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PREDICTING AGENCY SURVIVAL AS A FUNCTION OF CONSTITUENCY  
SUPPORT IN THE MICHIGAN MENTAL HEALTH SYSTEM

by

R. Dee L. Woell

A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
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Western Michigan University  
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PREDICTING AGENCY SURVIVAL AS A FUNCTION OF CONSTITUENCY  
SUPPORT IN THE MICHIGAN MENTAL HEALTH SYSTEM

R. Dee L. Woell, D.P.A

Western Michigan University, 1985

Two public facilities for the mentally ill, Michigan Institute for Mental Health and Lafayette Clinic were examined, using a framework provided by Douglas R. Boulter (1983). The basic research question was, why did Lafayette Clinic survive while Michigan Institute did not?

The following research propositions were explored:

1. Organizations that receive strong constituency and media support are more likely to survive than those which do not.
2. Program success or failure is dependent on the decision-maker's perception of the sum of public support.
3. The media serves both as a carrier of opinion and as an influential actor in its own right, and thus impacts on mental health decisions.
4. The decision to maintain or close an agency for the mentally ill (particularly during crises) will, therefore, be influenced by newspaper coverage.

Only the third proposition was not sustained. A content analysis of mental health newspaper articles for

the years 1973 through 1983 showed minimal press coverage of institutional programs and negligible media involvement with the two facilities. Out of a total of 887 articles in the Detroit Free Press, Detroit News and Lansing State Journal, 34 mentioned Lafayette Clinic and 28 named MIMH.

Additional research methods included a historical review, administrative case studies, interviews and document analysis. These methods were undertaken to validate and elaborate upon content analysis findings.

Using Boulter's (1983) framework, 17 key actors were found to be initially supportive of Michigan Institute. Only six remained advocates throughout the agency's history. For Lafayette Clinic, in the years before budget reductions, 20 actors or groups were strongly supportive. Fifteen continued to maintain support.

What explains the difference between an agency that remained open and managed to protect its programs during a time of cutback management and one that closed? The conclusion is that decision makers changed their perception of utility and value as manifested by support groups. Therefore, the initial propositions were sustained.

Decisions about agency survival appeared to be politically, rather than programmatically, motivated.



Through the use of the Boulter (1983) framework and several alternative methods of gathering and verifying data, an understanding and appreciation of this process occurred.

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*Western Michigan University*

**D.P.A. 1985**

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R. Dee L. Woell

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## CHAPTER I

### INTRODUCTION

One fundamental question serves to drive the research that follows. How are decisions regarding public policy issues made? Although it is usually possible to pinpoint key actors involved in policy-making, the "why?" of specific decisions is harder to trace. Without knowledge of the process, it is difficult to understand the outcome.

We like to think of ourselves as rational human beings. We operate under the pervasive, everyday assumption that what other people do is purposeful, goal directed and at least "intendedly rational" (Allison, 1971, p. 28). Rationality presumes that behaviors can be predicted with certainty and specificity if goals are known.

Public policy decisions, especially in human service areas, are often believed to be based on an exhaustive gathering of information, leading to a final decision selected from constrained alternatives, that is value maximizing. Why then would two different policies be adopted in similar situations? That question becomes especially problematic when, to the observer at least, outcomes differ even when decision makers appear to be

facing similar constraints, embedded in the same situational milieu, operating with equally limited resources within the same system.

The rational actor model presumes that information and value-maximization dictate choice. The political model presumes that parochial interest and preferences control choice (Pfeffer, 1981, p. 22). The following study considers these possibilities as well as the argument that organizations operate under a layer of rationality which cloaks the interplay of power and politics among a variety of key actors, knowledgeable and interest groups. Under this model, decisions ultimately rest upon bureaucratic and politician perceptions of public interest and support.

Decision making is almost universally defined as choosing between alternatives through a series of dynamically related steps. Public policy making is broader in scope but incorporates decision-making activities. Thomas R. Dye (1978), in Understanding Public Policy, defines public policy as "whatever governments choose to do or not to do" (p.3). Dye (1978) adds that "today the focus of political science is shifting to public policy -- to the description and explanation of the causes and consequences of government activity" (p.5). Decisions are outcomes of public policy.

There is a rich history of public policy and decision theory. It is appealing to simplify research by concentrating on one or two of the more distinct models, such as rational versus political man. Yet, it is generally acknowledged that decision-making processes occur in complex and multi-faceted environments. As a result, they are rarely reducible to such a degree. Nor can any one theory be expected to explain fully the diversity of governmental activities.

As Dye (1978) makes clear, "These models are not competitive, in the sense that any one of them could be judged 'best.' Each one provides a separate focus on political life, and each can help us to understand different things about public policy (p. 19)." He goes on to say that, while on the surface it may appear that a given policy or decision outcome can be explained by one model, most policies are a combination of "rational planning, incrementalism, interest group activity, elite preferences, systemic forces, competition and institutional influences" (p. 20).

Douglas R. Boulter (1983) in his essay in Applied Political Inquiry: Reading and Research Methodology, offers one structure which can be used to incorporate a variety of policy theories, while allowing examination of a specific decision.

Boulter (1983) conceptualizes the policy-making process according to Figure 1, which shows that policy is made by politicians and bureaucrats as influenced by interest groups and the media, as well as attentives and the general public. He also suggests that decisions are shaped by the environment, culture, tradition and institutions in which they are embedded.

Boulter's (1983) framework will be used to focus case material while exploring a single decision, closing or retaining a Michigan mental health facility. By developing information within the parameters of this policy ladder, it becomes possible to further assess its utility for public sector administrators.

Specifically, the framework will be examined in a comparative study of differing decisions regarding two similar public Michigan mental health institutions: Lafayette Clinic, located in Detroit, and Michigan Institute for Mental Health in Lansing. Both agencies operated under the auspices of the Michigan Department of Mental Health; both served the acutely mentally ill in a short-term, intensive treatment program; both had strong affiliations with a local University; both seemed to be meeting community needs and were providing services efficiently and effectively; both operated within the fiscal constraints of a recessionary period. Yet

LEVEL I

POLICY

made by

LEVEL II  
(Proximate  
Policy-makers)

POLITICIANS  
AND  
BUREAUCRATS

influenced by

LEVEL III  
(Influential  
Actors)

MEDIA, INTEREST GROUPS,  
ATTENTIVES, GENERAL PUBLIC

shaped by

LEVEL IV

ENVIRONMENT, INSTITUTIONS,  
CULTURE, HISTORY, TRADITION

Figure 1. Boulter's (1983) policy-making ladder.



the decision was to retain one facility and close the other.

Research will explore the decision process using a case study methodology. Traditionally, case studies offer a variety of in-depth materials about total agency operations. The research that follows, however, attempts to narrow that view and look at a series of interactions in relationship to a single decision: whether or not the agency should survive.

Chapter II offers a closer look at Boulter's (1983) decision model and a review of the literature within that structure. Discussion of how Boulter's (1983) framework may be used to examine the layers of interaction within Michigan institutions for the mentally ill, is also provided.

Based on available literature, a conceptualization of the decision ladder, and relevant assumptions, a series of propositions are set forth. These will be studied in subsequent chapters.

Chapter III discusses research methods and procedures. Newspaper content analysis, interviews and document analysis all serve to flesh out the case studies and establish a foundation for comparison.

Chapter IV offers an overview of Michigan's mental health system. Environmental contingencies, inputs and outputs are considered integral to a number of decision-

making theories. In the literature, purveyors of mental health care (especially governmental providers) are often considered purveyors of the moral and socio-economic interests of the state as well (Kitsuse, 1968; Szasz, 1970; Weinberg, 1978). Both state hospitals resided in the same culture, both were serving a potentially volatile population about whom community opinions were seldom neutral. It is useful to understand this milieu, which provides the background for case studies to follow.

Chapter IV also delineates the crisis period, providing an understanding of the Michigan mental health system and an appreciation of the significance of actor positions.

Chapter V provides in-depth studies of two specific treatment facilities, Lafayette Clinic and Michigan Institute for Mental Health. Again, Boulter's (1983) decision ladder is used as an overlay to delineate key actors, stakes and stands in each of the programs and at a variety of levels. This exploration of key issues and decisions paves the way for a comparative analysis of the two facilities in Chapter VII.

