warn a third person of dangerousness of the psychiatric patient, since the third person was aware of the danger, having been attacked by the patient several times prior to the fatal attack" (Michigan Digest, 1985, Addendum, p. 26). If this was not explicit enough, the court further ruled that the hospital "had no authority or ability to keep a voluntary patient hospitalized upon his decision to leave, and thus had no duty to third persons to control the patient's conduct following his departure" (Michigan Digest, 1985, Addendum, p. 27).

Other major milestones have affected state mental health facilities. Incidentally, historically the majority of these current rulings have occurred since the 1950s. Earlier cases tended to focus on patient commitment, court procedures, and patient

rights. A very important court decision regarding state hospital records was handed down in 1971.

#### In the Matter of Hospital Procedures

In the matter of Gaertner v. State (187 N.W. 2d 429, 385 Mich. 49) (Michigan Digest, 1985, p. 437), the bench stated that a state facility could not deny a guardian of a patient access to ward records based upon the statute preventing disclosure of information as acquired by an attending physician. In essence, confidentiality did not prevail in this kind of situation. If the revelation of such records could be harmful to the patient, then the courts reserved the right to suppress the material, but allow the patient or his/her guardian access to the remainder of the records. The courts further granted the state hospital and physician to protect themselves legally by requiring the "execution of a valid consent and waiver of physician-patient privilege" prior to the release of patient information.

After the 1974 Mental Health Code came into law in Michigan, two other major decisions influenced state hospital procedures.

In 1978, probate court heard People ex rel. Book v. Hooker (268 N.W. 2d 698, 83 Mich. App. 495) (Michigan Digest, 1985, p. 440). An initial commitment was established as being for 60 days, to include care and treatment. If this court order ran its course with no patient relief of symptomology, then the state hospital or its representative (attending psychiatrist) could seek a recommitment



order for an additional 90 days. The state hospital was also granted some leeway by the courts in this regard. Even if there was a remission of symptoms, the "imminent possibility of recurrence of symptoms," if substantiated by medical testimony, the patient could be required to remain in the hospital up to 90 days on the second commitment order.

As late as 1979, involuntary hospitalization remained a legal problem. The Matter of Wagstaff (287 N.W. 2d 339, 93 Mich. App. 755) (Michigan Digest, 1985, p. 440) was presented in probate court, resulting in the decision to prevent patients from being hospitalized against their will if they did not meet statutory requirements for inpatient treatment. It was necessary to follow commitment proceedings from the beginning of the petition of the patient and not to retain the individual involuntarily in a state hospital until such procedures could be implemented. The state mental hospital clearly had its role defined by the courts.

#### Summary

Throughout the years of judicial hearings, reviews, and rulings involving thousands of cases, the courts have demonstrated a concerted effort to protect the civil rights of all parties involved. In countless decisions, the courts have had to proceed with caution in light of the nebulous nature of mental illness. However, the judicial system has met the challenge and preserved the

integrity of the citizenry. Human rights have been upheld by compassionate officers of the court; commitment proceedings have been well established; and, most important, therapeutic treatment has been made available to an enormous number of patients over the past several decades. All of this has been accomplished without a precise definition of mental incompetence.

The mental health community has also played a major role, especially in recent times. Many segments have impacted the care and treatment of the mentally ill. Their contribution is now presented.

## CHAPTER VI

### PERCEPTIONS OF THE COMMUNITY

At the beginning of the 1980s, Michigan was facing an economic decline. Not all regions of the country were as dramatically affected, perhaps because Michigan's automobile industry and related businesses were hit the hardest. A philosophical approach to government administration reemerged as department mergers, layoffs, and computerized automation began to dominate the decision-making process. As the Michigan economy began to wane, executive-ordered cutbacks were made in the state budget.

The MDMH was a primary target of a severe scaling down of services; as a result, treatment for a dependent population also was curtailed. Institutionalized mentally ill were gradually placed elsewhere--in foster homes, in group homes, or returned to their families. Supportive services such as community treatment were made available, but no longer did large institutions function as caretakers for many of the mentally afflicted.

Thus, state mental hospitals were decentralized as a consequence of economic uncertainty. The executive branch of Michigan government was forced to reexamine the role of state institutions. The MDMH ordered employee layoffs and patient discharges. The hospitals were to be streamlined insofar as daily operations would allow. A new order emerged as external sources of

treatment, i.e., community mental health and group homes, began to dominate the mental health care scene in Michigan.

### A Brief Historical Overview

Concerns of community members regarding mental health issues during the six periods of focus in this research cannot be adequately covered because the State of Michigan archives and related references do not reflect society's attitude toward mental illness. This assertion was substantiated by State Library of Michigan personnel. Anecdotal material is available that conveys public thinking, but for the most part such material comprises reactions to stressful situations regarding the mentally ill, which often resulted in legislative and legal action to address current situations.

Society has usually regarded mental illness as an anathema. Although problems surrounding the mentally ill have had to be confronted, the parties involved with their treatment and care have voiced the most concern. During the past few decades, the news media have brought to light some of the concerns regarding mental illness, but seldom has this topic made the headlines.

Over the years, many organizations have been established to underscore the need for improvement of inpatient care. These organizations have circulated brochures, and newsletters have been published in an attempt to illustrate the problems surrounding the treatment of mental illness; however, only small segments of society

have been influenced by such publications. These organizations were established out of a need to address an immediate problem or situation, just as the Michigan Legislature and judiciary responded with necessary interventions regarding mental illness.

Although the State of Michigan Archives contains numerous volumes on mental illness, the writings therein do not project a clear picture of citizens' attitudes toward mental illness. It is evident that, throughout the years, society has left it to government to provide for treatment of the mentally ill. Only when there has been dissatisfaction with government have citizen groups made a concerted effort to respond. The following discussion provides an overview of perceptions of mental illness from the beginning of the mental health movement and the extent to which society has served as a vanguard for treatment programs.

Dorothea Dix is often credited with founding the mental health movement. Beginning in 1820, she brought mental health issues and the plight of the mentally ill to public attention. Aside from public concerns and complaints regarding mental illness, however, very little took place during the remainder of the nineteenth century. Indeed, not until the early 1950s was another national association formed to assist the mentally ill.

Clifford Beers (cited in Sargent, 1944) also published his own experiences with mental illness in A Mind That Found Itself. He went even further, though, in elucidating the inhumane treatment

that was inflicted upon the residents that shared his nightmare. Beers eventually was able to overcome his manic-depressive state, and along with recovery came a dynamic effort to enlighten the public regarding the decadence of the mental institutional environment. Because of his momentum, the mental hygiene movement became a leading proponent of improving mental institutions throughout the country. The National Committee for Mental Hygiene later evolved and became the formal organization to dedicate its efforts to the prevention of mental illness.

The National Association for Retarded Citizens, founded in the early 1950s, helped streamline the care and treatment of mentally ill individuals by advocating changes in existing mental health laws. The demand for more facilities and better treatment was the focus of this organization. Once again, however, there was a lack of attention to mental health issues for many years.

In 1972, the national Head Start program was established to prevent children from becoming victims of mental retardation or mental illness. This program was designed to foster better education for youth. The national movement to sponsor special programs for handicapped people resulted in Section 504 of the Rehabilitation Act (1973), intended to enable people with multiple handicaps to receive free and appropriate education (Mondou, 1990). Michigan was already working to insure an education for the mentally ill as local organizations sponsored a similar act in 1971. The federal act was not adopted until 1975.

In 1986, the Education for All Handicapped Children Act was amended to include a broader range of citizens who needed treatment for a variety of afflictions, including mental illness. Most recently, in July 1990, the federal Disability Act 504 reinforced the provision of continuing education for people with all types of afflictions (Mondou, 1990). All has not boded that well, especially for the past two decades.

#### Acknowledgment of Treatment Failure

Over the decades, then, the public has endeavored to ensure that the mentally ill receive the necessary care and treatment. The news media have illustrated some of the problems in treating the mentally ill, as well as the plight of those so afflicted.

Both medical and humanistic scientists have studied the causes of mental illness, but all too often treatment has failed to effect a cure. Some patients have experienced a relief of adverse symptoms and have gone on to lead fairly successful lives. Other patients, however, have continued to suffer. In some cases, state programs have been blamed for these failures. Barbara Walters (1988), a staff writer for the Kalamazoo Gazette, addressed an important consequence of program failure:

The price Michigan is paying for its failure to adequately deal with its seriously mentally ill is increased criminal behavior. The year 1988 showed a dramatic increase in the number of individuals being transferred from the jail to Kalamazoo Regional Psychiatric Hospital and back again, according to county Human Services Department report to county commissioners in September. (p. 5)

Walters (1988) noted that many mentally ill people have no place to live, which raises the question: Are psychiatric facilities designed simply to house the mentally ill, or is treatment supposed to be the primary concern? The MDMH must define its responsibilities so that community members clearly understand its role and function. Many interest groups have encouraged the MDMH to concentrate on the seriously and chronically mentally ill, and not to extend itself beyond its capacity to serve.

Consequences of substance abuse among young people have placed a growing demand on community mental health services, especially outpatient treatment programs. This is another reason why the MDMH must reevaluate its priorities and determine what interventions it can provide. Until the various governmental agencies can clearly define their roles and the populations they serve, there will be a crossover of patient groups--from the criminal justice system to outpatient treatment programs to inpatient care--and a tremendous demand on the mental health system in general. "Charged with protecting society and preserving the rights of the mentally ill, the courts and mental health system . . . often [have] failed to do either" (Walters, 1988, p. 5).

In an important news brief released in July 1987 (MDMH, 1987c), an MDMH spokesperson stated:

Restoration of services and staffing since mid-decade at Kalamazoo Regional Psychiatric Hospital becomes the legal basis for future improvements, according to a state-federal agreement signed earlier this month. The agreement signed by MDMH



director, Quanis D. Watkins, Jr., attorney general Frank Kelly and William Bradford Reynolds of the United States Justice Department provides for upgraded services and assures higher staffing ratios for most classes of professional staff. (p. 1)

Although adequate staffing is important, many constraints were placed on treatment of the mentally ill at this facility because of poor control over who could receive services. It is evident that the MDMH has continually found itself in a defensive position.

#### Pressing Financial Concerns by the MDMH

An example of an attempt by the MDMH to alleviate financial problems is its decision to close the Traverse City psychiatric facility. Detroit News reporters Belloli and Bevier (1988) wrote:

The Traverse City Regional Psychiatric Hospital, a century-old state facility serving almost thirty northern Michigan counties, will close within two years. . . . The one hundred and fifty patients are to be transferred to other psychiatric hospitals or to adult foster care homes by September. The hospital was opened in 1885 as the northern Michigan asylum. (p. 1)

Belloli and Bevier (1988) cited an example of community action to address concern about the facility closing when "several patients began circulating petitions opposing the decision" (p. 1). Also, in a letter of protest to Governor Blanchard, three lawmakers wrote: "This decision would be devastating to the patients and their families, as well as to the dedicated hospital employees and their families and wreak havoc on the local economy of Traverse City" (p. 1).

It would seem that the MDMH needed to address cost containment and to define how it planned to serve the mentally ill in the region. However, this was not the case. Chargot (1989) reported in the Detroit Free Press:

With only four patients left at Traverse City Regional Psychiatric Hospital, the legislature has taken action to keep the facility open until it has some assurance that patients that need hospitalization will be cared for in their communities.

The move, which still awaits approval from Governor James Blanchard, is strongly opposed by state mental health director Thomas Watkins, Jr., who said it would cost five million dollars to keep the hospital open for another year. Admissions to the facility were cut as of June 1. (p. 4)

No one can say that the Michigan Legislature was not concerned about patient care.

On Thursday, the legislature passed a bill that included an amendment to keep the hospital open until Community Mental Health [CMH] can contract with local hospitals to accept patients suffering psychotic episodes who previously would have gone to the state hospital in Traverse City. Mentally ill patients from 29 northern Michigan counties covered by twelve [CMH facilities] have been served by the Traverse City facility. (Chargot, 1989, p. 4)

No doubt the interested parties had legitimate concerns. However, the mentally ill were not being served adequately. Chargot (1989) went on to note that:

Watkins "has just not been cooperative in trying to resolve what we feel is an insensitivity to patients and patients' families," said state senator Connie Binsfeldt, R-Maple City, who sponsored the amendment. She described her concerns more directly: "We happen to know there are people who need care and they are sending them to facilities" in other parts of the state, she said. "And that is wrong to us because they are sending them to other state facilities, not to community-based hospitals. (p. 4)

The disarray that pervaded the MDMH and the Michigan Legislature reflected the inadequacy of those agencies involved in determining how the mentally ill were to be cared for, and even how society might benefit from their endeavors. It was important for strong leadership to pursue the important cause of mental health care.

#### The Response of the MDMH

The MDMH did respond with its own Quality Care Task Force project. The recommendations of the task force are outlined in its June 1988 final report (Quality Care Task Force, 1988) (see Appendix M). The task force addressed some important concerns, specifically, the lack of an adequate support system for the chronically ill. Care for the elderly and substance abusers has also been of great importance to the MDMH. Maximizing reimbursement revenues was another concern that needed to be examined.

The MDMH Quality Care Task Force (1988) examined the conditions in state mental health hospitals. Testimony at public hearings and an investigation by the hospitals themselves revealed that the living arrangements in these facilities were inadequate. The condition of the wards was poor, and it was difficult to view and monitor ambulatory patients. The interaction between staff and patients was hampered by the poor design of these facilities. The task force concluded that older hospitals were heavily institutionalized, nontherapeutic, and for the most part unsafe. (A

description of the 10 adult psychiatric facilities is included in Appendix M.)

Close examination has brought to light many of the problems surrounding state mental institutions. Attempts to deal with these failures and disappointments are discussed further. It is necessary, though, to put the diminished mental health treatment in historical perspective.

#### Separation of Authority Leads to Deinstitutionalization Problems

"Deinstitutionalization" is the contemporary term describing a sudden discharge of large numbers of patients from state mental hospitals. This also involves the decentralization of treatment, under which local (usually county based) mental health service agencies assume responsibility for serving a greater proportion of clients. Davis (1985) reflected on this change:

Michigan has actively promoted local mental health services since the first boards became operational in the mid-1960's. The primary goal of DMH in the first decade of the board system was to induce counties to develop local mental health boards, a goal that was almost complete by the mid-1970's. Once most counties had elected to participate, the CMH role was expanded significantly with passage of the revised Mental Health Code of 1974. The new law includes provisions that the state begin to turn over all mental health responsibilities to the boards. . . . And in Chapter 2 of Act 258, the department is to "seek to develop and establish arrangements and procedures for the effective coordination and integration of state services and county program services." (pp. 7-8)

Pilot projects were instituted at the local level to effect a transition from the mental institution to community living.

However, conflicts arose concerning different treatment modalities. One such conflict existed within the institutional setting as a major emphasis was placed upon upgrading patients' social skills before discharge or community placement. The problems arising between the state hospitals and community mental health boards are now discussed.

### Beginning Flaws of Decentralization

The MDMH faced a critical challenge, according to Davis (1985): "How to transfer state services to the boards while retaining adequate policy control, and while assuring that high quality, comprehensive services were accessible to all citizens of the state" (p. 10).

Establishing one authority for community mental health services was precluded because each locale was responsible for the patients under its own jurisdiction. Attempts to coordinate services between the community mental health center and the local state hospital led to conflict. Davis (1985) cited how each authority had its own power and control, and often there was an overlapping of authority. To complicate matters further, the MDMH had its own agenda, which was not always congruent with that of local mental health policy makers. The players involved in this scenario--the MDMH, state hospitals, and community mental health centers--remained isolated, with inadequate direction coming from Lansing. Continuity of patient care was impeded.

Because the MDMH had established separate programs, problems arose with regard to allocating funds. Money went directly to hospital budgets and community mental health centers. But the funds needed to transfer patients from a state hospital to a community mental health center were lacking. Living arrangements were often inadequately planned because necessary funds were unavailable.

During the past several years, the inpatient clinical population has dramatically decreased. However, the demands on Michigan's mental health system have remained intense. The burden has shifted from large state hospitals to community mental health centers. There have never been sufficient resources.

#### The Deinstitutionalization Movement

Articles reviewing the funding-related issues provided a satisfactory explanation of program costs but have fallen short in quantifying benefits and effectiveness. Furthermore, little research is available on changes in clients' social and economic functioning after release from an institution. Few writers have gathered substantial information on the quality of care and services provided at facilities. Finally, the costs and benefits of deinstitutionalization are unclear.