Chapter VI explores media influence regarding these two institutions and its effect on the policy-making process.

Chapter VII ties together the mental health history, case studies and discussion of media influence by offering an analytical comparison of the positions of constituents involved in the decision processes at each agency. A check sheet is used to show graphically actor positions toward the facilities both before and after the crisis period. Using this outline, the years 1977-79 will be compared to 1980-81 at several levels.

The resultant information will assist in demonstrating why institutional survival outcomes differed, even though programs appeared similar and were part of the same environment.

With this application of Boulter's (1983) framework, it becomes possible to assess its utility for the public sector administrator. Its value as a decision-making tool can be examined. The final chapter offers conclusions, recommendations, plans for future research and suggestions for revising Boulter's (1983) decision ladder to make it more useful for both the researcher and practitioner.

## CHAPTER II

### THE THEORETICAL FRAMEWORK

When decisions are made by public figures, there is a tendency to attribute outcomes to specific policy-making processes. Two such conceptualizations have already been mentioned briefly, the rational actor and political process models. They by no means provide the boundaries of explanatory theory.

There is a long and rich history of research regarding public policy and decision-making. Leadership and ambition theories, group process and environmental impact models are all useful conceptualizations of what occurs when a decision is made. How then can we sort among a variety of theories and models to examine a specific decision?

Graham T. Allison (1971), in Essence of Decision: Explaining the Cuban Missile Crisis, reveals the difficulties of this task. He details how a single decision can be viewed from three distinct perspectives. The rational actor, organizational process, and governmental (bureaucratic) politics paradigms are equally plausible explanations for events surrounding the Cuban missile crisis.

Different models can be used to explain the same decision. Our question then becomes even more prob-

lematic. How can we predict different outcomes given similar decision-making situations?

Douglas R. Boulter (1983) offers one form of integrative framework which allows examination of a variety of theories and models. He also provides a first step toward attempting to predict policy decisions, rather than simply observing or explaining them.

In his essay in Applied Political Inquiry: Reading and Research Methodology, Boulter (1983) begins by postulating a policy ladder. Figure 2 shows that, according to this conceptualization, decisions are made by politicians and bureaucrats. They, in turn, are influenced by interest groups and the media, as well as attentives and the general public. Attentives are considered by Boulter (1983) to be "...those members of Gabriel Almond's attentive public who follow a particular issue and possess some expertise on the subject. They participate in the policy debate by taking a public position on the issue, most frequently in the news media" (p.252).

Boulter (1983) uses a score sheet to rate each of the major actor's positions toward a policy outcome during and after the crisis period. A modified version of this rating form can be seen in Table 1. The resultant check sheet, marked according to the involved

LEVEL I

POLICY

made by

LEVEL II  
(Proximate  
Policy-makers)

POLITICIANS  
AND  
BUREAUCRATS

influenced by

LEVEL III  
(Influential  
Actors)

MEDIA, INTEREST GROUPS,  
ATTENTIVES, GENERAL PUBLIC

shaped by

LEVEL IV

ENVIRONMENT, INSTITUTIONS,  
CULTURE, HISTORY, TRADITION

Figure 2. Boulter's (1983) policy-making ladder.

Table 1

## Actor Positions Toward Agencies During and After Crisis

	Majority Against	Serious Split	Majority For	Majority Against	Serious Split	Majority For
Bureaucrats						
MIMH						
Lafayette						
Legislators						
MIMH						
Lafayette						
University						
Officials						
MIMH						
Lafayette						
Community						
Officials						
MIMH						
Lafayette						
Staff						
MIMH						
Lafayette						
Interest Groups						
MIMH						
Lafayette						
Attentives						
MIMH						
Lafayette						
Media						
MIMH						
Lafayette						
Public						
MIMH						
Lafayette						

actors' public expressions of opinion, is expected to show clear support for (or against) the policy as a sum of individual positions.

Using this framework, Boulter (1983) compared three countries on a single decision, setting highway speed limits in response to anticipated world oil shortages. He was able to trace the inevitable policy outputs, which were different in each country.

During the study, American policy makers received strongly favorable signals for their position to retain the 55 mile-per-hour speed limit after the gas shortage crisis had ended. The general public, attentive elites, the media and many interest groups supported the policy. With that support, the decision to retain the lowered limit in the U.S. was an easy one to predict. In Britain and Germany the final tabulation showed strong negative feelings toward the existing policy. As a result, speed limits were allowed to return to pre-crisis levels.

That same type of analysis can be used to show public support for or against a given mental health institution.

Boulter (1983) considers policy output to be a factor of actor positions during and after the decision period, as defined by conflict and crises. In order to study these issues and gather data, two different public



mental health decisions concerning the survival of comparable institutions will be examined.

With additional application of Boulter's (1983) framework, it should then be possible to step back and assess its usefulness for further research.

But, how does this structure mesh with other decision-making theories? Let us examine Boulter's (1983) conceptualization in light of existing literature.

#### Level I -- The Decision

Clearly, few key decisions are simple "go" or "no go" problems for policy-makers. Decisions are generally the outcome of a number of impinging contingencies. Boulter (1983) sees decisions as the outgrowth of at least three levels of influence, all of which impact in a number of ways. However, there is one acknowledged "given". If the base of support for a decision is perceived by the policy maker to be missing or deteriorating, the astute actor will generally begin to re-evaluate his own position and/or modify the decision outcome.

Although there is a wide variety of possible paradigms under which politicians and bureaucrats may be seen as operating, one early theory has inherent appeal for governmental observers -- the rational actor model.

## Level II -- Politicians and Bureaucrats

### The Rational Actor Model

Although the rational model was originally postulated by such scholars as Max Weber (1947) in The Theory of Social and Economic Organization, Talcott Parsons (1949) in The Structure of Social Action and Herbert A. Simon (1957) in Models of Man, this theory remains one of the most studied, albeit in a variety of modernized forms.

Many types of rational decision models are found in the literature of economics, political science, management, administrative science and budgeting. Generally it is agreed that a truly rational person selects the best possible decision based on an exhaustive gathering of information and a careful evaluation of alternatives.

The outcome choice is value maximizing, offering the greatest value within situational constraints.

Rationalists would argue that in order to improve public administration, one need only take an economic approach (Quade, 1979, p. 22). Many Chief Executive Officers (CEOs) at Level II of Boulter's (1983) policy ladder perceive themselves as operating under this paradigm, equating quality service with lowered costs to the taxpayer. In the mental health field, for instance, the rationalist is guided by costs per patient day.

Systematic efforts to quantify costs and benefits for the care and treatment of the mentally ill are an example of the rational, scientific management approach. Does a given policy save money? Is it more efficient and/or more beneficial to place a person in an institution than in a community home? Most such studies in the field of mental health look at patient aggregates to determine how best to structure state-wide services (Herman, 1981, 1982, 1983; Intagliata, Wilder, & Cooley, 1979; Krowinski & Fitt, 1978; Murphy & Datel, 1976).

Of course, these concerns are not confined to the mental health field. There is ongoing discussion in the literature regarding such topics as zero-based budgeting (Dillon, 1979) and cost-benefit analyses (Bernard, 1979; Brown, Pratt, & Luszczyk, 1980; Doelker, 1979; Frank, Klein, & Jacobs, 1982; Hellinger, 1980).

An organization can be considered a technical instrument for mobilizing human energies and directing them toward set aims. It may be seen as a rational tool designed to perform a job efficiently. But, it is generally acknowledged that despite our best attempts at rationality, agency output is still the product of individuals with their own needs and goals.

Martin Landau (1969) attacked what he considered a limited approach in "Redundancy, Rationality and the Problem of Duplication and Overlap," published in the

Public Administration Review. Herbert A. Simon (1957) coined the term "satisficing" to refer to decisions that are "good enough" as opposed to those that meet all of the requirements of "perfect rationality".

In its purest form rational decision-making is difficult to reconcile with the exigencies of daily activities. Yet, the concept itself remains valuable.

The following research examines the theory that public administrators make rational choices based on what they perceive as the balance of constituency support. A modified form of Boulter's (1983) check-sheet will be used to quantify actor positions and stands so that outcomes are predictable as an arithmetic sum of behaviors.