To answer the questions and resolve some of the problems associated with deinstitutionalization, closer attention must be given to existing empirical data and to the type of research that

must occur in the future. Models must be developed to facilitate comparative, quantitative assessments of the value of institutionalization versus community placement--despite the inherent difficulties of quantifying the benefits involved in human care programs. Only the collection and use of empirical data will allow policy makers and program planners to establish a direction for the deinstitutionalization movement.

In 1963, the U.S. Congress passed legislation that funded community mental health centers. In the 1960s, as a result, the number of residents in mental hospitals gradually declined as more and more people were placed in alternative community homes and programs. For a time, the media reported that the move from institutions to community-based facilities was a positive, more humane approach to long-term care for the severely disabled.

Some observers believed that deinstitutionalization or community placement has merit, but it has been poorly executed. A contrast in approach to treating the mentally ill is now presented.

To suddenly place an institutionalized patient in the community has invited major consequences. This phenomenon will be addressed later. Suffice it to say, it has not been possible to establish mental health policy based upon economic factors, even though the MDMH has done just that.

The patient's life is regulated and ordered according to a disciplinarian system developed for the management by a small staff of a large number of involuntary inmates. In this system the attendant is likely to be the key staff person, informing the patient of the punishments and rewards that are to regulate

his life and arranging for medical authorization for such privileges and punishments. Quiet, obedient behavior leads to the patient's promotion in the ward system; obstreperous, untidy behavior to demotion. (Goffman, 1961, p. 361)

The mentally ill have nevertheless become quite accustomed to the controlled environment. Gradually they become outcasts, having nowhere to live and not being equipped to cope with pressures in society. Goffman (1961) characterized the problem as follows:

A mental hospital is ill-equipped to be a place where the classic repair cycle occurs. In state mental hospitals, and to a greater extent in private and veterans' hospitals, opportunity for observing the patient is available, but staff are often too busy to record anything but acts of disobedience. Even when staff time is available for this work, the patient's conduct on the ward can hardly be taken as a sample of his conduct off it. (p. 360)

Decreasing the state mental hospital population has been of major concern to the MDMH. Not only has it been necessary to reduce costs, it is also understood that patients are better off in the community if they are able to function independently.

Seven years after passage of the federal legislation, deinstitutionalization became a MDMH program goal under Dr. E. Gordon Yudashkin. This led to many innovations in mental health care delivery and, more significantly, changed the thinking of relevant actors regarding how services should be provided, and by whom.

As more people became aware of the negative effects of custodial care, attempts were made to help individuals become as independent as possible. These efforts first began in the institutions. As the movement to reduce the negative effects of



custodial care grew, the next natural step was to remove patients from an institutional environment. Movement to the community was coupled with treatment designed to reduce the level of institutional dependency and the establishment of alternative living arrangements.

State appropriations for establishment of mental health boards rose from approximately \$7 million in 1967-68 to more than \$14 million in 1969-70. It was the MDMH's position that all state-supported programs should be considered part of an integrated whole, subject to statewide priorities.

The deinstitutionalization issue has not been resolved; implementation of the process was to satisfy the policy makers more than to evolve as a benefit of hospitalization. The MDMH could have responded more favorably by examining the clinical issues and the practicalities of the lives of mental patients. Social workers, especially, had to contend with providing the best fit between patient and environment--in essence, the transfer of clinical issues to another treatment modality. Who could actually be satisfied? Budget sheets may have served as evidence of cost containment, or did they? This development is analyzed in Chapter VII. For now, it is clear that the concerns surrounding deinstitutionalization, which were cited years ago, were not sufficiently considered.

## Hospitalization Versus the Cottage Concept

Two mental treatment facilities are described in this section to illustrate different approaches to treating the mentally ill. First, Clinton Valley Center is described, followed by a discussion of the Vinton Cottage Program--a cottage attachment of this facility.

### Clinton Valley Center

The economic recession of the early 1980s dramatically affected the MDMH budget, requiring staff layoffs and culminating in the discharge of patients to group homes with community support. Many professionals experienced dramatic changes with just a brief transition period.

In an interview with this researcher on January 28, 1991, Dr. Selwyn Fidelman, Chief of Psychology at Clinton Valley Center in Pontiac, Michigan, reflected on his professional experiences and perceptions of what occurred during that challenging time. Dr. Fidelman described himself as a patient advocate and observed: "Patients are not getting help anywhere. They're actually a victim of the system. Effective treatment has not been provided for a long time." Dr. Fidelman was addressing the fact that most patients have a shortened stay in the facility, only to return repeatedly for crisis intervention with little or no therapeutic value. To circumvent the "revolving-door syndrome," Dr. Fidelman, with the aid

of support staff, designed the Vinton Cottage Program. This treatment modality was very beneficial and still may be offered as an alternative to the traditional mental hospital concept. Dr. Fidelman is a strong advocate of this approach to inpatient mental health.

### The Vinton Cottage Program

The Vinton Cottage was located on the grounds of Clinton Valley Center. It housed 15 women (ages 18 to 64) on an inpatient basis; these patients were referred to Vinton Cottage from hospital wards. This experimental program, serving as an alternative method of hospitalization for the mentally ill, operated for about 14 years. Its philosophy and low cost of operation were its strong suits, especially with regard to the myriad problems of state mental hospitals and aftercare facilities. Of those patients who were discharged from Vinton Cottage into the community, just 16.7% had to be readmitted to the hospital, even though they were previously long-term state hospital patients (Fidelman, 1991).

Vinton Cottage was started as a pilot project to address the effect of institutionalization on patients. Because the dependency arising from institutionalization comes about gradually and in an unobservable manner, it is difficult for staff members to intervene effectively. The resultant frustration and apathy that occurs among many staff further accentuates the process.

The Vinton Cottage program was begun to counteract this process by making the residents more responsible for their daily functioning. The residents were responsible for taking their own medications, writing their passes, preparing meals, and cleaning the cottage themselves. In general, they had much greater control over their lives than their counterparts who were hospitalized in the main facility.

Aside from the money saved by not paying for custodial salaries, even greater benefits were realized in terms of human dignity and in helping residents maintain everyday skills that were essential if they were to function outside the hospital.

Two paid staff members were responsible for most patient counseling and for program continuity. All others working at Vinton Cottage taught classes and provided some treatment and additional support. Students and interns participated according to their professional specialty.

The Vinton Cottage program had three main goals:

1. It allowed college students who did not have vast experience to "plug into" the Vinton Cottage framework and use their previous learning and creativity.
2. It provided an intensive daily schedule for residents, leading to increased training for work and jobs outside the cottage. At the fourth level, residents were expected to spend 40 hours a week at work, in school, or training for work.

3. The main focus of the program was to move toward development of a "therapeutic community." Most patients end up in mental hospitals because of the early onset and pervasiveness of a family-based pathology. To reverse the process, patients need to experience again a family-type setting, but this time a more loving and yet disciplined one (Fidelman, 1991).

A further aim of Vinton Cottage was to allow residents to get to know one another well enough so that they could share apartments in the community. There, the interpersonal and domestic skills residents learned in the cottages were useful and supportive.

Unfortunately, the Vinton Cottage program was forced to close.

Dr. Fidelman (1991) noted:

The Vinton network began in 1969 and was terminated in 1983. It was not administered on a medical model. We actually could not hire a psychiatrist to work briefly and at the same time not be in charge. This just was unheard of at the time. Some local MDs were angry because of this. Even the union was mad. We had our own cooks and housekeepers--the patients. The union resented this. There was pressure. Then the recession came, and the hospital withdrew our funding. The program didn't cost a lot. Resentments really got in the way, as well. The Vinton program addressed the no-treatment issue and patients being dependent on the hospital. They developed their dependency whether they were there 2 months or 30 years. They were so used to having others take care of them, the hospital provided dependent, conforming behaviors. They were thrown into seclusion to be compliant, not to be independent.

The Vinton was very successful. There was never a runaway, never anyone in seclusion. They received human attention; it was very personal. We also worked on cost containment using students and patients themselves for self-help.

Dr. Fidelman (1991) compared the spirit of the hospital network to the Vinton Cottage program:

The hospital system was taken advantage of and abused--it was financially abused especially with overtime compensation in which staff did not produce. With the Vinton, patients were impacted to care for themselves. There was a patient by the name of Doris. She complained, "My hands are cut off at the wrist; how do I cook for everybody?" This was part of her delusional thinking. We told her that she had to do the job or other patients would not be able to eat. You know, she never missed preparing a meal. We never heard anything further about her hand, either. She had many other problems, but Doris became very productive at the Vinton.

Just to let the reader know, Dr. Fidelman has always been a very caring and compassionate person, dedicated to his profession with a strong commitment to see his patients successfully discharged from inpatient status. I have known him both professionally and personally. His dedication to the care and treatment of the mentally ill is impeccable. Conversely, his vulnerability and frustration with respect to administrative policy prevails as well. Dr. Fidelman has always recognized the importance of and need for an institution to be organized and managed proficiently; however, his first priority has been for his patients to not just improve behaviorally, but to become well. His dedication has transcended the norm. Dr. Fidelman's disappointment and disillusionment is therefore quite understandable.

#### Lack of Coordination of Local and State Authorities

Many of these problems have been present in Michigan for some time. Little concern for coordinating local and state mental health services has been evident. In 1969, Dr. William Anderson, Director of the Michigan Department of Mental Health, observed that:

We are working with a system, built up over several decades, in which there are at least seven kinds of mental health regions or districts into which the state is divided, each overlapping the others. Each of the major programs (mentally ill, mentally retarded, and community services) is separately administered through this maze of districts, and the first point of convergence is the Director of the Department. (p. 1)

As a result, methods of encouraging maximum self-sufficiency for all clients, whether in institutions or the community, came under increased scrutiny.

### Changes in Decentralization

Recognizing the need to rectify the problems noted above, the MDMH sought to implement contractual arrangements between state hospitals and community mental health boards. These arrangements included service productivity, financial compensation, and even penalties if there was any patient fee violation. The patient flow from outpatient to inpatient status was directed primarily by the community mental health center. The MDMH offered these centers an incentive: Any money saved at the end of the fiscal year by sharing state hospital services could be retained by community mental health boards and allocated for special programs. These changes were implemented in fiscal 1980 as a pilot study in conjunction with four mental health centers. Modification of the state hospital-community mental health center contract was necessary, but only to facilitate an easier transfer of funding. Also, a few local mental health centers were allowed to withhold from contractual participation

because they were not working with a large volume of patient services.

C. Patrick Babcock (1983), former director of the MDMH, summarized the budget reductions that were made because of the state economy: "We simply do not have the resources to provide services to all of those who need help. In terms of the severity of problems, on a scale of 1 to 10, we are serving people with problems in the 8 to 10 range" (p. 2).

For fiscal 1983, the state allocation for local mental health services in Kent County was cut nearly three-quarters of a million dollars from the preceding year (Babcock, 1983). Agencies were trying to make up for the reduction by charging higher fees to clients who could pay and by collecting funds from other sources.

Additional cutbacks went into effect, and early prevention programs were dramatically affected. Acute patient care was the primary priority. Federally funded programs eased some of the burden. However, the number of staff workers was reduced, placing even greater pressure on those individuals serving the mentally impaired. In summary, for fiscal 1983, local community mental health boards faced unavoidable cost increases of \$4.2 million, along with a gross program reduction of nearly \$12 million--in effect, a program reduction of \$16.2 million. Because of these reductions, local boards estimated that the number of local mental health workers in their agencies would be reduced by more than 500 persons (Babcock, 1983, p. 6).



In Michigan during fiscal 1980, 1.75% of the population was served by a community mental health agency. By 1982, this figure had been cut to 1.6%. If Michigan had been able to maintain its 1981/1982 levels of service, an additional 14,700 patients would have been served by community mental health agencies. Assuming that these cases were mostly adult outpatients with moderate emotional/psychiatric problems, an additional \$8.8 million in community mental health funding would have been required (Babcock, 1983, p. 6).

For fiscal 1983, it was estimated that an additional 21,459 cases would not be served because of that year's reductions. Thus, for the period 1980 through 1983, it was projected that more than 36,000 patients would not be served because of the fiscal crisis in Michigan (Babcock, 1983, p. 6).

In the MDMH's attempt to handle financial and staff cutbacks, quality treatment suffered. A change in philosophy concerning the provision of quality care has been the central issue. The MDMH has not been able to provide all patients with optimum care and treatment. This contention can best be supported by describing the dilemma of Clinton Valley Center during the economic crisis of the early 1980s (Babcock, 1983).

#### Budget Impact at Clinton Valley Center

At Clinton Valley Center in Pontiac, overcrowding forced hospital administrators to open an additional ward in the fall of

1983, staffed by existing personnel. Even with this additional ward, overcrowding continued to be a problem, and an average of 30 patients had to be escorted to temporary sleeping quarters each night because beds were not available on their assigned wards (Babcock, 1983, p. 7).

### The State at Large Suffers

The decrease in mental health workers throughout Michigan is a clear example of the effect of budget reductions. For example, from January 1980 through January 1983, the MDMH reduced its work force by more than 6,000 people. During the same period, the number of residents in state facilities was reduced by 2,546. Although personnel reductions were anticipated, because of significant reductions in the census at various facilities, staff reductions far exceeded reductions in the number of patients. These reductions affected all categories of workers in all agencies. The number of personnel on the central payroll (including reimbursement officers, rights officers, data processors, and training staff assigned to field agencies) fell from 721 to 446. Personnel at developmental centers dropped from 8,462 to 4,637, and staff at psychiatric hospitals was cut from 8,198 to 6,183 (Babcock, 1983, p. 7).

### Other Significant Views

The following emotion-laden vignette describes some sorrowful consequences of the limitations of the Michigan economy and the MDMH, as alluded to earlier:

Dear Mr. Babcock:

I am the lady who is so desperately in need of a respite care program. . . .

We have had our grand-daughter with us for the past ten years. She is 16 years old, severely mentally handicapped, unable to sit, walk or talk. . . .

We love this little girl very much, she's very sweet and lovable, and we don't want to have to give her up, but we get so tired and despondent at times, because there doesn't seem to be any relief in sight. (Babcock, 1983, p. 2)

The teenager mentioned in the preceding letter was just one of many hundreds of Michigan citizens who needed help but could not obtain it. As stated in Special Report--Impact of Budget Reductions (Babcock, 1983), "Each week, state and community mental health workers review cases to try to determine who is most desperate. There are not enough resources to assist all of those who need help" (p. 2). Obviously, difficult decisions had to be made. But the reductions in mental health treatment were a disservice to all: the patients, their loved ones, and even health personnel (Babcock, 1983).

### Competition Between Treatment Programs

The overlapping of health care systems creates monumental problems. Neither arena, be it the state institution or the community mental health center, should be threatened by the other. A closed-loop system would actually be the most beneficial one, each program respecting the integrity of the other and joining in coordination of services. Both types of services are needed; neither can be everything to everyone.

On the talk show "Point of View," which aired on WJR in Detroit on July 1, 1977, Dr. Donald C. Smith, then Director of the Department of Mental Health, argued for continued support of both community placement and institutional services:

My point of view is that all of us, professionals and laymen alike, must recognize this essential need for multiple types of services. Experience in other states tells us that we should not and must not support institutional programs at the expense of community services--and vice versa.

If we are going to build a balanced, comprehensive system of mental health services in Michigan, we must continue to support a range of services including those provided by community agencies, state hospitals, and state centers for the developmentally disabled. It is not an either/or situation.

### Rejection of the Group Homes

The reemergence of group-homes during the early 1980s was met with mixed emotions by neighborhood residents. Group homes offered some relief to the Michigan economy in that the mental health budget would be reduced. Decreasing the patient population enabled the

state hospitals to reduce their budgets. However, few parties welcomed the discharge of patients into the community. The MDMH (1984a) Fact Sheet revealed some of the reasons community members gave for not wanting group homes in their neighborhoods:

### Did Neighbors Really Say That?

We are all aware of the common reasons neighbors give for not wanting a group home on their street, such as deed restrictions, commercialization, property values, and dangerousness. But neighbors sometimes give peculiar reasons, such as the following:

### Contrasting Reasons

Our road is too wide./Our road is too narrow.  
 It's too dangerous in the country with all the farm equipment./  
 It's too dangerous in the city with all the traffic.  
 Handicapped people would be better off in the country so they  
 can raise animals./Handicapped people would be better off in  
 cities so they can be close to services.  
 We have dangerous railroad tracks here in town./We have  
 dangerous railroad tracks here in the country.  
 The residents of the group home may hurt my kids./The cruel  
 kids in the neighborhood may hurt the group home residents.  
 The house is at the end of the street./The house is at the  
 beginning of the street.  
 The house is on a cul-de-sac./The house is located in the  
 middle of the block.  
 The house (lot) is too small./The house (lot) is too big and  
 expensive.  
 It's too expensive (a tax ripoff)./It's not expensive enough  
 (how can you hire adequate staff?).  
 It's too close to the road (too dangerous)./It's too far away  
 from the road (how can you plow out the driveway in the  
 winter?).  
 They shouldn't be placed on mileroads because mileroads attract  
 businesses./They should be on mileroads where businesses are.  
 What about the rights of the retarded--did they choose this  
 setting?/What about the rights of neighbors? We chose to  
 live here.

### Other Reasons

We don't have sidewalks.  
 A school bus will have to come on our street.  
 Our street is a deadend, and it's the last to be plowed in the winter.  
 There are no street lights.  
 It will add too much traffic to the neighborhood.  
 We have small rattlesnakes.  
 There's water nearby.  
 We have quicksand a half mile away.  
 They'll get lost in the fields and woods.  
 We have dangerous motorcycles and snowmobiles.  
 They might get hurt by our horses.  
 We let our dogs run free.  
 The house should be on the main road (more convenient to services).  
 We have 100 children under the age of two in our subdivision.  
 My children won't have somebody to play with.  
 My kids won't be able to play outside.  
 My husband and I argue over this issue, and it's causing us to get a divorce.  
 I moved out in the country to get away from *everybody*.  
 It's sadistic to put handicapped people in the community-- they'll be prisoners in that home.  
 It's an offensive and noxious use of the property.  
 We already have too many licensed homes here.  
 The retarded make funny noises.  
 They stay up and scream all night.  
 The problem is that the home is located in such a way that many neighbors can look into the backyard and see them.  
 I believe in normalization but not group homes.  
 Dust from the industry next door is a health hazard. (p. 1)

Dr. Fidelman (1991) concluded in his commentary:

Heaven forbid Bloomfield Hills and Birmingham should be so subjected. Petitions against such kinds of homes were circulated in those cities. Communities felt overwhelmed with ex-mental patients, or they were frightened and had a need to protect themselves against the placement of any ex-patients within their neighborhoods.

### Summary

Where will the patients go if they are not welcomed anywhere? How will they survive, especially after many years of emptiness, loneliness, and futility, with no hope or motivation to aspire--only to exist and fulfill their immediate needs? They have been scorned, ridiculed, and mocked. Being largely oblivious to their surroundings and benefiting from physical protection certainly spared them. With more individuals diagnosed as mentally ill and requiring basic care, where will they seek help? Society no doubt wishes the problem of patient care would disappear. As for administrators, legislators, and the like, they perceive a social problem but now with makeshift solutions. Families and friends pursue their course as advocates of the mentally ill, but where do they find suitable answers? The mental health budget will certainly have to be taken into consideration. Let us now view this important factor.

## CHAPTER VII

### BUDGETARY CHALLENGE FOR THE MDMH IN THE 1990s

The highly respected Michigan Psychiatric Society commissioned the Task Force on Public Policy and subsequently enumerated crucial concerns for Michigan mental health in 1984. The Task Force did not conceal any of its own priorities, either. Its point of view is now presented.

Mental health in-patient services have fallen drastically as the 1990s usher in a new era in Michigan mental health. The Task Force on Public Policy (1984) observed that there has never been a recovery from the downgrading of treatment. It is also noteworthy that outpatient community treatment has not been sufficient in this regard, either.

The Task Force on Public Policy (1984) advocated the need for continuing the psychiatric hospital:

Although public psychiatric facilities have seldom been good enough in any state, the Michigan system of mental health care was, until after mid-century, one of the better in the nation. Michigan mental health institutions, well supported by the state legislature, were able to provide an excellent level of clinical service to adults, and toward mid-century, greatly improved service for children. The last several decades have been a progressively deteriorating pattern of public service for all age groups, the physical deterioration of clinical facilities for lack of adequate maintenance, and the selective abandonment of professional training programs, both in psychiatry and other mental health disciplines. (p. 3)



As a policy statement, the Michigan Psychiatric Society gave a brief overview of the Michigan psychiatric institution in Where Michigan Psychiatry Stands (Task Force on Public Policy, 1984):

If the publicly funded hospital is to be preserved and enhanced, trained psychiatrists, who have been exposed to the public hospital, will be urgently required. Such psychiatrists should learn the scientifically exciting prospects for the public hospital, especially its important role in research on major mental illness. If Michigan is to provide adequate care for a growing number of mentally ill persons, to produce leaders in public policy of national stature, to educate the future leaders of regional and national mental health organizations, vital training programs are needed in all state facilities capable of mounting them. (pp. 18-19)

This professional organization clearly elucidated the difficulty in providing upgraded care for many people with mental and emotional problems. Greater education for professional staff becomes even more crucial. The area of mental health treatment certainly is complex.

The Michigan Psychiatric Society's Task Force on Public Policy of 1984 had a threefold concern: to enhance psychiatric education in the mental health setting, to increase public funding for community psychiatric programs, and to upgrade the public mental hospital. These recommendations are of substance. However, further elaboration and integration of MDMH policy is required, and the implementation of any changes must fit into budget constraints.

The genuine concern for the mentally ill is beyond question. All who are involved are concerned about the plight of this unfortunate segment of our society. The objective is to provide services, but in a cost-effective manner. Let us examine this

problem more fully in the hope that some solutions might become apparent.

### The MDMH Presents Contemporary Perceptions

The MDMH was not without its own feasibility studies. The Department commissioned the Mental Health Advisory Council for two successive years. First, the 1985-86 Annual Report of the Council is discussed.

Seldom have private citizens had a direct influence on mental health treatment. This occurred, though, as two members of the Mental Health Advisory Council were selected from the community. They, along with more than 50 volunteers, were authorized to tour Northville Regional Psychiatric Hospital periodically to inspect this facility and provide recommendations to improve it. The Mental Health Advisory Council's 1985-86 Annual Report contained the following significant conclusion:

The report offers seven major recommendations. The most important of these being "a major review of the health care delivery system and all its components with a view to reorganizing and reforming the system internally, or contracting out the delivery of medical care services to a large well-organized regional medical services group or HMO" (p. 4)

The Advisory Council eventually visited 15 state facilities (not all adult mental health) over an 8-month period and came to recommend that the MDMH contract with private hospitals for in-patient care. Caution so as not to offend other interest groups was

observed in the Mental Health Advisory Council's 1985-86 Annual Report:

The Advisory Council recommends the cautious continuation of the policy of contracting with private hospitals to provide inpatient care for some mentally ill clients in a variety of different communities. This continuation should have as its primary objective the reduction in size of the state hospitals, particularly those in the southern part of the state, and the delivery of a type of care superior to that which can be provided in the state hospitals. (Appendix 2, p. 1)

The Advisory Council continued its efforts into 1986-87. The parties involved had the best of intentions with respect to improving treatment for mental illness, but once again the nemesis of limited funding impeded the realization of this dream. The care of the mentally ill has always lagged behind, primarily because of the costs involved. The Advisory Council continued with its input for new programming, but not without the problem of securing the necessary funds to move forward with hospital improvements. The Council presented its concern in the Mental Health Advisory Council's 1986-87 Annual Report:

The Site Visitation Program functions to improve conditions at facilities and build advocacy groups for the mentally ill. However, the program cannot expand or continue unless a full-time staff person is hired. The Council strongly supported the Site Visitation Program at CVC and NRPH and encouraged the Department to support the expansion of these programs to other facilities. Support should be administrative with no direct financial support provided unless it cannot be obtained elsewhere. . . .

The Council decided to identify successful new and innovative programs in the state's mental health system and sent letters to CMH boards, advocacy groups, and other interested groups. The Council will allow time on the agenda of future meetings for brief presentations of programs. (p. 10)

### The Closing of Mental Institutions

It is difficult to relinquish the old and familiar. No longer do the large mental institutions exhibit the splendor or grandeur that once characterized their physical existence and served to create an environment of care as well as protection. These once-massive buildings have been eroding, as efforts to preserve them continue. The reader should note that none of these vital players have ever advocated complete closure of the state mental hospital complex. Some facilities have either been destined for closure or, indeed, have been closed. This situation sets the tone for the remainder of this research and discussion. Budgetary problems of the mental institutions in Michigan is now presented.

### The Mental Health Budget

The MDMH has published the amounts appropriated for operation during the years 1979 through 1991 (see Table 5). As noted, the costs to maintain Department programming escalated enormously as the Michigan economy declined. Even with huge cuts in services, more money was needed to support the various treatment modalities. A concerted effort to revitalize treatment for the mentally ill was not in keeping with some hard realities.

Mental institutions continued to age, even though renovations were authorized. Personnel functions dramatically changed as state hospitals began to serve more in the role of crisis intervention and

Table 5

**Operating Appropriations, Michigan Department of Mental  
Health, 1979-1991 (Millions of Dollars)**

Year	Michigan General Fund	Other Revenue	Total Budget
1979	\$412.0	\$ 48.0	\$ 459.0
1980	\$494.7	& 72.8	\$ 567.5
1981	\$479.1	\$ 86.4	\$ 565.5
1982	\$548.0	\$ 87.6	\$ 635.6
1983	\$537.7	\$141.9	\$ 679.6
1984	\$596.3	\$145.2	\$ 741.5
1985	\$593.5	\$232.3	\$ 825.8
1986	\$656.5	\$265.0	\$ 921.5
1987	\$707.5	\$309.4	\$1,016.9
1988	\$772.2	\$326.7	\$1,098.9
1989	\$807.6	\$331.9	\$1,139.5
1990	\$878.1	\$366.3	\$1,244.4
1991	\$915.5	\$386.2	\$1,301.6

Source: Michigan Department of Mental Health. (1991b). Fact Sheet. Lansing: Author. (Available from the Michigan Department of Mental Health, Lewis Cass Building, Lansing, MI 48933)

to be less involved with long-term care. To illustrate the exorbitant cost to treat a mentally ill patient, a close examination of the state hospital budget is presented. Beginning with fiscal year 1980 and ending with fiscal year 1989, each state hospital was surveyed according to its budget (see Table 5). According to the budget, the number of full-time-equivalent (FTE) employees and annual number of patients (ANP), the total budget was then divided by the ANP to determine the approximate cost of maintaining the stated number of active patients annually. The budget/ANP ratio is presented in Table 6. A discussion of the findings follows.

The operating appropriations for the period 1979-1991 (Table 5) substantiate the progression of the total mental health budget, with the exception of a slight decrease from 1980 to 1981. The Michigan economy was most notably responsible for this occurrence. Otherwise, substantial increases prevailed for successive years. Policy makers were also cognizant of funding needed for the patient population. Whereas the Michigan general fund was reduced in 1981, 1983, and again in 1985, other revenues aided in making up the balance in order to prevent major reductions. Hence, it is evident that for this decade mental health remained an important priority of state government.

**Table 6**  
**Budget/ANP Ratio for the State of Michigan**  
**Psychiatric Hospitals, 1980-1989**

Year	Budget/ANP Ratio
1980	\$30,783
1981	\$31,769
1982	\$38,813
1983	\$37,875
1984	\$42,147
1985	\$45,520
1986	\$58,217
1987	\$51,538
1988	\$49,278
1989	\$59,215

Source: Michigan Department of Mental Health. (1991b). Fact Sheet. Lansing: Author. (Available from the Michigan Department of Mental Health, Lewis Cass Building, Lansing, MI 48933)

The budget/ANP ratio in Table 6 once again reflects budgetary constraints, as would be expected with any decline in the Michigan economy. The reader should once again keep in mind that it was demonstrated how important it has been for the state government to provide financial support for mental health. A more thorough analysis of the budget will be discussed with respect to the active

inpatient facilities as presented in Appendix N. As for the dollars spent annually per patient, with the exception of 1983, in which year the budget/ANP ratio dropped slightly, and in 1987 and 1988, in which years the ratio fell dramatically, the cost to house and treat the mentally ill in state facilities has risen significantly over this 10-year period.

Curtailling government spending will become an even greater issue as a new consciousness about the economy and social programs permeates our society and government. Advances in medicine will also continue to impact the role of the state mental hospital.

A detailed review of each state facility now warrants examination, as presented in Appendix N.

#### Summary of Annual Costs for the State of Michigan Hospitals, 1980 Through 1989

As indicated, Appendix N serves to provide an accounting of the budget for each active inpatient mental health facility from 1980 through 1989. Meaningful comparisons can be drawn with respect to the various hospitals. However, for the purpose of this discussion, the summation of these descriptive statistics will be elaborated upon and used for further conclusions in this research.

The state hospital budget declined significantly in 1982; this was not the case for the total operating appropriations as presented in Table 5. The number of FTE also decreased at this time. However, the budget/ANP ratio increased significantly, suggesting



that other costs were spiraling. The state hospital budget did modestly increase once again in 1983, but not to the 1981 level, and the operating appropriations were less during this year.

A substantial gain did occur in 1984. Incidentally, there was also a significant number of FTE added to the civil service rolls and without question a major increase in the budget/ANP ratio.

Numerical values can sometimes be quite challenging to comprehend. For example, 1985 witnessed a considerable increase in hospital allocations, although the FTE decreased. The budget/ANP ratio rose slightly, even though there was a slight decline in the operating appropriations.

Evidently, 1986 was a year of optimism and/or worry because the state provided for a very healthy hospital budget and an increase in FTE, resulting in a marked ascent in the budget/ANP ratio. More than likely, inflation accounted for this sudden upturn of events as well.

The budget did come down slightly the following year (1987), but the need for more personnel escalated. Perhaps other areas of service and treatment suffered as a consequence, since the budget/ANP ratio dropped from its previous all-time high.

The 1988 hospital budget was reduced even further from the all-time high in 1986. The same did not hold true for the FTE, though. In addition, the budget/ANP ratio again declined slightly, suggesting a reduction of services elsewhere.

As for 1989, the budget for our institutions called for more appropriations, with no significant increase in personnel; however, the budget/ANP ratio reached its highest level. With the exception of the years cited, the operating appropriations for the MDMH continued to climb, as noted in Table 5.

At times, the government has been hard pressed to provide for adequate hospitalization for mental illness. The demands and challenges have always been present. Perhaps it has been necessary to be a little creative with the mental health budget. Nevertheless, it can be unequivocally stated that those people who have suffered from their mental afflictions have not been forgotten. At least minimal financial resources have been provided. To reiterate, this research was not intended to offer any commentary on the dynamics of mental illness or treatment intervention, only the availability of care and services. To this extent, the State of Michigan has exhibited concern and support for the patient population and all other concerned parties.

#### Summary

It is unfortunate that inpatient treatment is contingent on state revenues. Services of this kind do not generate monies that would realize self-support. Instead, there is a provision of work and the hope of intangible benefits--another kind of value that exists in our society. It has now been substantiated that the mentally ill are a very important segment of our society. The

government and populace have been quite charitable in caring for those individuals residing in our state institutions. Indifference does not characterize our intentions; meaningful alternatives to changing times do offer concern, however. The concluding chapter underscores some of the problems we face as a people and perhaps a new direction that can be pursued.

## CHAPTER VIII

### CONCLUSION: THE FUTURE OF THE STATE MENTAL HOSPITAL

The evidence suggests that the state mental hospital system can no longer justify its own existence, but as of this writing a number of hospitals remain functional at least in housing indigent and severely disturbed individuals. Unfortunately, Michigan political leaders have not ventured to scale down a top-heavy mental health program that has seemingly outlived its usefulness; rather, the objective has been to repair the existing state hospital network. Even the idea of revamping the mental hospital concept has met with little response, as witnessed by the ever-increasing budget to maintain what must now be considered archaic treatment centers.

The MDMH Quality Care Task Force (1988) did attempt to remedy the perceived weaknesses of the state hospitals (see Appendix M). These recommendations are noteworthy; however, to some extent they only served as makeshift solutions. More detail should have been provided, to say the least. Be that as it may, this commission did illustrate the need for change. This concept should not be so easily dismissed; more will be said shortly regarding the need for change. However, the MDMH has not been able to contain costs and streamline its many components. Alternatives need to be addressed. One proposal has been for private hospitals to provide immediate

intervention and state hospitals to care for only the most extreme cases for whom no other options are available.