One obvious drawback is the requirement that opinion be quantified by reduction to a plus or minus rating. Seldom are our positions that clear-cut; seldom are weights and strengths of opinions directly comparable. Nevertheless, the attempt to incorporate a rational component in what may be considered an inherently irrational process, serves to clarify the decision process and outcome.

#### The Political Actor Model

Boulter (1983) aggregates the effects of politicians and bureaucrats, totaling their support toward a

specific decision. We know, however, that such decision-making bodies as the Legislature and Executive Office are comprised of individuals.

In the public sector, Levinson and Klerman (1972) consider leadership to be an inherently political process. They tell us that:

The executive operating on the boundary between his organization and numerous others has no authority to give orders as he sees fit. Instead he is engaged in a complex process of negotiations with other parties who have different constituencies, formal and informal affiliations, control over resources and bargaining leverage. (pp. 52-67)

Authors such as Richard Neustadt (1960), Gabriel Almond (1950) and Charles Lindblom (1959) argue that as a result of the complicity of human involvement, outcomes are generally unpredictable and difficult to trace through the system. The final product, in this case a single decision, is a blend of individual and group impacts through key decision makers.

According to Allison's (1971) governmental (bureaucratic) politics paradigm, outcomes are not chosen as solutions to problems so much as result from compromise, conflict and confusion of officials with diverse interests and unequal influence.

Although Ritchie (1971) was referring to the Canadian government in his discussion of organizational policy-making, his insight is applicable:

The common pattern is for information to be inadequate, alternatives to be unidentified or unappraised. More often than not, we appear to drift into solutions or expedients. ...A pessimist might say that we react to crisis by sowing the seed of new crisis as yet unforeseen. (p. 12)

Politics involves how differing preferences are resolved in conflicts over the allocation of scarce resources. Thus, as Pfeffer (1981) adds, "politics involves activities which attempt to influence decisions over critical issues that are not readily resolved through the introduction of new data and in which there are differing points of view" (p. 6).

Political models view organizations as pluralistic and divided into various interdependent interests, units and subcultures (Baldrige, 1971). Conflict is considered to be normal or at least customary (p. 25). Power follows from conflict.

Budget becomes the battleground. "If politics is regarded as the conflict over whose preferences are to prevail, then the budget records the outcome of this struggle", according to Wildavsky (1979, p. 193). He defines budgets ultimately as attempts to allocate financial resources through political processes.

Lasswell and Kaplan (1950) consider politics to be a "study of influence and the influential" (p. 240). It is this definition that will serve as a guide for Chapter V, case studies of two mental health facilities.

Self (1975) adds an additional dimension. He believes that organizational politicians want to be perceived as rational actors. However, the effort is illusory. While the actions of administrators may generally be regarded by politicians, the public and even themselves as the result of the simple application of rational, legal, economic or technical criteria to questions of policy, generally that is not the case. Such thinking simply tends to make otherwise unacceptable decisions more palatable to both decision makers and their constituents (Self, 1975).

#### Elite Theory

One decision-making theory that meshes poorly with Boulter's (1983) structure is that of elitism. While Boulter agrees that decisions are made by politicians and bureaucrats, elite theory argues that the average citizen is unconcerned, uninvolved and uninformed about public policy. Therefore, decisions reflect the preferences of elites and are imposed from the top down.

Boulter (1983) sees a much richer conceptualization of policy-making, one that is more traditionally pluralistic and which acknowledges a variety of factors and inputs that shape the final outcome. Politicians and bureaucrats are expected to be aware of, and influenced by, their constituents.

It is acknowledged, however, that those outside the system may wield inordinate power. In the case studies presented in Chapter V, it is apparent that University officials and institutional directors can be power brokers whose opinions and influence are important to decision makers. While Boulter's (1983) model does not allow us to weigh the value of support, clearly support from some quarters is of greater utility than from others. Wallace S. Sayre and Herbert Kaufman (1960) in Governing New York City say it well:

In a manner of speaking, many group leaders become intimate parts of the city's machinery of governmental decision in certain spheres. They are non-governmental in the sense that they cannot promulgate binding orders and rules the way officeholders clothed with public authority can, but they often have as much to say about what officeholders promulgate as the officeholders themselves. ...Officeholders feel compelled to cooperate with them because they have so much influence, knowledge and interest. (p. 511)

Organization implies the tendency to oligarchy, according to Michels (1958): "In every organization, whether it be a political party, a professional union, or any other association of the kind, the aristocratic tendency manifests itself very clearly" (p. 37). Michels (1958) argues that an elite stratum necessarily exists because of the large numbers of people involved in governmental issues and the need to decide matters of dispute among members. This naturally leads to a system



of delegation, and inevitably to an elite that no longer represents the masses.

In the slightly modified "theory of democratic elitism", appointed politicians are expected to represent the mass of members and execute their will. The explicit task of the voters, therefore, according to Campbell (1964) is not to decide what the government should do, but rather who should make decisions on political matters (p. 281).

#### Level III -- Media, Interest Groups and Attentives

The question of "who really governs" is not only interesting, but has considerable potential impact throughout the public sector. Almond (1958), in his comparative study of interest groups and the political process, was one of the first to expand the scope of decision-making to include interest group impacts on outcomes. Others peripherally addressed the same issues (Bowers & Ochs, 1971; Cobb & Elder, 1972). A thought-provoking book by Vogel (1978) provides insight into how citizens increasingly are lobbying corporations and, as a result, are mounting a growing challenge to business authority.

As America is transformed from an industrial to an information-electronic society, the public administrator

will also have to change. Participatory, rather than representative, democracy has become more of a reality in this era of instantaneously shared information.

Increasing levels of education and involvement have led to renewed awareness of the ability of groups to influence public decisions and heightened belief in their impact. Harris (1982), for instance, identified organizations actively involved in attempting to influence the Mental Health Systems Act of 1980 (PL 96-398), how they functioned and the major issues with which they were concerned.

Cigler and Loomis (1983) call it a "participation revolution" as large numbers of citizens become active in ever-increasing numbers of protest groups, citizen's organizations and special interest groups (p. 11). They add that major technological developments in information processing promote more sophisticated, timely and specialized grass roots lobbying (p. 1).

Pfeffer and Salancik (1978) in The External Control of Organizations: A Resource Dependence Perspective argue that, "Organizations are not so much concrete social entities as a process of organizing support sufficient to continue existence" (p. 24). Such a perspective is particularly valid in the mental health field, where programs operate in a turbulent, ever-

changing environment of new techniques, technologies and philosophies.

Thompson (1965) had already observed that administrative action in the modern world "is not the product of one person's mind or heart. It reflects the concerns of all legitimate interests in the appropriate administrative constituency" (p. 205-206).

As a result of a variety of societal changes, characterized by increasing social complexity, economic specialization and social differentiation (Truman, 1971, p. 57), today's public administrators are forced to deal with an increasingly educated, knowledgeable, and even militant immediate constituency. They are forced to be more open to social, political and economic concerns. They must negotiate with a wide variety of divergent and frequently conflicting groups including employees, stockholders, unions, various government agencies and the general public.

At the same time, there are growing numbers of people who remain outside the system. Public constituencies can be divided into three basic groups: activists, attentives and the apathetic. Declining voter turnouts and a multiplicity of public agencies serving disenfranchised populations are evidence of the changing role of public administrators.

Decisions in the public sector affect a large

number of people. The public leader is more visible, more vulnerable and makes an easier target than his business counterpart. Chandler and Plano (1982) have observed that, "A public administrator's life is lived in the bright light of publicity and in response to the public's right to know" (p. 25).

The necessity to provide public mental health services, combined with this substantive area's high visibility, community salience and potential volatility, insures that decision-makers are sensitive to interest groups, the media and attentives.

### Pluralism

One major difference between public and private administration relates to two distinct but similar issues. The public sector, by definition, includes every citizen. Its audience is immense, its scope and scale of operation potentially ever increasing.

Citizens are both the owners (through taxation and political participation) and consumers. Acknowledgement of ownership and increased awareness and involvement in public sector activities by this immense group have steadily grown.