#### The Staffing Needs Assessment Process-Generated Model

The Staffing Needs Assessment Process (SNAP) is a system intended to ensure that there is an adequate ratio of staff members to the patients they serve. This assessment was applied to the hospital system for the mentally ill, both children and adults. In 1987, the MDMH conducted a survey to assess the extent of direct patient care; the report was concluded in February 1988. Table 7 shows the results of this SNAP survey. The figures would seem to indicate that the patient population has been receiving very close direct care. The MDMH recognized that it was necessary to provide direct patient care, to achieve patients' release from hospitalization. A model program was developed in the hope that this objective would be fulfilled. This model is described as follows (MDMH, Office of Management Services, 1988):

The model was developed through the transactions of an MDMH select committee of clinicians. The committee adopted a set of values which are shown in the model as Typical Program Hours per Client per Week. Those hours are the sum of the weekly time involvement of the typical client in individual, group, and family therapy, rehabilitation therapies of many kinds, mandatory education, and all other individually planned program activities. The other column shows the result of translating the total weekly client hours to one staff to one client time, based on typical staff to client group sizes as observed in the hospitals and centers during field surveys. (p. 31)

Table 7  
Results of SNAP Survey: 1987

Program Title	Typical Program Hours Per Client Per Week	Equated to 1.1 Hours Per Client Per Week
<u>Adult Programs:</u>		
Acute Psychiatry	32.0	7.1
Extended Treatment	27.5	3.9
Geriatric Psychiatry	17.5	2.9

Source: Michigan Department of Mental Health, Office of Management Services. (1988, February). Staffing needs assessment process (SNAP): Report of 1987 surveys, hospitals for the mentally ill and centers for emotionally disturbed children. Lansing: Author.

Statistics on the actual model program are given in Table 8. This program was initiated by the MDMH to provide more intense patient care and to focus on the treatment of mental illness. It was also recognized that patients' needs would vary. Even with this dynamic programming, the patient population at the various state hospitals appears to have grown, rather than returning to the community. The MDMH recognized that much more needed to be done to assist the mentally ill; strong follow-up support was needed for those individuals who could resume independent living in society. In an attempt to meet this need, assertive community treatment (ACT) programs were developed (MDMH, 1988b).

Table 8

**Staffing Needs Assessment Process: Staffing Summary,  
Michigan Adult Hospitals and Children's Centers--  
1987 Surveys**

Adult Programs	Survey Census	100% SNAP Direct Care FTEs	Client to Direct Care Staff Ratios
Caro RMHC-MI	105	147.20	1 to 1.40
Center for Forensic Psychiatry	198	375.95	1 to 1.90
Clinton Valley Center	431	425.41	1 to 0.99
Coldwater RMHC-MI	206	240.80	1 to 1.17
Detroit Psychiatric Institute	155	237.79	1 to 1.53
Kalamazoo RPH	553	625.72	1 to 1.13
Lafayette Clinic	65	77.29	1 to 1.19
Newberry RMHC-MI	57	79.61	1 to 1.40
Northville RPH	857	930.55	1 to 1.09
Walter P. Reuther PH	280	362.45	1 to 1.29
Traverse City RPH	142	182.34	1 to 1.28
Ypsilanti RPH	486	544.20	1 to 1.12
<b>Totals</b>	<b>3,535</b>	<b>4,229.31</b>	<b>1 to 1.20</b>

Source: Michigan Department of Mental Health, Office of Management Services. (1988, February). Staffing needs assessment process (SNAP): Report of 1987 surveys, hospitals for the mentally ill and centers for emotionally disturbed children. Lansing: Author.

### The Assertive Community Treatment Model

MDMH funded the development of 43 assertive community treatment (ACT) programs from 1985 through 1989; 1,114 patients received this treatment (MDMH, 1988b). The intention was to provide comprehensive and integrative mental health services to individuals with ongoing mental illness, in their own locales. Local community mental health boards were to oversee the treatment intervention. Each of the ACT programs was then to submit information on its own program development to the Bureau of Community Mental Health Services (MDMH, 1988b, p. 1).

A review of the data suggests that ACT has been successful in lowering admissions to state mental health hospitals, as well as in reducing the number of days needed for inpatient treatment (MDMH, 1988b):

The average number of total hospital admissions for ACT clients dropped by 53% after the first year of receiving ACT services, and 78% after the third year. These reductions were most significant for admissions to state regional psychiatric facilities, which dropped by 65% in the first year and dropped 90% after the third year. Reductions of admissions to local private hospitals dropped by 33% after the first year and 58% after the third year of ACT services.

The average number of total hospital days per ACT program dropped by 72% after the first year of receiving ACT services and 91% after the third year. Total days spent in state regional psychiatric hospitals dropped by 76% in the first year and 94% after the third year whereas total days in local psychiatric hospitals dropped by 48% after the first year and 76% after the third year. (p. 2)

As for patients' average length of stay, the Narrative Report of ACT Program Development (MDMH, 1988b) indicated:



The average length of hospital stay per ACT program dropped by 36% after the first year of receiving ACT services and by 58% after the third year. The average length of hospital stay per program remained stable and/or increased slightly (in the case of regional psychiatric hospitals) between the first and second year of client involvement with ACT services, but continued to drop again in the third year. The average length of stay in regional psychiatric hospitals dropped by 44% after the first year, and 64% after the third year. Reductions in average length of stay at private psychiatric hospitals dropped by 9% in the first year and 36% after the third year. (p. 3)

According to the Narrative Report (MDMH, 1988b), enough individuals have been enrolled continuously in relation to the program's capacity to treat them. In addition, these patients have been linked to other community services that can enhance their independence. These patients have been helped through crisis intervention, provision of emergency assistance, and services to aid daily living. The MDMH concluded that the ACT intervention has been successful, and it plans to continue using this avenue of treatment (MDMH, 1988b).

### The Group Home Alternative

Group homes are another important means of alleviating the overpopulation of state mental health hospitals, and the MDMH has proposed implementing this form of treatment and living for the mentally ill. In 1979, 200 group homes were opened for a three-year period to accommodate 1,200 developmentally disabled individuals. In the April 1979 issue of Link, the MDMH underscored the importance of group homes: "There is, of course, nothing unusual about group homes. They have been in operation in this state, and many others

for years. Thousands of mentally handicapped persons have found their transition to the community has been eased by a group home" ("Group Homes," 1979, p. 1). Hence, an old idea was revived to modernize the mental health system and decrease the inpatient population.

Group homes have become a permanent fixture in many communities. Initially, the public was skeptical about this type of communal living arrangement, and they worried that their property values would diminish because of proximity to a group home. According to V. A. Stehman, acting director of the MDMH:

I don't believe the majority of Michigan citizens want the state to build more institutions. I think they will support us in implementing this new group home project, but we will have to convince them we'll do a good job, hold up our end of the deal. ("Group Homes," 1979, p. 3)

Because of controversy surrounding the group home concept, the Michigan Supreme Court had to rule on the legality of zoning to permit such facilities to exist in neighborhoods. In an opinion written by Justice Cavanaugh and joined by Chief Justice Williams and Justices Levin, Ryan, Brickley, and Boyle, the right of the mentally ill to live in the community was defended. The following is an excerpt from an opinion rendered in City of Livonia v. the Department of Social Services, and Greentrees Civic Association, Incorporated, v. Pignatiello (1985):

During the latter part of the 1980's the mentally ill were to gain even more support for their right to exist in Michigan neighborhoods. Furthermore, their situation was cited in an executive summary and report prepared by the governor's office

for human services. This was a task force that defined the needs of the mentally ill and homeless. "Life in Transit" provided a bleak description of this population as discussed by the MDMH in March, 1986: "The homeless are a diverse group. Many have multiple problems. As a result, a wide variety of services are necessary to restore the homeless to stable residences and independent living. This includes food and shelter, income support, case management, basic education, vocational preparation and employment opportunities, mental health services and counseling, habilitation and rehabilitation, substance abuse treatment, and medical as well as dental care and nutrition services." (MDMH, 1985, p. 23)

This report made it clear that the homeless and mentally ill need support and that their right to live in dignity has been impaired. A coordinated-service program is essential if these individuals are to rehabilitate themselves. The Task Force observed that implementing such a program is feasible, practical, and, in the long run, cost-beneficial to all Michigan citizens.

As an alternative to institutions, group homes were successful as recently as 1986. The MDMH has reported that many Michigan citizens have benefited from such a transition. Group homes serve people who have a variety of special health care needs but do not require continuous nursing care. The MDMH (1986a) reported that, in 1978, 28 individuals who were primarily mentally retarded or had other developmental disabilities lived in group homes. By 1986, that figure had grown to 1,505. Thus, group homes are increasingly being used to help the mentally ill lead more productive lives in a more natural setting (MDMH, 1986a, p. 1).

In May 1989, the cost for these group homes averaged \$125 per day, which included care within the home as well as the patients'

daily program. The costs for patients in state facilities are significantly higher. Some of the funds for community residential programs are obtained from the residents or their families, private insurance company providers, and local, state, and/or federal government grants (MDMH, 1988a, p. 1).

State government officials have witnessed not only a positive response to the mentally ill, but also the success of moving individuals from institutions to group homes. With this in mind, Governor James Blanchard appropriated an additional \$2 million to expand these services for the mentally ill. "This expansion of services across the state will help attack the problem of homelessness by assisting the homeless who have histories of chronic mental illness," Governor Blanchard stated (State of Michigan, 1988b, p. 1).

#### Contemporary Changes in Hospitalization

MDMH has moved the state hospital system into a support role for those patients requiring structured living. It is essential to provide for the treatment and care of the severely disturbed, and institutions can provide such a service. Changes in the state hospital structure--the physical plant itself, as well as the environment and system for treating the mentally ill--have come under scrutiny by the administration and government. The inpatient traditional methods of treating the mentally ill have been curtailed, with shorter treatment stays. Outpatient treatment has

come to the forefront, and many individuals no longer require long-term institutionalization. The State of Michigan, then, has to question whether the hospitals can furnish a viable therapeutic approach. Costs and benefits must be weighed carefully, and the feasibility of keeping many large institutions open at enormous cost must be addressed.

Some individuals do require admission to a psychiatric hospital, but only if they can benefit from such treatment. Responsible treatment must be provided in an atmosphere that is conducive to the well being of patients.

The costs and benefits involved in alternative methods of treating the mentally ill, especially if state institutions no longer prove to be beneficial, have received increased attention during the past decade.

Should existing programming remain, or should alternative approaches be implemented? This researcher suggests that a new approach to mental health be pursued, bringing economic factors into consideration. No longer can mental health be viewed strictly from a humanitarian perspective. Economic costs and benefits are primary factors to consider before building new hospitals, treating patient populations, or modifying programs. Maintaining the status quo in mental health simply to appease patients, their families, the community, and/or government is no longer realistic.

Before going any further, then, it is necessary to consider the concept of social equity and how it applies to mental health

administration and services provided to the afflicted. The reader will recall in Chapter I the importance of referring to public administration as defined by Chandler and Plano (1988). Does the MDMH continue to exist in its present form, or does a new public administration of mental health revitalize a very complex organization?

### Social Equity

The new public administration was introduced in September 1968 by Dwight Waldo. This new movement has been characterized as a moral conscience, with values, ethics, and personal development being its underpinnings (Chandler & Plano, 1988). Added to the traditional understanding of public administration was the following question: "Does this service enhance social equity?" (Frederickson, 1971, p. 426). Let me expand on and apply this concept to mental health administration.

In essence, social equity is referring to minority groups that are either discriminated against or receive little recognition of their cause and plight by bureaucracies established by pluralistic government (Frederickson, 1971, p. 426). The minority group that is of concern in our discussion is the mentally ill in Michigan.

According to the availability of programs, expenditures, and concern for mental illness, we would have to conclude that the afflicted have not been denied. As Frederickson (1971) stated,

"Social Equity, then, includes activities designed to enhance the political power and economic well-being of these minorities" (p. 426). It has now been documented that, historically, whether we have been providing services to the "insane" or a clinical population, the support has been there. This does not preclude pursuing the style of administration that has existed within the MDMH. Perhaps a new administrative approach to clinical treatment is indicated. Before going any further, though, a discussion of the more recent MDMH administration should be highlighted.

#### The MDMH Approach to State Hospitalization

The MDMH has attempted to streamline its treatment programs, to make them more efficient, but in reality these cutbacks have negatively affected care given the mentally ill. Whereas institutions previously offered treatment programs, state hospitals now primarily provide basic residential care. Very little, if any, treatment can be expected because of the serious decline in personnel, the aging of facilities, and the lack of coordinated support services.

The MDMH's response to unsettling economic conditions has been to move patients out of state hospitals and into community placement programs, but this has not solved the problem. It has only shifted the burden of treatment to smaller programs that have similar or more serious revenue problems. Along with reductions in intensive

treatment, the following cost-containment measures have been implemented:

1. Elimination of all department financial reserves.
2. Reduction in facility support accounts for equipment, maintenance, and patient and staff travel.
3. Maintenance of vacancies for state facility indirect staff (housekeeping, food services, skilled trades, and other indirect categories).
4. Postponement of some previously scheduled staffing improvements.
5. Reduction of central and facility administrative expenses through attrition and freezing of vacant positions.
6. Reduction in special services to patients who are both mentally retarded and emotionally disturbed (referred to as dually diagnosed patients).

Economic costs and benefits have become the primary factors to consider in treating patient populations and providing comprehensive programs. It is essential to note that hospitalization is available for the mentally ill, but there is a lack of dynamic programming--the MDMH has not been in a position to be aggressive or, for that matter, innovative.

Expanding the community home concept and/or having private industry assume the task of treating the mentally ill seem to be attractive treatment alternatives. However, private enterprise would probably implement a number of changes that could prove



unacceptable to long-term mental health professionals. A better approach would be to take advantage of existing resources within the community and to tap into the wealth of knowledge, ideas, and services available.

It is not easy to develop defensible alternatives to long-term institutional care. Legally sponsored committees are essential to represent the interests of the mentally ill. This is not enough, though; new ways of perceiving the problem need to be developed. The fact remains that it takes considerable money to treat the mentally ill, and the benefits of such expenditures might not be readily apparent. It is difficult to evaluate costs and benefits of psychiatric services in Michigan institutions primarily because of the intangibles involved. Unfortunately, it appears that the MDMH has to develop policy according to economics, thus placing the administration in a continued defensive posture.

#### A Further Examination of Public Administration

It behooves the MDMH to adopt the essential aspects of new public administration as a precursor to better management of state hospitals, along with a new approach to the provision of services for mental illness. Frederickson (1971) contended: "Administrators are not neutral. They should be committed to both good management and social equity as values, things to be achieved, or rationales" (p. 426). This also means that there must be a commitment to

"change" as a matter of policy. Frederickson continued: "Simply put, new public administration seeks to change those policies and structures that systematically inhibit social equity" (p. 426). Frederickson was careful to point out that change is necessary for the betterment of minorities, not to simply reinvent the wheel.

The new public administration continually works toward the objectives of "good management, efficiency, economy, and social equity" (Frederickson, 1971, p. 426). The MDMH has attempted to pursue its policies in good faith, but efficiency has certainly been lacking, and considering the age of the state institutions, there have been unnecessary expenditures when it is evident that some facilities could have been closed earlier. Change must be a priority of mental health administration. Whereas the MDMH has recognized the need for a new direction, there has been much hesitancy about executing the conclusions of these investigations.

#### Projected Use of State Mental Health Facilities

The MDMH has authorized feasibility studies to determine the best course to treat mental illness in Michigan in the 1990s and beyond. Giffels Consultants, Inc., of Bloomfield Hills, Michigan; CHI Systems, Inc., of Ann Arbor, Michigan; and NBBJ Rosenfield of New York investigated the Michigan state mental hospital system, and in December 1990 they submitted a feasibility plan for future use of state mental health facilities. Architects, engineers, and health care planners assisted in gathering the data. This group studied

more than 600 buildings that came under the auspices of the MDMH. Their conclusions follow.

The recommended changes were to be completed over a five-year period at the cost of \$277 million. A bond issue was suggested as a means of financing this project. The final recommendations, as reported in the MDMH News Briefs (MDMH, 1991a), were as follows:

The Mental Health Department's projection of a decline in the need for mental health beds through 1995 was confirmed.

Existing bed capacity is greater than currently required by the state.

Cost of renovating existing buildings to meet criteria established for the new prototype psychiatric hospital exceeds the cost of new construction.