Truman (1971) notes the "multiplicity of co-ordinate or nearly co-ordinate points of access to governmental decisions," and concludes that:

The significance of these many points of access and of the complicated texture of relationships among them is great. This diversity assures various ways for interest groups to participate in the formation of policy, and this variety is a flexible, stabilizing element. (p. 519)

"Participation as a technique", according to Luthans (1981), "means that individuals or groups are involved in the decision-making process" (p. 490).

With this increasing involvement, however, comes increasing complexity and growing pressures on decision makers. Cigler and Loomis (1983) view the major challenge to the American political system in the 1980s as "its ability to respond to a demanding electorate in a political environment that supports numerous diverse interests -- often passionately expressed."

While Lowi (1969) talks about a growing network of alliances between interest groups, he considers them subversive of the legislature, and, concurrently, of democracy. His opinion is that this network favors discretionary authority so that it may make accommodations as problems arise without going back to decision makers (p. 96). Interest-group liberalism, argues Lowi (1979), is an attitude that produces ambiguous legislation, facilitating the efforts of interest groups to define public policy (Chapter 3).

Although government has in recent years devoted a growing share of the nation's resources to policies and

programs for meeting societal needs, dissatisfaction has never been more widespread, according to Nachmias (1979). "Manifestation of this discontent", he writes, "can be seen in complaints about inefficiency, ineffectiveness and waste." (p. 1).

Taxpayers are becoming more demanding, more willing to express dissatisfaction and more willing to act on that expression because of increasing concerns about program costs and a growing awareness of their own responsibilities.

A relatively new concern of this constituency is that public employees be aware of the legitimacy of political demands, understanding that an organization must be held accountable for its actions to the public and its elected and appointed leaders. Thompson (1965) writes, "Occasionally some participants in organizations (or participants in some organizations) lose sight of their social moorings and come to believe they are untouchable -- part of an autonomous community independent of outside evaluation, power and control -- independent of outside 'ownership'" (p. 44). The media are playing an integral part in this awakening process.

Media involvement in shaping policy decisions is considered an important facet by Boulter (1983). Compared to other aspects of the political process, there have been relatively few studies of pressure

groups and their relationship to the media. Gabriel Almond (1958) in "A Comparative Study of Interest Groups and the Political Process" published in American Political Science Review, was among the first to explore this issue.

Not having formal legitimacy obviously reduces the acceptability of some special-interest influence on policy. Nor can public acceptance be won unless the larger public can become aware of the issues. Publicity becomes the tool for ad-hoc groups searching for some measure of control. Peters (1978) mentions that it is particularly useful in dealing with bureaucratic actions (p. 208).

According to Peters (1978), when officials are reluctant to do as they are told, publicity spurs execution. But, Richard Neustadt (1960, p. 19) in Presidential Power adds that publicity does so at the risk of turning private reluctance into public defiance.

Cobb and Elder (1972) also note that the greater the size of the audience to which an issue can be enlarged, the greater the likelihood that it will attain systematic agenda standing and thus access to the formal agenda (p. 110). Rumor is another effective weapon.

In Boulter's (1983) model, the question then becomes, how does the decision maker locate the true expression of the public will? How does he know which

groups or individuals to count and which to discount? Is it the group or person that is the most persistent, the loudest, the one which appears to garner the most support? Cigler and Loomis (1983) find the question of determining impact a difficult one, "The difficulty is, in fact, compounded by groups' claims of impact and decision makers' equally vociferous claims of freedom from any outside influence" (p. 25).

The corollary for the researcher is, how do we know that we are measuring and aggregating community opinion in the same way that the decision maker is? If a decision is determined by the sum of perceived community support, how do we know perceptions are similar? Boulter (1983) counters these concerns by recording publicly stated opinions. Therefore, only those who are involved in a given issue or policy and act as public spokespersons would tend to be included. Nevertheless, in an attempt to score accurately opinion on a check sheet, we are hampered by the concept of delineating the component parts that constitute the sum of support.

#### Group Theory: Policy as Group Equilibrium

An interest group is seen by David Truman (1971, p. 37) as "a shared-attitude group that makes certain claims upon other groups in the society." Politics then, becomes the struggle between coalitions attempting



to influence public decisions. According to group theorists, as explained by Dye (1978, p. 23-24), public policy at any given time is the equilibrium reached in this struggle and is partially determined by the relative influence of involved groups.

Virtually all political systems encompass pressure groups intent on swaying outcomes in their favor. "The minority faction theorists," according to Andrew McFarland (1983), "tend to see American government as a collection of such coalitions, each controlling its own 'turf', public policy making in a particular area of economic interest" (p. 335). This appears to hold true in the mental health field as well, as will be shown in Chapter IV.

Harmon Zeigler (1964) in Interest Groups in American Society talks about the power of such alliances:

Organization represents a concentration of resources toward the realization of political influence. Organized structures of power can wield a predominant force when confronted by diffuse, unorganized interests. Therefore, if one could equalize all other factors it could be said that interests which are supported by organizations have a better chance of success than interests which do not enjoy the participation of organizations. (p. 32)

Latham (1952) adds: "They (organized groups) are structures of power because they concentrate human wit, energy, and muscle for the achievement of a given purpose" (p. 12). As a result, Olson (1965) finds that

the few tend to defeat the many because the few tend to be better organized.

Even development of agencies and institutions can be considered an outgrowth of such processes. Medeiros and Schmitt (1977) find that "public organizations are usually created in response to a problem perceived or articulated by a salient interest group within the political environment" (p. 15).

While Boulter (1983) embraces part of group theory, he expands it to include individuals (bureaucrats and politicians) as well as the groups of which they are a part (organizations, legislature). He looks beyond pressure groups to incorporate media influence, the general public and attentive involvement. Each faction helps to weigh the balance of public opinion. Politicians are influenced by the outcome of group struggles, but not exclusively.

As the House Select Committee on Lobbying Activities (1950) has noted, "No public policy could ever be the mere sum of the demands of organized special interests, for there are vital common interests that cannot be organized by pressure groups" (p.99).

Boulter (1983) suggests consideration of both external and internal organizational forces. Institutions can be described as structured patterns of behavior of individuals and groups. "Structured" means

that patterns of behavior tend to persist over time (Dye, 1978, p. 21).

#### Level IV -- Environment, Culture and Tradition

##### Institutionalism

Selznick (1957) differentiates between organizations -- "technical instruments designed as means to definite goals", and institutions -- "products of interaction and adaptation ... receptacles of group idealism" (p. 21-22).

It is possible to view an institution as a unitary actor. It can acquire an image, a perception of purpose and standard patterns of behavior conditioned by long-established practices.

This unitary institutional actor may not be perceived, however, as operating in an entirely rational manner because it is molded by people who do not always make decisions based on the greater good, what is best for the institution. Rather, individuals are concerned with what they believe are the best alternatives for them. Decisions become the results of value-maximizing choices which, by necessity, must be negotiated through others in the agency. Such maneuvering implies action as political output, rather than action as choice.

### Systems Theory

In contrast to the basic ideas of the rationalistic tradition, the systems perspective does not consider the decision maker as primarily an instrument for the realization of specific goals. Rather, he is perceived as responding to, and adjusting himself to, a multitude of claims. He is engaged in ongoing attempts to maintain balance by reconciling divergent demands.

One of the most significant characteristics of a system is that changes in one part of it affect other parts as well. Components are interrelated and interdependent. Among the general environmental conditions that may be considered part of this relationship are technology; legal precedents; and political, economic and cultural impacts.

The organization as a system is continuously involved in exchange with the environment. Abrahamsson (1977) adds that, "The character of the exchange varies with the different needs of the organization, and consequently, the set of stakeholders also differs from time to time and between organizations" (p. 93).

Even the most traditional public organizations are thought to be open to outside influences, dependent on the environment for both legitimacy and needed resources. "The indeterminateness and uncertainty

created by this dependency," wrote Miles (1980), "so contribute to the tensions that must be managed from within" (p. 6). According to Dye (1978, P. 38), "The system can respond to forces in its environment, and ... it will do so in order to preserve itself. Inputs are received into the political system in the form of both demands and support."

This concept is fully accepted by Boulter (1983) who tells us that policy is shaped by external contingencies, a response of the political system to forces brought to bear upon it by the environment (Easton, 1957). Chapter IV will show that institutional survival is dependent upon environmental inputs (money, community resources, patients) and environmental acceptance of outputs (ex-patients).

Modern authors, including Miles (1980) and Pfeffer and Salancik (1978), describe ways of helping organizations to become aware of environmental impacts on the agency and thereby make strategic choices in managing contingencies. However, these theories assume that the organization is a rational actor in the decision-making process. Instead, what is being postulated here is that the organization, and even its formal internal leadership, are single factors in a larger system.

Legislators hold the purse-strings for public agencies. It has been argued that, as a result, they

may carry the weight of the final decision. In the mental health field, perhaps alliances established between conservative legislators who favor institutionalization (because it is less disruptive to their constituents and district) and hospital professionals defending the last bastions of the medical model serve to arbitrate community needs.

Such an approach, however, ignores the richness of the decision process. The environment, as well as organizational culture and tradition, are all part of the system. Clearly, "government decisions are not all made in the hallowed halls of the legislature; rather, a good number of them are made in the less impressive but more numerous halls of administrative office buildings" (Peters, 1978, p. 4).

This less visible group of attentives and affiliated associations are a natural part of the organizational system. Zeigler (1964) clarifies their role:

The clientele of an agency -- "groups whose interests (are) strongly affected by an agency's activities (and provide) the principal sources of political support and opposition" (Simon, Smithburg, & Thompson, 1950, p. 461) -- may have great impact on the way the agency's programs are enforced. If the clientele of the agency is large and heterogeneous, the agency will function in a climate of greater potential conflict than if the clientele is limited and relatively united. (p. 280)

As will be discussed more thoroughly in Chapter IV, however, recipients of mental health services are gener-

ally less a part of the policy-making system than are service providers, who are also considered agency clients by Zeigler (1964).

#### Level I -- The Decision

As is often the case, we find that the discussion has come full circle. Clearly there are a variety of models and theories that can account for a given decision outcome. We see that Boulter's (1983) framework incorporates a number of them into a manageable structure.

Boulter (1983) argues that decision makers are faced with a sum of public opinion that weighs on the final decision. As Shils (1961) tells us, a Congressman has to be "hypersensitive to the faintest whisper of a constituent's voice" if he is to survive. While agency operation, including economy and efficiency, should not be discounted, a more important aspect is decision-maker perception of agency viability as a sum of its continued value. Only peripherally can the agency itself, because of its obvious vested interest, do much to manage its constituencies.

In the public sector the organization, as an entity, remains a bystander, perhaps not an "innocent" bystander but one whose fate is most often decided by external pressures brought to bear on key decision

makers. One conduit through which this pressure flows is the media, specifically newspapers.

### Propositions

The foundation for this revised theory of public decision-making rests on the assumption that public programs are highly dependent on constituency involvement and support. Survival becomes contingent on awareness and acknowledgement of community-based power interests. A simplified conceptualization of this process is provided in Figure 3.

Based on this model, and Boulter's (1983) framework, it is proposed that:

1. Those organizations that receive strong public constituency and media support are more likely to survive than those which receive less support.

2. Program success or failure is dependent on the decision-maker's perception of the sum of constituency support (symbolized by solid lines of influence). Part of this perception of public concern is obtained from the media, particularly newspapers.

A study by the American Society of Newspaper Editors states that the majority (53%) of readers believe that newspapers are usually inaccurate. Key decision makers, nevertheless, have few other gauges with which to measure public opinion ("Editors



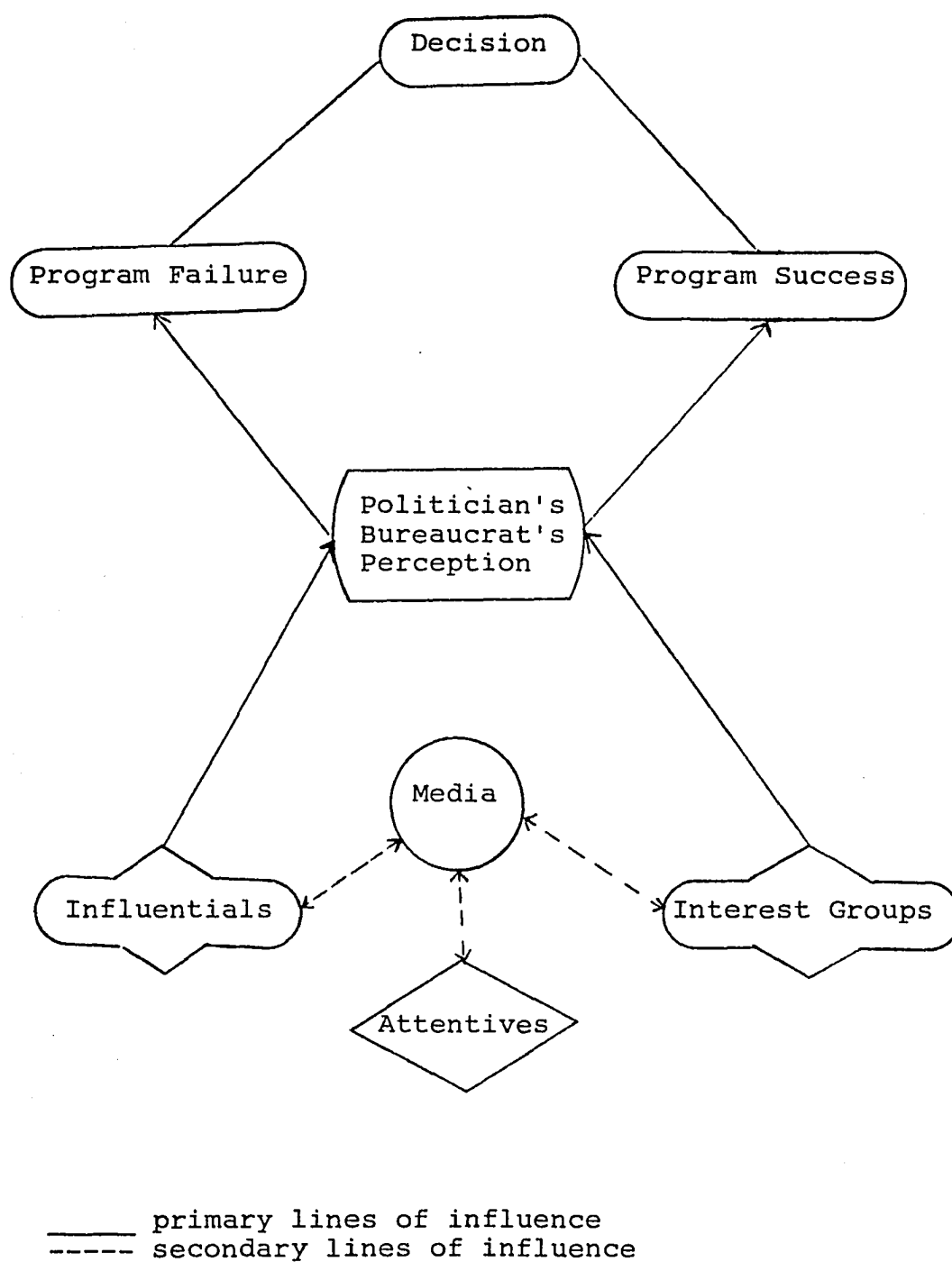


Figure 3. A conceptualization of the decision-making process.

Learn,...." 1984). Polls, advisors, and commissions offer only limited and circumscribed insight into a myriad of issues confronting the policy analyst.

3. As a result of this decision-maker interest, the media impacts on mental health policy. It serves both as a carrier of opinion and as an influential actor in its own right.

This last proposition is clarified by modifying Boulter's (1983) policy ladder (see Figure 4) to differentiate interest groups and the media from attentives and the general public, since Level III groups would be expected to have relatively more influence than Level IV groups.

4. The decision to maintain or close an institution for the mentally ill (particularly in a time of crisis) will be influenced by newspaper coverage.

#### Secondary Propositions

Interest group beliefs in both the efficacy of media coverage and their own ability to sway opinion through publicity will lead naturally to the development of strategies for managing issues and events.