Projected capital outlay costs needed to maintain buildings at current levels for the next five years total \$179 million.

A prototype psychiatric hospital to replace the aging Clinton Valley Center in Pontiac should be built at a cost of \$55 million.

The Ypsilanti Regional Psychiatric Hospital complex should be phased out if certain other conditions are met.

The Muskegon Regional Center should be phased out.

Facilities serving emotionally disturbed children should be consolidated. As part of the process, the Arnell Engstrom facility in Traverse City and Pheasant Ridge Center in Kalama-zoo should be considered for privatization while the York Woods Center in Ypsilanti should be phased out.

Two separate hospitals should be created at the current site of Northville Regional Psychiatric Hospital.

Oakdale Regional Center in Lapeer should be considered for alternative mental health use or should be converted for other use, possibly by another state agency.

The study projects substantial operating savings as a result of moving to a modern physical plant. These savings could be used to offset construction and renovation costs. The authors also recommended that funds from sale of surplus mental health property be used to offset construction costs. (p. 1)

Additional construction of prototype hospitals would be initiated as the second phase of the conversion project. The following projected figures were used to support this part of the recommendation:

The consulting team said that in five years, Michigan will require capacity for 2,500 adult psychiatric patients, and an additional capacity for 400 children and adolescents. The latter number could be reduced by contracting and/or support of certain community-based services. The report estimated that in five years, 500 beds will remain in centers for persons with developmental disabilities.

If the plan is adopted, service districts throughout the state would change, in keeping with the new physical plant capacities.

"Many of the recommendations address issues initially raised by the department's Quality Care Task Force two years ago," said Watkins. "It is the supreme irony that we are issuing a report calling for substantial capital outlay expenditures at the same time the state is calling for budget reductions."

"This proposal defines the changes we need to make in physical plant and service arrangements to meet needs of the coming decade. We owe it to our clients to provide services in decent, safe surroundings," said Watkins. (MDMH, 1991a, p. 1)

The MDMH was exhorted to consider acting upon the recommendations of these investigators, but there was never any commitment to do so.

### The Dismal Nature of the State Mental Health Hospital

Maintaining the status quo of the state mental health system is counterproductive. Strong administrative leadership is required to

pursue a new direction. The Michigan economy can no longer endure the provision of mental health services with such an outdated system. If necessary, private hospitals may be required to assume a greater responsibility for treating mental health patients; it is essential that these individuals receive effective and comprehensive services. Michigan once was able to provide adequate intervention; this is no longer possible because programs are not coordinated with one another and there has been a breakdown of treatment. Goffman (1961) recognized not only the limitations of state mental health hospitals, but also the inadequacy of the overall program network:

We must see the mental hospital in the recent historical context in which it developed, as one among a network of institutions designed to provide a residence for various categories of socially troublesome people. . . . Every state hospital has an appreciable fraction of patients who might better be contained in some one of these other institutions. . . but who must be retained because no space is available, or can be afforded, in these other institutions. Each time the mental hospital functions as a holding station, within a network of such stations, for dealing with public charges, the service model is disaffirmed. All of these facts of patient recruitment are part of what staff must overlook, rationalize, gloss over about their place of service. (p. 354)

Goffman (1961) also referred to the negative consequences of hospitalization:

In response to his stigmatization and to the sensed deprivation that occurs when he enters the hospital, the inmate frequently develops some alienation from civil society, sometimes expressed by an unwillingness to leave the hospital. This alienation can develop regardless of the type of disorder for which the patient was committed, constituting a side effect of hospitalization that frequently has more significance for the patient and his personal circle than do his original difficulties. Here again we deal with something that does not fit the service model. (pp. 355-356)

Many factors affect whether hospitalization of the mentally ill has a positive outcome. It is not enough to simply care for individuals until they stabilize mentally; hospitalization must work for mentally ill patients in the same way it does for those afflicted with medical problems. Patients in state mental institutions should be there only if they can receive quality treatment and reimburse the state for their care. Financial compensation could be handled through a contractual relationship between the patient and the State of Michigan, or through private pay, federal funding, or third-party payment such as by an insurance carrier.

Goffman (1961) described an ineffective hospital environment. Although he was discussing treatment three decades ago, there have been no dramatic improvements in Michigan's mental health program in the intervening years. He wrote:

The period in the mental hospital is a difficult one for the patient to assimilate to the medical model. A very standard complaint is: "Nothing is being done with me--I'm just left to sit." And corresponding to this difficulty is the fact that current official psychiatric treatment for functional disorders does not, in itself, provide a probability of success great enough easily to justify the practice of institutional psychiatry as an expert service occupation, as here defined, especially since the probability that hospitalization will damage the life chances of the individual is, as already suggested, positive and high. (p. 362)

#### The Need for a Concerted Effort

Heretofore, this discussion has singled out the mental health administration as being responsible for inadequacies in the state

hospital system. The other arms of government must share the burden of this monumental problem as well. Even public and private advocates of the mentally ill cannot escape scrutiny. There has not been any strong leadership to generate change in the dynamics or functioning of Michigan's mental health hospitals. Let us not forget that the civil service bureaucracy has to be willing to rethink its own position in providing care and treatment to this helpless population. Without question, many interested parties have been lackadaisical in providing the spirit of constructive change.

No matter who is held accountable, the MDMH comes to mind as failing to exert strong leadership in serving the state institutions. There has not been the vision required to promote change with "programming-planning-budgeting systems, executive inventories, and social indicators . . . as enhancing change in the direction of social equity" (Frederickson, 1971, p. 427). Mental health administration must lobby the State Legislature in its quest for social equity. The judiciary needs to be kept abreast of the changes needed to enhance the well being of the mentally ill. Interest groups and advocates of this minority should be invited to participate in meaningful discussions and planning for change. If the current mental health administration is to become an inspiring new public administration seeking social equity, it must rally "support for its clientele" (Frederickson, 1971, p. 427).

For many years, state mental hospitals have not been able to influence change for the patient population either clinically or administratively. The system has come to a virtual standstill, with little meaningful activity save for housing patients and perhaps providing a safer community.

If the state hospitals are to continue, their role must be clearly defined; there should be no pretense about the services that can be provided. If crisis intervention is required, involving observation, assessment, and medication, then hospitalization for mental illness should be defined in that regard. State hospital administrators must speak up and endorse a united objective. The executive branch of government and the state legislature need to address the issue of revamping the mental health system. Cost effectiveness is of considerable importance; the rights and treatment of mental health patients are even more critical. The judiciary should oversee the legal concerns to ensure that patients' rights are not violated and that individuals needing care are afforded this opportunity or referred to a more appropriate treatment center.

Many of Michigan's mental hospitals have outlived their usefulness. Mentally ill individuals can be helped with brief hospitalization, followed by quality aftercare. The State of Michigan mental health care now must move in a new direction.



### From Institution to the Community

Frederickson (1971) endorsed new public administration working toward change by establishing alternatives to the challenges it faces. The new public administrator in mental health will be required to greatly modify the mental institution or design new facilities in an endeavor to resolve long-term problems of institutional intervention. An incremental approach will need to be initiated with any new pursuits.

Coincidentally, in 1971, B. A. Weisbrod, Professor of Economics at the University of Wisconsin-Madison, went into the local community in order to enhance the life style of a minority--the mentally ill. A brief review of his novel research is now presented.

### The Weisbrod Proposal

Weisbrod (1971) postulated an alternative to traditional mental health treatment. Using cost-benefit analysis, he compared two groups, one receiving traditional hospital-based treatment and the other a nontraditional community-based treatment. It must be kept in mind that it is difficult to account for all costs and benefits quantitatively; some values have to be approximated, and other factors need to be weighted. Weisbrod's economic approach to assessing treatment of the mentally ill offers an alternative in

terms of the financing of treatment, as well as a new perspective on mental health intervention.

Weisbrod (1971) discussed the intricacies of treating mental illness. He defined the various concepts in economic terms, operationalizing the treatment of the mentally ill as follows:

Increased earnings from work, other indicators of performance on the job, consumer expenditure behavior that reflects greater planning, patient's own reported satisfaction, decreased clinical symptomology of patients, increased patient social involvement. (p. 523)

Weisbrod (1971) did not imply that the above-mentioned factors can be measured or compared with one another. He also noted that institutionalization may not really be a cost saver; rather, it might merely represent a shift of funds from one treatment orientation to another. Perhaps it will be more cost-effective to treat the mentally ill in the community, rather than placing them in institutions. Weisbrod also advised that mentally ill patients need to assume at least some of the responsibility for the cost of their treatment as they live in the community, work there, and receive therapy. This is the most unique characteristic of his treatment model.

#### Weisbrod's Experimental Design

In his research, Weisbrod (1971) compared patients in a hospital-based treatment group, which served as his control group, with those in a community-based experimental program. Both groups

contained 65 individuals. According to Weisbrod, the advantages of the experimental program were as follows:

1. Hospitalization was virtually eliminated, or at least minimized.

2. Staff members worked with patients in their neighborhoods, residences, and places of employment, providing support and teaching the coping skills necessary to maintain a satisfactory community adjustment.

3. The staff attempted to minimize the number of patients dropping out of treatment prematurely and to maximize their engagement in jobs and other aspects of responsible, independent community living (p. 524).

#### Weisbrod's Conclusion

The primary emphasis in treating the patient population with this new approach was to use resources available in the community. From an economic standpoint, this new approach made patients' support staff more cognizant of the costs involved, and the patients themselves began to develop a greater social awareness.

Patients in both groups were seeking admission to the Mendota Mental Health Institute in Madison, Wisconsin. The experimental group did not receive any hospitalization except when intensive drug therapy was necessary. As part of their treatment, they were to experience community living for approximately 14 months, and afterwards live on their own without any further treatment

intervention. Weisbrod's (1971) data consisted of participants' answers to questions he asked them over a 14-month period. Weisbrod sought to demonstrate significant behavioral changes in patients by approaching treatment from a cost-containment perspective. He did realize beneficial results. The findings supported the hypothesis that institutionalization of the mentally ill is less effective than community-based treatment. It is more costly to care for mental affliction, and the benefits are not as apparent when institutional care is provided. Gloom settles over the environment in a mental health hospital. A self-fulfilling prophecy permeates the atmosphere for both patients and staff to experience. The former cannot escape, whereas the latter do find some relief as their existence in this type of surrounding is not ongoing, with no hope for the future.

Community living not only reduces costs, but patients are acclimated to a more natural life style, with a more enhanced self-concept and hope for the future. Professional staff members also receive reinforcement in knowing that they have influenced another person's life and that they have provided an incentive for their patients to pursue a healthier state of mind and even assume some risks toward independence.

#### Time for Change

When society did not comprehend behavioral anomalies, it was understandable to place the afflicted in asylums. Care was then

provided, but equally significant was the removal of those people who caused embarrassment. Families who could not afford to financially care for a family member who was ill did find a viable alternative to their burden. Relief was almost a godsend. Our understanding of mental illness has progressed considerably, though. Contemporary treatment allows many individuals diagnosed with mental or emotional conflict to function in society, albeit with some structure and support. The expectations of community-based living beget a more "normal" approach to life. No longer is institutional care a prerequisite to mental healing. Traditional attitudes toward mental health care must now catch up with more realistic approaches to treatment that have actually been available for some time. New public administration and community-based living most definitely can establish an everlasting bond. Many years have elapsed since the populace found it necessary to confine the mentally ill. The need for this approach was paramount. Now the same holds true for community-based living. Not all of our mental institutions need to be razed. We do need them for the severely impaired and for crisis intervention; however, cost-effectiveness is a critical issue. Let us conclude this century-and-a-half journey and look toward a new and more promising era in the evolution of mental health.

#### A Polemic for a Return to Community Living

Unless people have experienced the abyss of mental illness, they can only surmise the dynamics of despair with no awareness of

relief or hope for tomorrow. When mental illness was perceived as deviant behavior, witchcraft, and being possessed by evil, this outcast of society was embraced by the few but important members of the community. With care and compassion, a vanguard of a new cause, custodial care for the "insane," emerged as a force to be taken quite seriously. Not only did the citizens of specific localities combine their resources, they ensured that this movement would continue and that improvement in daily care for this unfortunate group of people would also prevail.

Gradually, a cause became a loosely formed organization. A leadership was born on different levels and on different fronts. The "insane" were not alone, even if they did exist as such. This new leadership provided support and reassurance for family and friends. Neighborhoods benefited not only in lessening potential ferment, but also in acknowledging a sense of good will.

The new leadership and concerted effort eventually gave birth to the "insane asylum," a rather grotesque rubric indeed. With the formulation of institutional administrations, it was not that long before a singular department in mental health and for the State of Michigan came into being. This new leadership became a powerful champion in a quest to serve mental illness, which, by the way, was not considered to be a disease of the mind. The new administration solicited the needed support from the state legislature, and the judicial branch of state government became the guarantor of human

rights. Citizen groups lent their support as a most noble cause further blossomed. There is no accounting of how many benefited from this massive input to treat the afflicted. We do know that this outpouring of a charitable community has been worth the effort, until recently. Since the oil embargo of the early 1970s, the state economy has experienced some severe shock waves, suggesting that our budget can no longer shoulder so noble a cause, not as in the past. Such a helpless minority must not be abandoned; however, to continue the waste on an archaic hospital system is inexcusable.

There are too many outmoded buildings, patients linger within these facilities, and there is only minimal restoration of compatible behavior with societal norms. The commissioning of a task force by the MDMH has substantiated the meager existence of the mentally ill. The mental health budget documents the financial support provided by state government. All parties involved are seemingly immobile in an endeavor to revamp the hospital complex that is now in its nadir.

The financing of mental health treatment will undoubtedly always be there, but at a price we cannot afford. Human dignity is another concern. Why should we as a people continue to cosign a state hospital program that does not advocate behavioral change, independence, enhanced self-esteem, hope for the future? We should all be aware that all of us are suffering a tremendous loss as we witness the plight of an ever-increasing patient population. Of course, brief psychotherapies, psychotropic medications, and support

systems offer some relief of a monumental social problem, but little else is realized. Those of us who look askance at what is required to revitalize an antiquated mental health program recognize that this hardship touches the life of every citizen. What, then, is the answer to a most troubled state of mental health affairs?

As noted previously, strong leadership must be exercised if there is to be a new direction for the mental health minority. Let me digress for a moment. To refer to the patient population using an unflattering label only serves to accentuate a negative self-concept, suggesting that a tormented mind has no alternative but to succumb to the dictates of institutionalized living. If we are to expect more from this clinical population, let us describe them as human beings deserving of a more enriching life even if there is a dependency on the state for survival. Surely we have come this far to grant this minority a healthier place in our hearts--so be it! As for new public administration, it can only come forth from the present MDMH, as alluded to earlier in this research.

#### New Public Administration in Mental Health-- Vehicle for Social Equity

We have come to the final chapter of the state institution--not its demise, but a considerable scaling down of purpose and role. If the private sector assumes greater responsibility for inpatient care, state hospitals operated by the MDMH will be relegated to a lesser status. The state mental health administration must give



thought to an inevitable reconstruction of hospital care. If this governmental organization is to influence policy, an audacious approach toward patient treatment must be initiated through innovative planning.

This study has underscored the need for new public administration to fill the void and assume the leadership required to promote change on behalf of the mental health minority. While an incremental approach may be indicated, there is a vital need by state mental health administrators to more aggressively advocate for the mentally ill and their families. After all, the MDMH is a trustee of the public good and therefore must confront the powers that be if their constituency is to be more than adequately served. Whereas classical public administrators have written comprehensive policies and procedures, it has been traditional to stay within expected guidelines of their era and not to deviate from the expected.

Recognition of the inadequacies facing mental health in Michigan has been clearly defined. The difficulty will be for the current leadership to acknowledge past failures and adopt a new orientation by aligning itself with the mental health minority. All possible consequences should be cast aside. The opposition should not matter. Once this position is established, new public administration can initiate objectives that will plot a more beneficial direction. Apprehensions will remain, although change

that promotes social equity should enhance the renewed commitment. Of significance is the recognition for change in behalf of inpatient treatment. The various branches of government will either acquiesce or enthusiastically endorse this concept. They would be hard pressed not to do so. This charting of new waters will invite confusion, errors in judgment, and conflict--what a refreshing atmosphere compared to the mind-set that has ingrained mental health policy for so many years. A new journey is to commence, and it is the responsibility of the current mental health administration to coordinate such a grand undertaking. Exploration of the alternatives is now possible. Rule out the private sector.