Based on these assumptions, two additional ideas are worth exploring. Strategies regarding the media will tend to gravitate toward one of two polar opposites, depending upon the pressure group's position

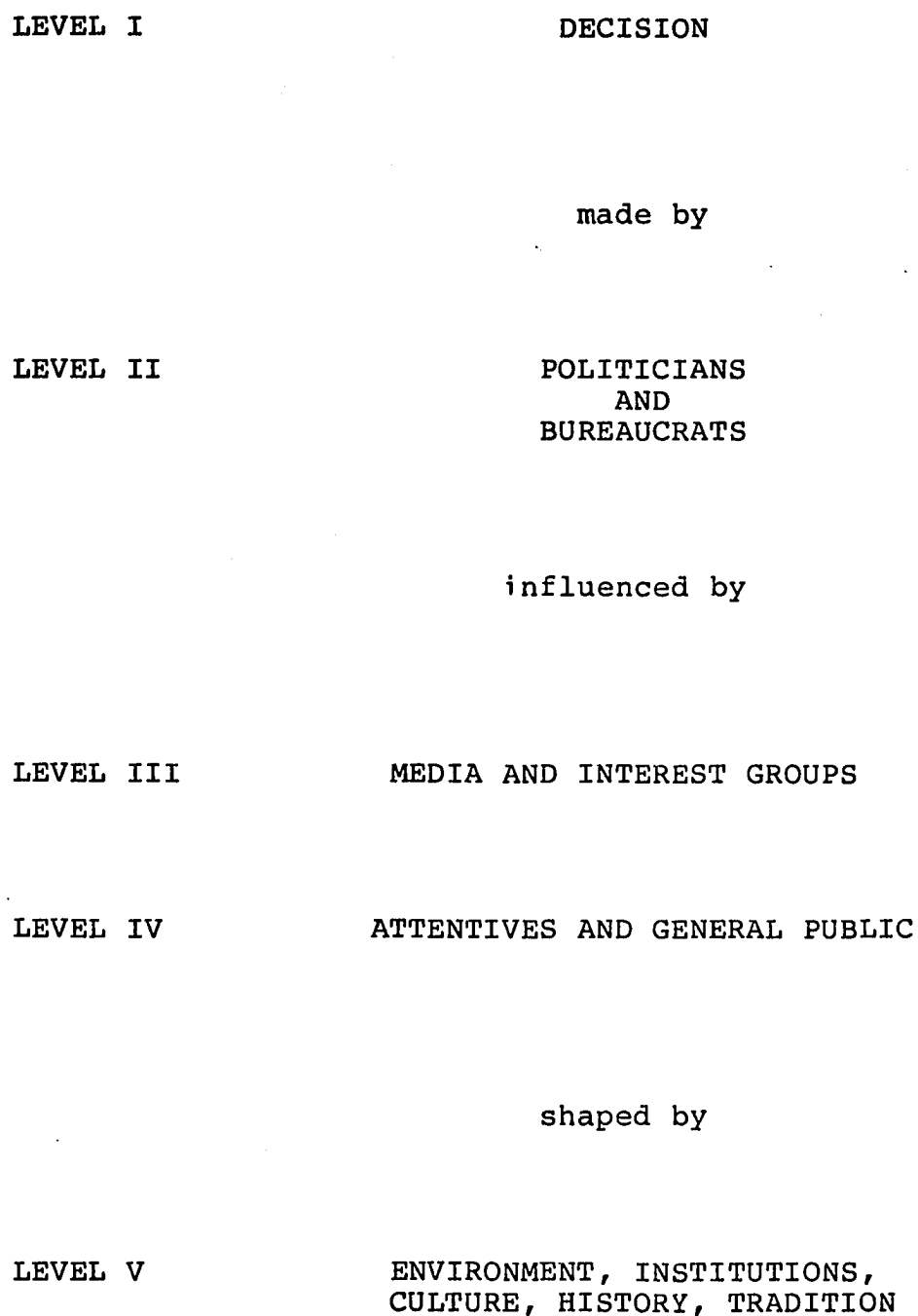


Figure 4. A Modification of Boulter's (1983) decision-making ladder.

in the system. Stakeholders can either deliberately seek support and publicity for a position in an attempt to sway decision makers by revealing the depth of public interest or they can try to minimize potentially negative risks by avoiding publicity.

It is expected that risk seeking behavior will occur more often in less powerful groups and by those outside the formal decision-making hierarchy. Leaders of institutions and organizations generally have more to lose if strategies backfire. Their strength often lies in the ability to insulate programs within the bureaucracy. Therefore, those who are firmly entrenched in the mental health system will seek to minimize risks by avoiding media attention.

A second issue is more specific to the institutions under study. Crises, almost by definition, threaten basic values or one's way of life (Boulter, 1983, p. 273). It could be argued that, with two strong interest groups competing within the Michigan Institute for Mental Health (DMH and MSU bureaucrats), power brokers were so busy supporting their own needs during crises that they failed to support the agency. Why would that occur in one facility and not the other? What were the issues involved in the crisis?

Perhaps influentials, interest groups and attentives creatively managed certain elements of the "crisis" such as staff-to-patient ratios and perceived patient dangerousness, using the media or other strategies to weigh public opinion more heavily on various sides of the issue.

There remain a number of interesting questions to be explored, including the usefulness of Boulter's (1983) policy ladder for the public administrator. A variety of contemporary theories attempt to explain public policy decisions, but few try to predict them. While post hoc explanations can be valuable, Boulter (1983) attempts to move one step further and provide a predictive tool which is incorporated in his check sheet.

There are acknowledged limitations to Boulter's (1983) framework, which will be discussed in Chapters VII and VIII, when check-sheets are provided for the two facilities under study. Perhaps one of the greatest weaknesses of this framework is that, in its applications to date, decision outcomes were known. With the inherent subjectivity involved in rating actor and group stands on a dichotomous scale, the final sum of ratings becomes suspect. Nor is there any weighting of the strength of opinions or the potential for greater

impact on the final decision based on greater power in the system. These issues will be explored more thoroughly in the following chapters.

### Summary

Douglas R. Boulter (1983) postulates a policy ladder which can be used to incorporate a variety of theories. This same ladder provides structure for the following research.

Boulter (1983) describes policy as occurring at several levels, each of which impacts on the decision maker. To broaden the research, a review of literature focused on models that are integral to this conceptualization and that can strengthen the study. The rational actor and political actor models, elite theory, pluralism, policy as group equilibrium, institutionalism and systems theory are each pieces of the larger framework which will be used to consider the issue of survival in two public mental health facilities: Michigan Institute for Mental Health and Lafayette Clinic.

It is suggested, based on this enlarged framework, that politicians and bureaucrats make decisions according to what they see as the sum of constituency support for a given outcome. In this instance, the decision is one of institutional survival. Perceptions of public interest and support are obtained, at least in part,

from the media. Therefore, it is further suggested that the media serves both as a carrier of opinion and as a public actor in its own right.

By assessing the positions of key groups toward these two mental health facilities, decision outcomes regarding survival can be studied.

## CHAPTER III

### METHODS AND PROCEDURES

#### Historical Review

Research should begin by laying a foundation upon which theory can build. Michigan mental health decision-making resided within a historical framework. If decisions are ultimately shaped by their environment, culture and traditions, as Boulter (1983) suggests, then we need to know what those factors were. In order to understand the forces that shaped attitudes and actions, it is first necessary to understand the milieu which created them or at least, according to Boulter (1983), shaped them. Chapter IV will provide that background in an overview of the Michigan mental health system and the people who shaped it.

Although cultural, historical and environmental forces are placed at the bottom of the policy ladder, this does not mean to imply they are insignificant. On the contrary, critical decisions revolve around crisis periods. In Michigan, mental health services were deeply affected by what has been variously described as a fiscal downturn, economic recession or depression. Limited funds impacted on programs, as did such philosophical issues as deinstitutionalization. While



individuals will argue about which forces drove which events, it is nevertheless important to outline the events.

Michigan's mental health experience was in many ways typical of what occurred in other midwest states. It also had a unique set of experiences that served to shape responses and, ultimately, reactions to crises.

### Case Studies

In Chapter V the research focus will narrow to examine in greater detail two mental health facilities operating within this milieu -- one that was forced to close during the crisis period, and one that was able to survive. A comparative case study approach is used to gather information within Boulter's (1983) framework in order to be able to discuss further the propositions, as well as the framework's applicability to this kind of public decision-making situation.

Because Boulter (1983) postulates that decisions are shaped by cultural factors, Table 2 matches eight Michigan mental health institutions along several critical environmental dimensions. Of these eight programs, six treated the mentally ill, one cared for geriatric patients, and one worked with developmentally disabled clients. Five were classified as urban, two rural.

Table 2

## A Comparison of Michigan Mental Health Facilities

ORGANIZATIONAL DIMENSIONS	Michigan Institute for Mental Health	Lafayette Clinic	Detroit Psychiatric Institute	Walter A. Reuther	Traverse City Regional Psychiatric Institute
BUDGET	\$4.1 M	\$5.4 M	\$8 M	\$7.9 M	\$14.7 M
NUMBER OF INPATIENTS	74	133 52 adult psych.	173	171	483
TYPE OF PATIENT SERVED	mentally ill	mentally ill	mentally ill	geriatric	mentally
TYPE OF SERVICE	inpatient adult		inpatient adult, child	inpatient adult	inpatient adult, child
PURPOSE	treatment, training, research	research, training, treatment	treatment	care	treatment
FOUNDING DATE	1977	1955	1972	1977	1885
LOCATION	Jarvis Acres Lansing/Diamondale	downtown Detroit	Herman Kiefer Hosp./Detroit	Eloise (1839) Detroit	Grand Traverse
URBAN/RURAL	urban	urban	urban	urban	rural
OWNERSHIP	DMH	DMH/Wayne State	transferred to DMH from City (1972)	transferred DMH from county (1977)	DMH
UNIVERSITY AFFILIATION	Yes/ MSU	Yes/Wayne State	no	no	psychiatric residency
LEGAL MANDATE	no	yes	no	no	no
ACCREDITED	yes	yes	yes	yes	no
CATCHMENT AREA	7 counties, lower half of lower peninsula	state-wide Detroit	east-side Detroit	state-wide	upper half lower peninsula
OUTPATIENT	no	yes/addiction	yes	no	no
IN-HOUSE MEDICAL	no	some	yes	no	some



Table 2

Michigan Mental Health Facilities for F.Y. 1978

	Walter A. Reuther	Traverse City Regional Psychiatric Hospital	Caro Regional Mental Health Center	Ypsilanti Regional Psychiatric Hospital	Alpine Center
	\$7.9 M	\$14.7 M	\$450,000	\$24.5 M	\$4.2 M
	171	483	12	966	175
y ill	geriatric	mentally ill	mentally ill	mentally ill	developmentally disabled
t ild	inpatient adult	inpatient adult, child	inpatient adult	inpatient adult, child	inpatient adult, child
t	care	treatment	treatment	treatment	habilitation
	1977	1885	1973	1931	1960
refer roit	Eloise (1839) Detroit	Grand Traverse	Caro Regional Center	Ypsilanti	Gaylord
	urban	rural	rural	urban	rural
ed to City	transferred DMH from county (1977)	DMH	DMH	DMH	DMH
	no	psychiatric residency	no	no	no
	no	no	no	no	no
	yes	no	no	no	yes
e	state-wide	upper half of lower peninsula	Thumb area	12 counties, lower half of lower peninsula	upper half of lower peninsula
	no	no	no	no	yes
	no	some	some	no	no



Despite the differences, Table 2 shows that Lafayette Clinic and Michigan Institute for Mental Health (MIMH) are the most directly comparable. Both were small (budgets of \$5.4 and \$4.1 million respectively); both were able to draw upon the resources of metropolitan areas; and both had a stated research and training orientation, with the apparent advantage of a unique relationship with a major university.

While these two agencies appear to have much in common, they varied along one critical dimension. Michigan Institute for Mental Health closed shortly after opening; Lafayette Clinic continues to thrive. It is this outcome difference within the context of the environmental similarity that will be explored.

Comparative case studies of Lafayette Clinic and Michigan Institute for Mental Health will be developed in Chapter V, in order to delineate key actors and relevant issues at each of the five policy levels. By structuring research within the framework of a modified decision ladder, the process and interplay between levels becomes clearer.

This in-depth look is less an attempt to explicate daily program operations than to offer renewed understanding of the various decision layers within the mental health system. Direct comparison will clarify

Boulter's (1983) policy ladder. It will also provide the basis for rating various actor and interest group stands that may ultimately have affected survival outcomes. Finally, by examining the agencies more closely, we can eliminate issues that by their nature might cause the decision to close a state hospital to be the only feasible alternative.

Formal organization charts, operational philosophies and agency environments are used to outline critical issues and responses to them. Information was gathered from such sources as annual reports, speeches, minutes of meetings, correspondence, public hearings, court depositions, audits, interviews, program policy reviews, legislative committee hearings and enacted legislation.

The case study method has been criticized as not being a specific research technique. Rather, Williams (1979, p. 2) calls it a way of collecting data with no inherent or intrinsic limit to the quality or quantity of information desired except for that established by the researcher. Here the purpose is not merely to collect information, but to outline specific aspects of the decision process in an effort to draw conclusions about our central question: What factors predict organizational survival? Case studies lay the foun-

dation for the next research step in an iterative process.

The study also serves as a tool for exploring the operations and functional relationships involved in political institutions and events. As mentioned, this approach is subject to criticism: "Data resources, e.g., official documents and newspaper accounts, are superficial or misleading. Information is often haphazardly selected and laced with imaginative reconstructions. Impressionistic and 'inside dopester' evidence, too, may be employed quite freely" (Davis and Weinbaum, 1969, p. 4).

Some of these pitfalls can be successfully avoided through "parallel verification" of information. Multiple methods of gathering data, including interviews and newspaper content analyses, serve to ameliorate concerns.

### Interviews

Open-ended interviews supplement both the historical background and case studies. They also serve as a source of ratings for comparing decision outcomes between the Lafayette Clinic and MIMH.

Forty-five people key to Michigan's mental health system were interviewed using questions that focused on



relationships, budgetary and policy decision-making processes, awareness and use of the media, knowledge of institutions and other central issues. All but five interviews were taped and transcribed, supplementing extensive notes.

Initial consideration was given to interviewing individuals who would be identified in a formal organizational chart as key decision makers, such as Department of Mental Health (DMH) Directors. Although many of these people are no longer part of the formal system (including the Governor, MIMH Director, Lafayette Clinic Director, Department of Mental Health Directors, Community Mental Health Director and Regional Directors), many remain accessible. In addition, there is some evidence that people outside a system feel more free to express critical opinions. The fact that the Michigan Institute had been closed for four years might also have served to eliminate inhibitions about expressing opinions, both positive and negative.

If policy can be considered the result of a series of activities by concerned and involved constituency groups, how do we know which groups and which people to include? During each interview an attempt was made to elicit names of other influentials, knowledgeable and attentive.

Interviews of those people, in turn, lead to identification of other actors in a "snowball" effect. Mention of a name or referral to an influential group served as an additional resource.

In-depth interviews with a variety of people, both inside and outside the system, provided a glimpse of the more informal decision-making process. Parents, advocacy and other interest groups, both formal and informal, were also included as valuable sources of data, since agency attentives could be expected to provide information from a different perspective than political leaders.

One group of knowledgeable not often considered in the interview process is newspaper reporters. City desk writers are generally more aware of community trends, concerns and issues than the average citizen. They are interested in, and understand, local events. Information obtained by interviewing several news observers served to counterbalance the inherent subjectivity of other, more involved actors.

By acknowledging the role of the media in the public information process, an enriched understanding of Level III impact on decision making can occur. In addition, the distinction between the media as an influential actor and the media as a conduit of public

opinion can be examined, thereby strengthening the study's theoretical base.

Although an attempt was made to contact individuals involved in mental health issues between 1977 and 1981, research was not confined to that period. Institutional history clearly did not begin or end during those years. With the case study as a guide to interviews and analyses, other critical events could also be explored.