It would be easy for the MDMH to adopt a conciliatory posture, given budget constraints and a faltering state hospital program, and refer to private hospitals and clinics; however, this would abrogate the public trust set forth long ago. Michigan mental health services are entrenched within our communities, and they should remain. To dismantle this tradition of aiding the lost souls in our neighborhoods would be inhumane and a travesty of justice as well. A supportive role from private hospitals and their affiliates should be welcomed by the MDMH, but the latter should not relinquish its authority over mental health. Hence, the rehabilitation of institutional intervention and community treatment should be the focal point of new public administration in Lansing, Michigan.

### Revamping the Aging Hospital Program

It is not necessary for the state government to own and operate so many inpatient facilities. There could be a substantial savings by combining resources such as physical plants, manpower, actually everything that is affiliated with any of the major state hospitals. Establishing mental health regions strategically located in the state, with vital linkage to a comprehensive mental health center, would be ideal. Daily living centers, supportive outpatient clinics, and ancillary services working in conjunction with one another could form an influential community-based program; a state hospital would be inclusive. Personnel on all levels of this massive operation should partake in both the planning and implementation of this new approach to mental health treatment. This would ensure that our minority came under the auspices of many concerned people and not just a board or task force.

The enormity of such a task might preclude any administration from overhauling the current mental health organization. Eventually it is going to disintegrate; then what happens? To be sure, this is only the genesis, so to elaborate any further carries us beyond the scope of this research. The debate of the state mental health hospital will continue without question. The last word on the matter has yet to be uttered.

For now, there are constituent elements that must not be neglected any longer:

1. Accentuate the civil liberties of patients and seek means to protect against any violation by others toward the mentally ill.

2. Reeducate the public about mental illness so as to foster a greater understanding and acceptance of group homes and modern mental health facilities.

3. Make available the necessary revenues to support a more comprehensive but also dynamic mental health department.

4. Develop better treatment facilities and interventions that will assist the patient population in Michigan.

5. Identify financial assistance and support for daily living activities and make this available to the mentally ill.

We are ready for dramatic change with the adoption of community-based living for the mentally ill. Intermediate hospitalization should be used only when absolutely necessary. Hospital admission policies must be clearly defined. It is hoped that further research will authenticate this position and lead to additional constituent elements.

New public administration leadership by the MDMH is now required to defend a helpless minority from drifting toward oblivion. Compassion for this group of people must be the thread that weaves together mental health policy. Leadership that challenges bureaucracy and indifference, most assuredly obstacles to the mental health movement in state government, not only serves a special interest, it embraces the public good.

## **Appendix A**

### **Chronology of Central Office Administration of the Department of Mental Health**

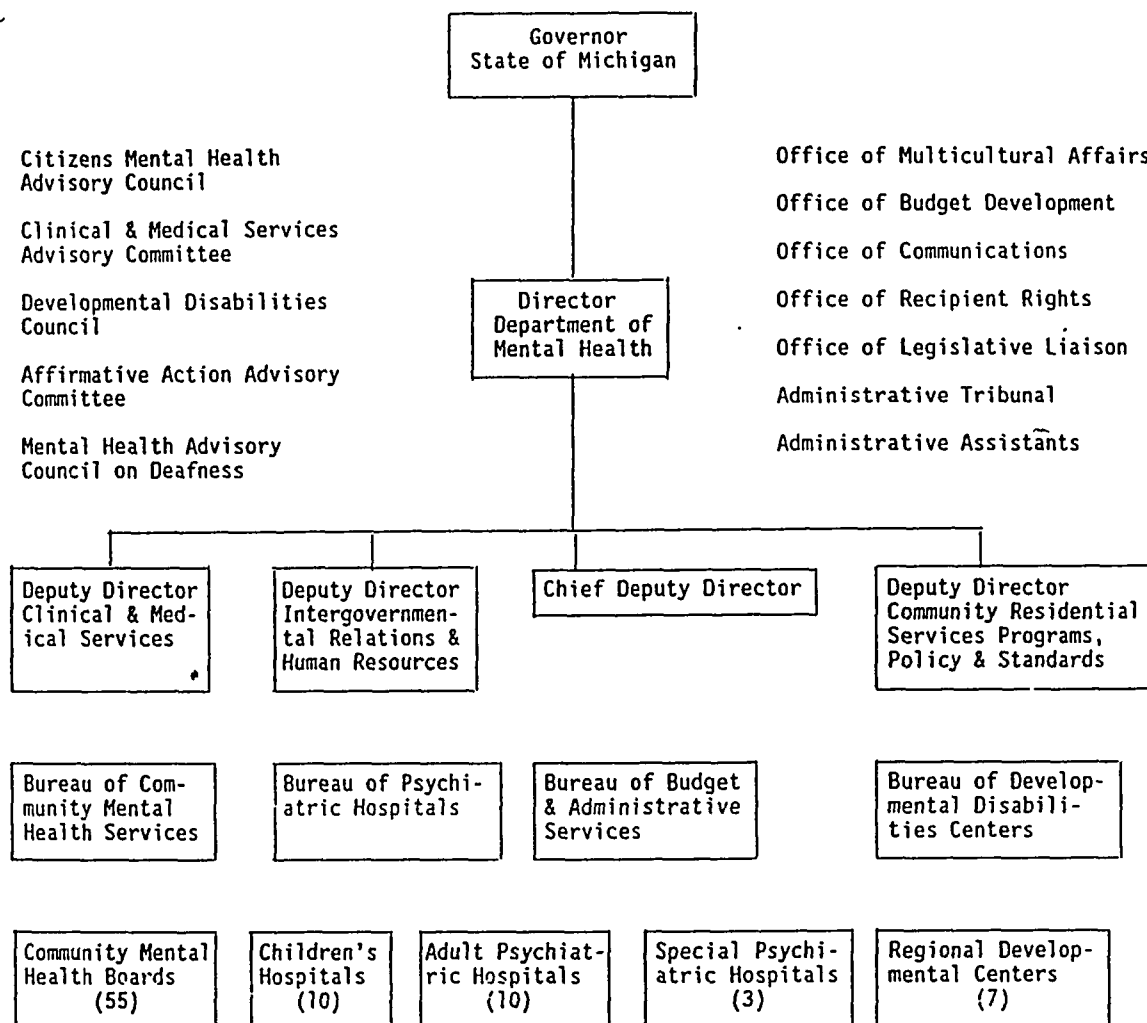
Michigan had no central agency equipped to give direction or supervision to its state mental health program prior to November 1937. In that year the Legislature established the first separate state mental health agency known as the State Hospital Commission. This Commission was given complete authority and responsibility for the operation of the state mental hospitals and was authorized to employ staff as required. For the first time in the state's history a Central Department of Mental Health was established on a state level.

The first Director of State Hospitals, Dr. Joseph E. Barrett, was appointed November 10, 1937. Dr. Barrett resigned in February 1939 as a result of a change in the statutes which abolished the position of Director of State Hospitals and created the position of Executive Secretary. The new staff arrangement became effective in March 1939, and Mr. Charles F. Wagg was appointed to the position of Executive Secretary on March 1, 1939. Additional staff was acquired and a central department, guiding and directing the state mental health program, was developed.

The next major change came in 1945 when the State Hospital Commission was abolished and the present Department of Mental Health created. The new law became effective in September 1945, and at that time the statutory provisions for Director of Mental Health required that the position be filled by a psychiatrist. Mr. Charles F. Wagg was appointed Acting Director and served until March 1, 1946, when Dr. Charles A. Zeller was appointed Director. Dr. Zeller resigned after sixteen months effective July 31, 1947, and Mr. Wagg was again appointed Acting Director. As of January 1, 1948, Dr. R. L. Dixon, Superintendent of the Caro State Hospital, was appointed part-time Acting Director, while at the same time retaining his position as Superintendent. The Legislature changed the statute governing qualifications for the Director in 1949, providing that an administrator with ten years of experience in the administration of mental health programs could serve as Director. This change became effective June 7, 1949, with Charles T. Wagg being appointed director.

Source: Michigan Department of Mental Health. (1962). Development and Growth of Michigan's Mental Health Program. Lansing: Author.

**Appendix B**  
**Organization of the Michigan Department of Mental Health**



Source: Michigan Department of Mental Health. (1987). Department of Mental Health fact sheet. Lansing: Author.



**Appendix C**  
**Accreditation/Certification Status for**  
**Each Michigan State Hospital**

**Accreditation/Certification Status for the State of Michigan  
Institutions Servicing Adult Mental Illness (1988)**

Hospital	Joint Commission on Hospital Accreditation (JCAH) Status	Medicaid/Medicare Certification Expiration Date
Caro Regional Mental Health Center--Psychiat- ric Services Unit	Accredited	11/30/87
Clinton Valley Center	Nonaccredited	Nonaccredited
Coldwater Regional Mental Health Center	Will by applying for accreditation	Will be applying for accreditation
Detroit Psychiatric Institute	Accredited	9/30/87
Kalamazoo Regional Psychiatric Hospital	Accredited	Nonaccredited
Newberry Regional Mental Health Center	Accredited	11/30/87
Northville Regional Psychiatric Hospital	Nonaccredited	Nonaccredited
Traverse City Regional Psychiatric Hospital	Accredited	Nonaccredited
Walter Reuther Psychi- atric Hospital	Will by applying for accreditation	Nonaccredited
Ypsilanti Regional Psychiatric Hospital	Accredited	Nonaccredited

Source: Michigan Department of Mental Health. (1988a). Department of Mental Health Fact Sheet. Lansing: Author.

## Appendix D

Report of the Select Panel on Abuse in  
Michigan Mental Health Institutions,  
April 1978 (A Summary)

In November, 1977, the Department of Mental Health named a Select Panel on Abuse, chaired by Ray Bishop, to focus attention on the prevention of resident abuse in all State facilities and to make recommendations for Department action. The Select Panel submitted their report in April, 1978.

On February 24, 1978, the Governor outlined a 13-step program designed to eliminate patient abuse in State mental health facilities. One point required the establishment of a special three-member task force, directed by Dr. Smith, then Director of the Department of Mental Health, to clear up pending and future complaints at the Plymouth Regional Center for Developmental Disabilities. Other members of the Task Force were representatives of the Departments of State Police and Social Services. Upon the appointment of Dr. Stehman as Acting Director of the Department, a Governor's Task Force on Prevention and Investigation of Abuse in State Institutions was formed, chaired by Professor Wilbur J. Cohen. The major Department Directors were transferred to this Task Force and the composition of the original three-member task force was altered to establish an investigating team that reported to the Cohen Task Force. The Final Report of the Governor's Task Force on Prevention and Investigation of Abuse in State Institutions was issued on July 20, 1978.

The Select Panel Report issued in April, 1978, recommended new definitions for abuse and neglect and included 112 recommendations intended to improve the Department's response to injury and suspected abuse and to reduce the occurrence of abuse and neglect. The majority of the Panel's recommendations were adopted by the Department as policy on May 15, 1978, with a directive that there be full adoption of the Panel's procedures effective August 15, 1978.

A 3-month period was self-imposed to establish appropriate procedures, develop budgets and set administrative structures in place.

In May, 1978, due to the interrelationship between the Bishop Report and the Governor's 13-point directive, the Department's reports to the Governor combined the recommendations and developed a matrix that indicated the relationship of each of the 112 recommendations to the 13-point directive. The Governor's Task Force Report of July 20, 1978, is highly interrelated to the Select Panel's recommendations as well. This status report format reflects the above relationships. We have used the Select Panel's 112 recommendations as the basic structure for staff work and reporting. Additional recommendations of the Governor's Task Force Report have been included in this report following the report on the Select Panel recommendations.

**Appendix E**  
**Description of the Michigan Department of Mental Health**

The goal of Michigan's mental health programs continues to be to respond to the needs of our state's developmentally disabled and mentally ill citizens through a continuum of care, which includes basic care where necessary; programming and therapy; and, which assures services appropriate to all age categories and ranges of dysfunction. The goal also includes providing these services in the least restrictive, appropriate setting, with quality treatment and services administered effectively with cost-efficient service delivery.

The fiscal year 1988 budget recommendations allow the state to make further progress in bringing state mental hospitals into conformance with quality care standards. Included is a funding commitment for community mental health programs, the backbone of Michigan's community-based approach to caring for mentally ill and developmentally disabled citizens. Community mental health services are provided by 55 community mental health boards serving the 83 counties in the state. The entire community mental health program is a contractual arrangement between the state and community mental health boards. The boards, in turn, subcontract many of their services. Even with the focus on community-based care alternatives, Michigan must still maintain mental health institutions for those citizens requiring intensive treatment and constant supervision.

The budget supports the operation of 21 facilities for the treatment of the mentally ill and developmentally disabled persons. Included are ten regional facilities for mentally ill adults; five facilities and one specialized program for mentally ill children; seven regional centers for the developmentally disabled; one specialized clinic for research and training, which treats mentally ill adults and children; and one center for the examination, diagnosis, and treatment of individuals who are or have been under criminal indictment. Since 1979 the state has closed six facilities. As a result of the community placement efforts and expanded community mental health programs, many patients can receive effective treatment with institutionalization.

In addition to overseeing the operation of community mental health services and operating facilities, the department also operates specialized programs such as the Family Support Subsidy program, which assists families who care for autistic or developmentally disabled children in their own homes rather than in institutions.

Mental health services are provided to Michigan residents under provisions of the Mental Health Code, Act 258 of 1974. These services are administered by the Department of Mental Health, whose director is appointed by the Governor, with the advice and consent of the Senate. Both the State Advisory Council on Mental Health

Services and the Mental Health Advisory Council on Services to the Deaf are appointed by the Governor. These councils review mental health policy and make recommendations to the director, the Governor, and the Legislature.

The department has completed the review of its programs to identify programs which could be done through a contract by a non-state government firm or agency, in accordance with section 141 of Act 431 of 1984, the Management and Budget Act. For the past several years the Department of Mental Health has been moving increasingly to contractual services instead of direct state delivered services. Examples of these contractual services are in the following categories: community-based contractual services for residential care and programming; contracted medical services for clients who are residents of state facilities as opposed to state-delivered services; contractual laundry services for state facilities and other maintenance support services formerly performed by state employees; contractual specialty medical/clinical professional services at state facilities; contractual acute inpatient psychiatric care as opposed to state facilities care; and the shift of the psychiatric residency program to a contractual program.

#### Description

This appropriation section supports the administrative and management structure of the Department of Mental Health by funding the department's Central Office and all similar administrative positions at all state facilities. Administratively, the department is charged with assuring that "adequate and appropriate mental health services are available to all citizens of the state."

Programmatically, to assure accountability in the service provision system, the department is responsible for:

- planning to identify, assess, and enunciate the mental health needs of the state;
- developing and establishing arrangements for the effective coordination and integration of all public mental health services;
- monitoring and evaluating the relevance, quality, effectiveness, and efficiency of all public mental health services provided; and
- carrying out licensing-certification responsibilities consistent with requirements of the Mental Health Code.

Administratively, the Department of Mental Health is responsible for:

- assuring that standard accounting and administrative requirements are met;

- program management, including state-administered services;
- personnel services, including training programs, to employees of the department;
- providing information on state and local mental health programs and services; and
- analyzing proposed legislation affecting the department and developing legislative proposals regarding mental health services.

This unit also provides a special appropriation that allows the department to accept and spend unanticipated specific-purpose federal funds which do not obligate the state for GF-GP expenditures. Funding for the State Advisory Council on Mental Health Services expenses as well as per diem allowances for the council are included in this unit. This unit also includes the internal audit function required by Act 272 of 1986. Because that act was passed after preparation of the fiscal year 1988 management plan, the department will identify by April 1, 1987, whatever transfer of positions and resources is necessary to fulfill the requirements of the act.

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Institutional Programs  
     Worker's Compensation  
     Institutional Services



# State Psychiatric Hospitals for Mentally Ill Adults

Central Account--Mentally Ill Adults  
 Caro Regional Mental Health Center--Psychiatric Services Unit  
 Clinton Valley Center  
 Coldwater Mental Health Center  
 Detroit Psychiatric Institute  
 Kalamazoo Regional Psychiatric Hospital  
 Newberry Regional Mental Health Center--Psychiatric Unit  
 Northville Regional Psychiatric Hospital  
 Reuther Facility  
 Traverse City Regional Psychiatric Hospital  
 Ypsilanti Regional Psychiatric Hospital

# State Psychiatric Hospitals for Mentally Ill Children

Central Account--Mentally Ill Children  
 Arnell Engstrom School at Traverse City  
 Detroit Psychiatric Institute--Children's Program  
 Fairlawn Center at Clinton Valley Center  
 Hawthorn Center  
 Pheasant Ridge Children's Center at Kalamazoo  
 York Woods Center at Ypsilanti Psychiatric Hospital  
 Special Services to Juvenile Offenders

# State Facility Reduction for Mentally Ill Adults and Children

## Special Facilities for the Mentally Ill

Central Account--Special Facilities Center for Forensic Psychiatry  
 Lafayette Clinic

# State Centers for the Developmentally Disabled

Central Account--Centers for the Developmentally Disabled  
 Caro Regional Mental Health Center  
 Joseph M. Snyder Macomb-Oakland Regional Center  
 Mount Pleasant Center  
 Muskegon Regional Center  
 Newberry Regional Mental Health Center  
 Oakdale Regional Center  
 Southgate Regional Center  
 Wayne Community Living Services  
 Plymouth Center Maintenance

# Sec. 116 Inpatient Care and Alternative Programs

## Employment Reduction

## Revenue and Expenditure Adjustment

Source: State of Michigan. (1980). Executive budget: Fiscal year 1980 (William G. Milliken, Governor). Lansing: Author.

## **Appendix F**

### **Report of Special Committee Appointed to Visit the Insane Asylum at Kalamazoo (Supporting Appropriations)**

Having briefly presented our views in regard to the building itself, we come now to consider "the propriety and necessity of the appropriation asked for by the Board of Trustees;" and the first inquiry to be answered is, does the State need such an institution? Upon this point we have very little to say. In all civilized countries, it is admitted to be the duty of the State to provide a suitable place for the treatment and cure of that most unfortunate, hopeless and helpless of all the human race, the insane.

Twenty-three years has Michigan been a State, and there is now no place within her limits where one of her four hundred and fifty insane, three hundred of whom are known to be proper subjects for Asylum treatment, can go with any certainty of kind treatment or proper care. Unless they are removed from the State, as most of them cannot be, there can be no hope of cure for them, and their case is not only hopeless, so far as regards themselves, but they are always the cause of deep anxiety, and often danger to their friends.

Too long has this matter been delayed already, and yet if the amount asked for be granted and expended, the building will then accomodate [sic] less than half the number that need immediate treatment.

It cannot be necessary to multiply reasons, or to resort to argument, where the honor of the State is so deply [sic] concerned.

The next inquiry is, will the appropriation, if made, be honestly and judiciously expended?

We believe up to this time there is no cause of complaint in this regard. From our own observation, and the best information we were able to obtain, we are satisfied that the appropriations so far have been well expended, and that there has been neither waste or extravagance allowed by the present or former Board of Trustees.

Taking into consideration the high prices that have prevailed for provisions, labor and material, during the most of the time the work has been in progress, it is gratifying to find that so much has been accomplished. . . .

There remains, then, one simple question to be considered -- will the people of the State bear to be taxed to complete this institution, and will they consent to pay a liberal portion of that tax within the next two years? . . .

Every motive of economy then, as well as the dictates of humanity, require the vigorous construction and speedy completion of the Asylum for the Insane at Kalamazoo, and your committee respectfully recommend that the amount asked for by the Trustees of the Institution be granted for that purpose. (State of Michigan, House of Representatives, 1859, pp. 3-4, 6)

## **Appendix G**

### **Mental Health Acts or Partial Acts That Were Repealed With the Mental Health Code of 1974**

Sec. 1106. The following acts and parts of acts, as amended, are repealed:

(a) Public Acts:

Public Act Number	Year of Act	Section Number	Compiled Law Number (1970)
380	1965	404	16.504
111	1961		325.175
271	1945		330.1 to 330.3
151	1923		330.11 to 330.71
270	1965		330.81 to 330.86
229	1956		330.91 to 330.94
7	1901		330.101
129	1945		330.161 to 330.166
223	1947		330.171 to 330.175
39	1935		330.181 to 330.183
48	1949		330.191 to 330.194
231	1923		330.201 to 330.202
392	1921		330.251 to 330.255
148	1957		330.261
148	1927		330.301 to 330.305
85	1937		330.401 to 330.407
217	1954		330.421 to 330.427
5	1951		330.451 to 330.453
12	1951		330.501 to 330.506
1	1955 (2nd Extra Sess.)		330.557 to 330.558
21	1963		330.561 to 330.562
56	1969		330.571 to 330.572
54	1963		330.601 to 330.615
335	1965		330.651 to 330.666
107	1974		330.701 to 330.720
281	1929		720.301 to 720.310
328	1931	187, 197b, 198	750.187, 750.197b, 750.198
175	1927	27a to 27c	767.27a to 767.27c
232	1953	68	791.268

(b) Revised Statutes of 1846:

Chapter	Section Number	Compiled Law Number (1970)
171	14, 15	801.14, 801.15

Source: Michigan Mental Health Code of 1974.

**Appendix H**  
**Description of the Mental Health Code**

## MENTAL HEALTH CODE

### Act 258 of 1974

AN ACT to modernize, add to, revise, consolidate, and codify the statutes relating to mental health; to delineate the powers and duties of the department of mental health; to establish county community mental health programs; to delineate state and county financial responsibility for public mental health services; to create certain funds; to establish procedures for the civil admission and discharge of mentally ill persons to and from mental health facilities; to establish procedures for the civil admission and discharge of mentally retarded and other developmentally disabled persons to and from facilities; to establish guardianship arrangements for mentally retarded persons; to establish certain rights of persons who receive mental health services; to establish financial liability for the receipt of public mental health services; to establish certain miscellaneous provisions relating to mental health; to establish procedures pertaining to mentally ill and mentally retarded persons who are under criminal sentence, to persons who are mentally incompetent to stand trial, and to persons who have been found not guilty by reason of insanity; and to repeal certain acts and parts of acts.

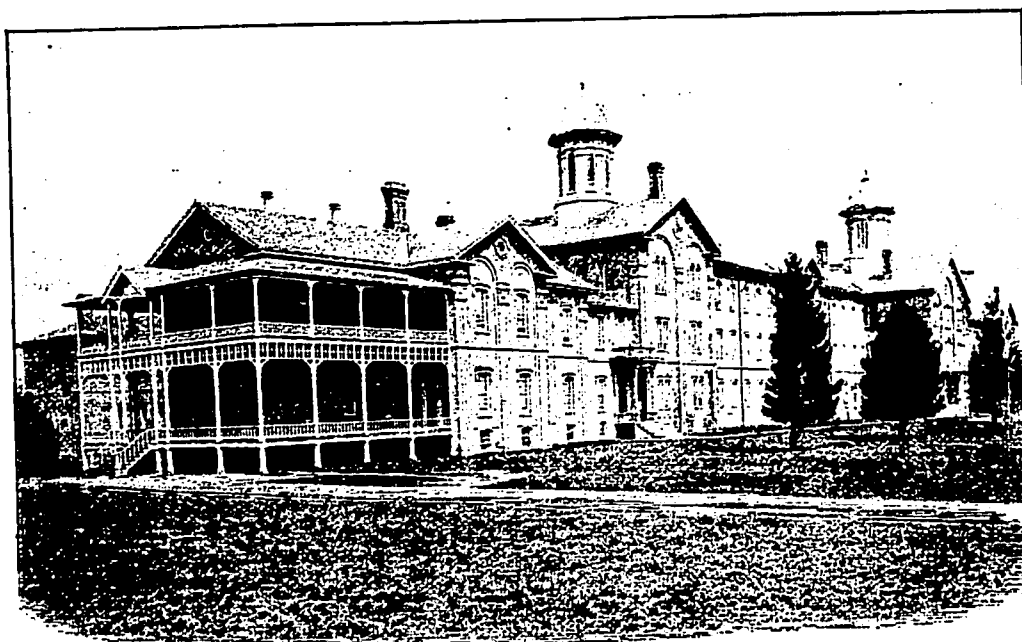
The People of the State of Michigan enact:

#### 330.1001 Short title.

Sec. 1. This act shall be known and may be cited as the "mental health code."

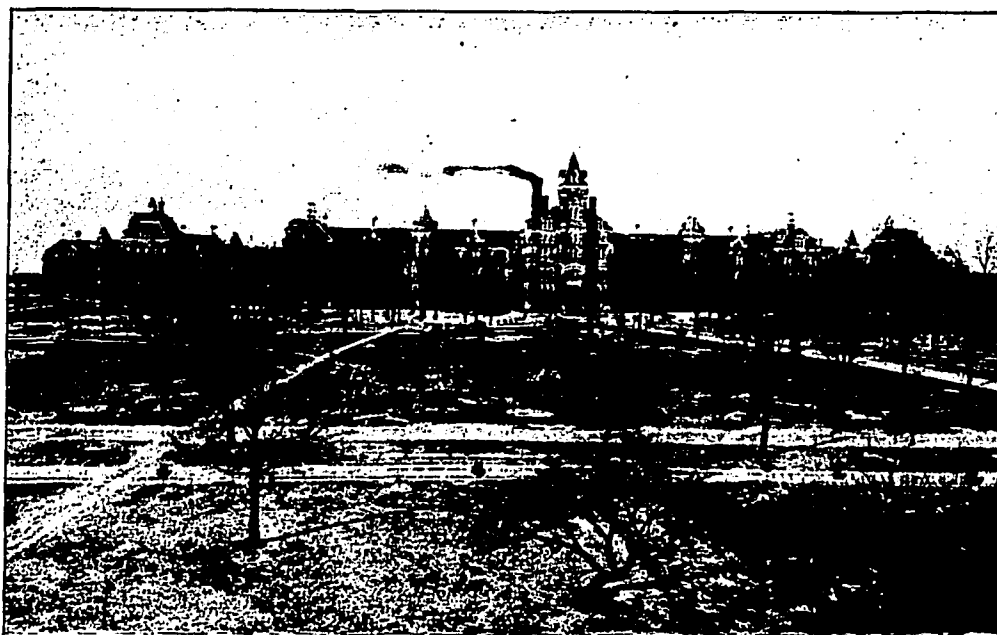


**Appendix I**  
**The Michigan Insane Asylums at the Turn of the Century**



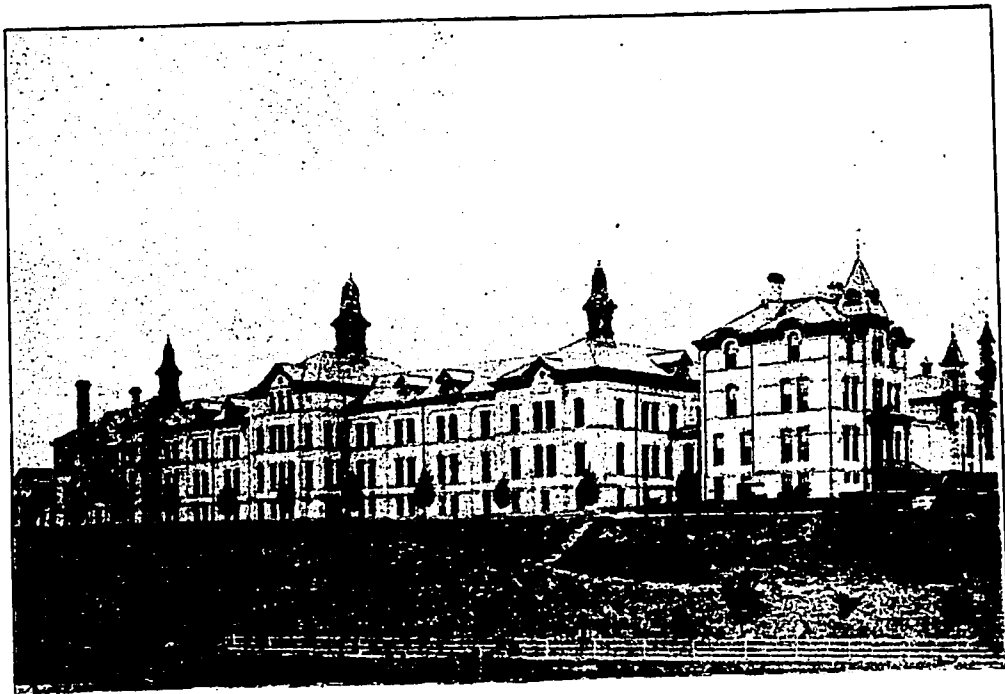
ASYLUM FOR THE INSANE, KALAMAZOO.  
Male Department.

Source: State of Michigan. (1901). Official directory and legislative manual for the years 1901-1902. Lansing: Hosmer & Kerr.



EASTERN MICHIGAN ASYLUM FOR INSANE, PONTIAC.  
Main Building.

Source: State of Michigan. (1901). Official directory and legislative manual for the years 1901-1902. Lansing: Hosmer & Kerr.



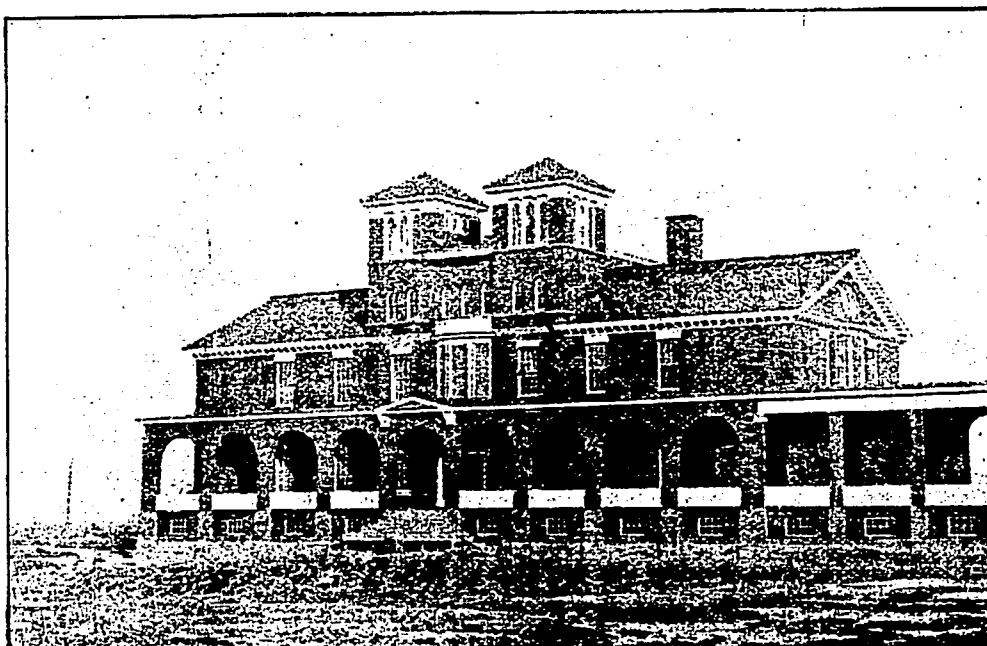
STATE ASYLUM, IONIA.

Source: State of Michigan. (1901). Official directory and legislative manual for the years 1901-1902. Lansing: Hosmer & Kerr.



NORTHERN MICHIGAN ASYLUM FOR INSANE, TRAVERSE CITY.

Source: State of Michigan. (1901). Official directory and legislative manual for the years 1901-1902. Lansing: Hosmer & Kerr.



U. P. HOSPITAL FOR INSANE, NEWBERRY

Source: State of Michigan. (1901). Official directory and legislative manual for the years 1901-1902. Lansing: Hosmer & Kerr.

**Appendix J**  
**Court Decisions Regulating Sterilization of Patients (1925)**

Mich. 1925. Under Pub.Acts 1923, No. 285, sec. 3, subd. (d), probate court has jurisdiction to hear and determine cases relating to sterilization of mental defectives.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.

Under Pub.Acts No. 285, sec. 4, guardian ad litem for mental defective must be appointed when order fixing date of hearing on petition to sterilize defective is made, and appointment of guardian a month after such hearing was jurisdictional defect.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.

Under Pub.Acts 1923, No. 285, secs. 5, 6, physicians appointed by court to examine mental defective sought to be sterilized must appear at hearing and filing of certificates by physicians was unauthorized.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.

Pub.Acts 1923, No. 285, sec. 6, requiring court to take full evidence in writing as to mental and physical condition of alleged defective and history of case, at hearing on petition to sterilize such defective, is mandatory.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.

Requirements of Pub.Acts 1923, No. 285, secs. 4-6, prescribing procedure in proceeding to sterilize mental defective, are jurisdictional, and no valid order can be made without substantial compliance therewith.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.

Mich. 1925. Pub.Acts 1923, No. 285, authorizing sterilization of mental defectives held proper and reasonable exercise of police power, in view of fact determined by biological science that feeble-mindedness is hereditary.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.

Sterilization of feeble-minded by X-ray or operation of vasectomy on males or salpingectomy on females or other treatment as may be least dangerous to life, prescribed by Pub.Acts 1923, No. 285, held not unreasonable, cruel, or oppressive.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.



Pub.Acts 1923, No. 285, authorizing sterilization of mental defectives, held not to violate Const. art. 11, sec. 15, providing that institutions for benefit of feeble-minded shall always be fostered and supported by state.

Smith v. Command, 204 N.W. 140, 231 Mich. 409, 40 A.L.R. 515, followed in In re Salloum, 210 N.W. 498, 236 Mich. 478.

Source: Michigan Digest, 1836-1990: Vol. 10. State and federal courts. (1985). St. Paul, MN: West Publishing, pp. 451, 439.

Appendix K

Discharge Criteria in the Matter of Teasel v. Department  
of Mental Health, 1984

**Mich. 1984.** Circuit court is constitutionally and statutorily empowered to review, upon a proper petition, procedure by which a patient, hospitalized under a probate court order of civil commitment, is discharged, in order to determine whether the official ordering the discharge decided according to criteria for discharge established by the legislature.--Teasel v. Department of Mental Health, 355 N.W.2d 75, 419 Mich. 390.

If it is determined upon an evidentiary hearing, that informed decision concerning discharge of mental patient has not been made, circuit court is empowered to compel its making.--Id.

Probate court did not have jurisdiction to determine whether director of mental health center made an informed judgment in ordering plaintiff's release and to grant relief if he did not; thus, remand of case by Court of Appeals to probate court for hearing to determine whether informed judgment was made and grant of defendant's motions were erroneous.--Id.

**Appendix L**  
**Legal Opinion Regarding Assault of Patients--1984**

**Mich. 1984.** Provision of mental health code stating that recipient of mental health services shall not be physically, sexually or otherwise abused was meant to prevent staff of mental health care facility from abusing patients in its care and was not meant to abolish governmental immunity in those cases where one patient attacks another. M.C.L.A. secs. 330.1722, 691.1407.--Ross v. Consumers Power Co., 363 N.W.2d 641, 420 Mich. 567.

**Assault by other patients.**

**Mich. 1984.** Department of Mental Health and mental health center were entitled to sovereign immunity from tort liability for injuries sustained when inmate of mental health facility was injured by other inmates while on field trip. M.C.L.A. secs. 330.1143, 330.1708, 330.1738, 691.1407.--Ross v. Consumers Power Co., 363 N.W.2d 641, 420 Mich. 567.

Provision of mental health code stating that recipient of mental health services shall not be physically, sexually or otherwise abused was meant to prevent staff of mental health care facility from abusing patients in its care and was not meant to abolish governmental immunity in those cases where one patient attacks another. M.C.L.A. secs. 330.1722, 691.1407.--Id.

## **Appendix M**

**Study Commissioned by the MDMH Quality Care  
Task Force--Management and Budget**

## **Review of Specific Hospital Recommendations**

**Arnell Engstrom Children's Center, Traverse City.** Maintain 40-84 beds and support services buildings. Retain the existing service area. For long-term use, consider private contracting for these services if demand is down.

**Mt. Pleasant Regional Center.** Maintain 400 beds with support services buildings. If need for services in the area is lower than anticipated, one building can be used for adult psychiatric services to relieve potential demand at Newberry or Caro. Additionally, this could decrease distance from home county for some residents with mental illness. Final decisions can be made after a period of monitoring. The service area should be expanded to include 38 counties in central, western, and southern Michigan.

**Muskegon Regional Center.** It is recommended the facility close and that residents be transferred to Mt. Pleasant. The facility is in good condition, and alternative uses should be sought. Proposed restructuring of the service area and high building renovation costs reduce the desirability for continued department use.

**Kalamazoo Regional Psychiatric Hospital.** Maintain 300 beds and support services buildings. Use one building for Pheasant Ridge Children's Center. Restructure service area to delete Cass, St. Joseph, Calhoun, Gratiot and Benzie counties.

**Pheasant Ridge Children's Center, Kalamazoo.** Short-term recommendation is to move facility to KRPH. The service area would expand to include Clinton, Eaton, Ingham, Jackson and Hillsdale counties. Consultants were inconclusive about long-term need, although they believe service demand will be insufficient to maintain facility. Consideration, they said, should be given to privatization of its services.

**Coldwater Regional Mental Health Center.** Maintain 298 beds and support services buildings. Use some buildings for transitional housing or for Fairweather programs. Expand service district to include Cass, Calhoun and St. Joseph counties.

**Ypsilanti Regional Psychiatric Hospital.** The facility should continue to be downsized in the short-term. In the long-term, it should close, with residents being transferred to Clinton Valley Center in Pontiac or other facilities in a restructured Wayne/Ypsilanti county service area. Consideration should be given to YRPH as a possible correctional facility.

**York Woods Center, Ypsilanti.** The facility should close, with residents relocated to Fairlawn and Hawthorn centers. Service area would be restructured.

**Center for Forensic Psychiatry, Ypsilanti.** Alternatives for this facility, which is situated on the grounds of YRPH and York Woods Center, include relocation to a redone Northville site, or being maintained at its current location as part of an overall correctional facility. Further study is needed before recommendations can be made, said the consultants.

**Newberry Regional Mental Health Center.** Maintain 167 beds, with support services buildings, to be continued as a combined psychiatric-developmental facility. Long-term need is unknown, and no determination of such was made by the study. One possible alternative is to move toward contracting all services through private providers. Hospital service area for persons with developmental disabilities would expand to include entire upper peninsula and northern portion of lower. Psychiatric service area would expand to include Benzie, Crawford and Oscoda counties.

Source: Quality Care Task Force, Michigan Department of Mental Health. (1988, June). Final report. Lansing: Author.



**Appendix N**  
**Summary of Annual Costs for the State of Michigan**  
**Hospitals, 1980-1989**

## Fiscal Year 1980

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$452,800	22.6	16
Clinton Valley Center	\$14,369,900	946.3	649
Coldwater Mental Health Center	--	--	--
Detroit Psychiatric Institute	\$7,494,400	293.6	172
Kalamazoo Regional Psychiatric Hospital	\$17,428,300	932.0	723
Metropolitan Regional Psychiatric Hospital	\$5,876,700	231.9	172
Michigan Institute for Mental Health	\$3,800,500	129.0	74
Newberry Regional Mental Health Center	\$6,521,400	323.7	178
Northville Regional Psychiatric Hospital	\$22,218,600	908.8	609
Traverse City Regional Psychiatric Hospital	\$12,595,900	615.5	379
Ypsilanti Regional Psychiatric Hospital	\$21,266,200	1,060.9	822
Reuther Facility, Wayne County <sup>a</sup>	\$9,000,000	405.0	300
Total	\$126,024,700	5,869.3	4,094

Source: State of Michigan. (1980). Executive budget: Fiscal year 1980 (William G. Milliken, Governor). Lansing: Author.

Budget/ANP Ratio = \$30,783.00

<sup>a</sup>Proposed figures.

## Fiscal Year 1981

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$512,200	2.21	16
Clinton Valley Center	\$21,109,100	928.4	649
Coldwater Mental Health Center	--	--	--
Detroit Psychiatric Institute	\$8,495,200	305.3	172
Kalamazoo Regional Psychiatric Hospital	\$18,453,500	852.4	723
Metropolitan Regional Psychiatric Hospital	\$7,533,000	265.6	172
Michigan Institute for Mental Health	\$4,216,600	126.6	74
Newberry Regional Mental Health Center	\$6,417,800	291.7	178
Northville Regional Psychiatric Hospital	\$22,579,200	909.7	609
Traverse City Regional Psychiatric Hospital	\$14,004,900	611.6	379
Ypsilanti Regional Psychiatric Hospital	\$21,741,800	987.9	822
Reuther Facility, Wayne County <sup>a</sup>	\$5,000,000	405.0	300
Total	\$130,063,300	5,706.3	4,094

Source: State of Michigan. (1981). Executive budget: Fiscal year 1981 (William G. Milliken, Governor). Lansing: Author.

Budget/ANP Ratio = \$31,769.00

<sup>a</sup>Proposed figures.

## Fiscal Year 1982

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$499,800	15.0	16
Clinton Valley Center	\$17,828,300	682.2	649
Coldwater Mental Health Center	--	--	--
Detroit Psychiatric Institute	\$7,693,300	234.5	150
Kalamazoo Regional Psychiatric Hospital	\$17,737,300	714.9	475
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	\$3,225,600	43.0	NA
Newberry Regional Mental Health Center	\$5,891,600	212.3	114
Northville Regional Psychiatric Hospital	\$24,221,800	803.4	500
Traverse City Regional Psychiatric Hospital	\$11,951,200	478.0	250
Ypsilanti Regional Psychiatric Hospital	\$20,705,100	786.0	580
Reuther Facility, Wayne County	\$10,254,300	362.0	358
Total	\$120,008,300	4,411.3	3,092

Source: State of Michigan. (1982). Executive budget: Fiscal year 1982 (William G. Milliken, Governor). Lansing: Author.

Budget/ANP Ratio = \$38,813.00

Fiscal Year 1983

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$643,300	22.0	13
Clinton Valley Center	\$17,622,900	626.0	348
Coldwater Mental Health Center	--	--	--
Detroit Psychiatric Institute	\$9,723,000	247.0	128
Kalamazoo Regional Psychiatric Hospital	\$18,592,700	692.0	624
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	--	--	--
Newberry Regional Mental Health Center	\$5,664,300	200.0	94
Northville Regional Psychiatric Hospital	\$25,471,600	793.0	953
Traverse City Regional Psychiatric Hospital	\$12,267,300	424.0	225
Ypsilanti Regional Psychiatric Hospital	\$21,977,600	709.0	612
Reuther Facility, Wayne County	\$13,706,700	469.0	321
Total	\$125,669,400	4,182.0	3,318

Source: State of Michigan. (1983). Executive budget: Fiscal year 1983 (William G. Milliken, Governor). Lansing: Author.

Budget/ANP Ratio = \$37,875.00

## Fiscal Year 1984

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$950,700	27.0	21
Clinton Valley Center	\$18,786,200	544.0	490
Coldwater Mental Health Center	--	--	--
Detroit Psychiatric Institute	\$9,684,900	241.5	166
Kalamazoo Regional Psychiatric Hospital	\$23,207,300	704.0	580
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	--	--	--
Newberry Regional Mental Health Center	\$4,380,100	123.0	70
Northville Regional Psychiatric Hospital	\$39,005,000	1,208.5	980
Traverse City Regional Psychiatric Hospital	\$10,875,200	332.0	169
Ypsilanti Regional Psychiatric Hospital	\$22,105,100	661.0	559
Reuther Facility, Wayne County	\$12,450,100	374.0	321
Total	\$141,444,500	4,215.0	3,356

Source: State of Michigan. (1984). Executive budget: Fiscal year 1984 (James J. Blanchard, Governor). Lansing: Author.

Budget/ANP Ratio = \$42,147.00

## Fiscal Year 1985

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$1,536,600	46.1	79
Clinton Valley Center	\$23,377,100	598.9	468
Coldwater Mental Health Center	--	--	--
Detroit Psychiatric Institute	\$11,679,400	264.1	166
Kalamazoo Regional Psychiatric Hospital	\$26,584,800	745.5	684
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	--	--	--
Newberry Regional Mental Health Center	\$4,028,100	107.8	73
Northville Regional Psychiatric Hospital	\$44,855,100	1,239.9	1,010
Traverse City Regional Psychiatric Hospital	\$10,667,300	294.1	176
Ypsilanti Regional Psychiatric Hospital	\$26,577,600	750.0	624
Reuther Facility, Wayne County	--	--	--
Total	\$149,306,000	4,046.4	3,280

Source: State of Michigan. (1985). Executive budget: Fiscal year 1985 (James J. Blanchard, Governor). Lansing: Author.

Budget/ANP Ratio = \$45,520.00

## Fiscal Year 1986

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$4,899,400	140.0	106
Clinton Valley Center	\$23,136,200	590.8	424
Coldwater Mental Health Center <sup>a</sup>	\$17,446,700	0	0
Detroit Psychiatric Institute	\$13,028,600	275.8	166
Kalamazoo Regional Psychiatric Hospital	\$31,653,700	836.2	674
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	--	--	--
Newberry Regional Mental Health Center	\$4,200,500	104.2	66
Northville Regional Psychiatric Hospital	\$56,471,400	1,189.2	980
Traverse City Regional Psychiatric Hospital	\$10,734,000	277.3	170
Ypsilanti Regional Psychiatric Hospital	\$29,062,900	750.3	613
Reuther Facility, Wayne County	\$14,291,700	373.4	321
Total	\$204,925,100	4,537.2	3,520

Source: State of Michigan. (1986). Executive budget: Fiscal year 1986 (James J. Blanchard, Governor). Lansing: Author.

Budget/ANP Ratio = \$58,217.00

<sup>a</sup>Reorganization to a state mental health hospital for adults.



## Fiscal Year 1987

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$5,344,500	150.0	106
Clinton Valley Center	\$21,168,300	566.0	424
Coldwater Mental Health Center	\$18,373,900	520.0	272
Detroit Psychiatric Institute	\$13,886,400	291.0	166
Kalamazoo Regional Psychiatric Hospital	\$30,812,700	793.0	674
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	--	--	--
Newberry Regional Mental Health Center	\$4,502,700	114.0	66
Northville Regional Psychiatric Hospital	\$48,015,500	1,266.0	980
Traverse City Regional Psychiatric Hospital	\$10,435,700	267.0	170
Ypsilanti Regional Psychiatric Hospital	\$25,874,400	651.0	613
Reuther Facility, Wayne County	\$17,018,500	437.0	321
Total	\$195,432,600	5,055.0	3,792

Source: State of Michigan. (1987). Executive budget: Fiscal year 1987 (James J. Blanchard, Governor). Lansing: Author.

Budget/ANP Ratio = \$51,538.00

## Fiscal Year 1988

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$4,300,700	143.0	106
Clinton Valley Center	\$17,916,700	592.5	406
Coldwater Mental Health Center	\$14,751,300	517.0	254
Detroit Psychiatric Institute	\$12,130,800	305.0	166
Kalamazoo Regional Psychiatric Hospital	\$25,585,800	805.5	555
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	--	--	--
Newberry Regional Mental Health Center	\$3,863,600	121.0	66
Northville Regional Psychiatric Hospital	\$41,669,200	1,414.0	850
Traverse City Regional Psychiatric Hospital	\$8,694,700	273.0	144
Ypsilanti Regional Psychiatric Hospital	\$22,735,400	689.0	491
Reuther Facility, Wayne County	\$13,875,400	432.0	321
Total	\$165,523,600	5,292.0	3,359

Source: State of Michigan. (1988a). Executive budget: Fiscal year 1988 (James J. Blanchard, Governor). Lansing: Author.

Budget/ANP Ratio = \$49,278.00

## Fiscal Year 1989

Institution	Budget	FTE	ANP
Caro Regional Mental Health Center	\$5,514,800	173.5	105
Clinton Valley Center	\$20,673,300	612.5	448
Coldwater Mental Health Center	\$15,581,000	508.0	236
Detroit Psychiatric Institute	\$12,977,300	312.0	160
Kalamazoo Regional Psychiatric Hospital	\$27,905,900	834.5	539
Metropolitan Regional Psychiatric Hospital	--	--	--
Michigan Institute for Mental Health	--	--	--
Newberry Regional Mental Health Center	\$4,348,200	126.0	55
Northville Regional Psychiatric Hospital	\$44,846,300	1,311.0	799
Traverse City Regional Psychiatric Hospital <sup>a</sup>	\$9,083,700	274.0	0
Ypsilanti Regional Psychiatric Hospital	\$23,957,200	689.0	405
Reuther Facility, Wayne County	\$14,889,000	442.0	289
Total	\$179,776,800	5,282.5	3,036

Source: State of Michigan. (1989). Executive budget: Fiscal year 1989 (James J. Blanchard, Governor). Lansing: Author.

Budget/ANP Ratio = \$59,215.00

<sup>a</sup>Official closing of the state mental health hospital for adults.

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