Through information gained from interviews and case studies, it became possible to begin mapping lines of power. By outlining agency histories, cultural and crisis events, power holders and brokers emerged. Actor affiliations and positions during crises became clearer. At this stage initial propositions regarding constituency support and the evolution of decision making were developed.

### Newspaper Content Analysis

The newspaper medium's role in this decision-making process has been mentioned several times. Specifically, two types of involvement are proposed. Newspapers serve as a conduit for information. They are communications devices through which much of our awareness of the larger world around us is filtered. Of necessity, there is selective sorting of material based on what editors

perceive as interesting to readers. It is within this selection process that additional value may be added to newspaper articles and editorials casually scanned by the agency attentive. Awareness of, and interest in, issues may be shaped by how they are treated by news writers and editors.

We are less interested in the "how" of newspaper influence than the "what". Although Boulter (1983) considers interest groups, attentives, the media and general public as a unit that influences decisions at Level III, it is suggested that newspapers have a greater impact by virtue of their dual role. Therefore, the decision ladder was modified to differentiate between the media (Level III) and attentives (Level IV).

As that line between news reporting and investigative journalism becomes finer, it would be expected that the focus of media attention will set the agenda for the general public, while pinpointing constituency concerns for politicians and bureaucrats.

A newspaper content analysis was performed using articles from the three local papers most likely to focus attention on occurrences at either the Michigan Institute or Lafayette Clinic. Covering an eleven-year period (1973 through 1983), the unit of analysis was the hospital, with coding based on the Lansing State

Journal, Detroit Free Press and Detroit News. Results are presented in Chapter VI.

The Lansing State Journal is a Gannett newspaper serving the MIMH area. It has a daily circulation of approximately 76,500. Other area newspapers, such as the Charlotte Republican Tribune, are weeklies with relatively small readership.

Detroit is served by both the Detroit News and Detroit Free Press. Because they have larger daily circulations, 634,000 and 609,000 respectively in 1984, it was expected that either newspaper would tend to limit continued coverage of a particular story. Local newspapers, unlike major metropolitan dailies, carry fewer wire service reports and tend to serve as primary sources of local information but supplementary sources of national news (M. Lane, personal communication, February 17, 1985). Therefore, stories may have to be either considerably more volatile or important to receive Detroit exposure.

Access was gained to both Lansing State Journal and Detroit Free Press Lansing-based files. Topic headings were Mental Disorders, Michigan Government - Department of Mental Health, Michigan Mental Institutions, and Michigan Mental Health. The newspapers filed articles somewhat differently, including separate categories for

some institutions which had generated widespread media interest in 1978. No separate files on either Lafayette Clinic or MIMH were available.

In order to assure that as many articles as possible were included, clipping files maintained by Michigan State University and the State of Michigan libraries were also reviewed, using the same general headings.

The Detroit News Lansing morgue was not accessible. Therefore, the Bell and Howell Newspaper Index to the Detroit News (1982) was used as reference. Each article generally described under the appropriate category heading was read and logged. In addition, The Free Press Index and Michigan Newspaper Index by Diversified Business Systems, Inc. of Kalamazoo Michigan (1983) cover all three papers and were surveyed to assure completeness of records.

Eight-hundred-and-eighty-seven newspaper articles spanning the years 1973 through 1983, were read. (See Appendix A.) A total of 149 Lansing State Journal, 207 Detroit Free Press and 531 Detroit News articles were reviewed.

The number for the Detroit News is almost double what might be expected, because of a newspaper peculiarity. The News, unlike other local papers, publishes

separate editions for its various metropolitan regions including Detroit, Oakland, West and North. Front pages and inside sections, particularly section B which tends to feature the mental health news of importance, often vary considerably between editions. It is not unusual to find the same article on different days, with different headlines and somewhat different copy, in different editions. For example, on March 23, 1983 page GD6 of the Detroit-area issue of the News featured a story headlined "Group Points With Pride Over Its Help For the Retarded." Almost two months later (May 22, 1983), essentially the same article appeared in the northern edition page HN6, "Group Points Proudly to Its Help For the Retarded."

Clippings from any single issue were included. There are instances when similar articles in different editions were counted several times, but, whenever possible, duplication was eliminated.

Articles concerning either the retarded or mentally ill were included. Although initially it may seem inappropriate to consider articles about the developmentally disabled when research is focused on the mentally ill, the two types of services are often tied inextricably together in Michigan's mental health system. This is especially true when budget and quality

of service issues are under discussion. Both MIMH and Lafayette Clinic were mentioned in articles about the retarded.

However, there is a deeper philosophical reason for considering the entire range of mental health programs. Our interest lies in community perception of specific public agencies. Not only are the mentally retarded and mentally ill often considered as one in the public mind, but so are such seemingly diverse problems as plea bargaining for the "insane" criminal and community foster home development. Readers consider this news in light of its impact upon the neighborhood and themselves.

Responsibility for mental health service is perceived to rest within a single system. The Department of Mental Health becomes a monolithic bureaucracy, embodied by the Director, making decisions affecting thousands of lives, including those most helpless within institutions and the community.

From a research perspective, the newspaper article about horticulture therapy for the developmentally disabled offers as much information about public attention and interest as that on involuntary sterilization. Positions, stakes and stands of the general public, as reflected within and by the media, offer



important insights. Each article helps us more clearly define the environment and culture during that period. It also presents and clarifies Level III issues.

We must first know where attention is focused; we must know what Level III constituency concerns are, as reflected in the newspaper, in order to ascertain where Level II attention (i.e., the decision maker's) is turned. If we wish to predict public policy outcomes, we must know what inputs are and how perceptions of them are shaped by the media to form a public view of the larger mental health system. We cannot know one without examining the other.

#### Document Analysis

A number of data sources regarding mental health programs and facility issues have already been mentioned. Most bureaucracies are sustained by a hearty flow of documentation. Agency policy manuals, Appropriations and Mental Health Committee hearings, DMH guidelines, archival records, audit reports, Communication Council and patient advocacy group minutes each offer insights into total systems operation.

Integrating such a diversity of materials into a larger study can pose problems, especially since many of the biases attributable to the case study methodology are also inherent in document analysis. Nevertheless,

an attempt was made to consider every source of information in an effort to ground firmly findings in available data.

One method of incorporating such documentation is to "interview the data" during different time periods, using the model already established. Consider 1977, the year that the Michigan Institute for Mental Health opened. Through legislative reports, speeches, interviews, news releases and other sources, it is possible to fill in the outline of Boulter's (1983) decision-making ladder for each agency during that year, in order to better compare the Lafayette Clinic with MIMH.

At a minimum key actors, decision or crises points, environmental issues and concerns can be identified. But, even more intriguing, such a format offers the opportunity to compare 1977 with 1981, the year the facility closed, at each of the various decision-making levels. Chapter VII presents this comparison.

In using the decision ladder framework we are forced to consider a broad variety of factors that may impinge upon institutional survival. What, for instance, is the role of the legislature in relationship to other first-order actors? While it would be far too complicated to delineate total system dynamics, it remains possible to draw attention to critical areas of the framework.

This process will clarify constituency opinions regarding each agency at each level, while serving as a source for developing rating charts of actor positions. Comparative ratings, in turn, will provide the basis for analyzing both the decision process and its outcomes.

Document analysis clarifies and expands the interviews by offering additional data on who makes decisions and how policy is influenced and shaped.

With information gathered from similar agencies, it should be possible to strengthen the study in the future by incorporating other facilities that differ in other ways. For instance, Alpine Center in Gaylord, a DMH program for the mentally retarded, was recently closed. It was a single ownership agency (not affiliated with a University), which seemed to have considerable community support. It was small and served the mentally retarded in a more isolated area of the state. It seemed to be meeting the needs of the Department, the community and its patients. Why was it closed when other, less innovative, facilities continue to survive? Ypsilanti Regional Psychiatric Center, for instance, is a large, old-fashioned institution that is perpetually overcrowded. It has never managed to win accreditation.

In examining the strategies and tactics used by constituency groups, as well as expressions of intended effect versus actual outcome, the broader issue of

public organizational survival will be explored. It is hoped that such information will lead to a more comprehensive theory of this relationship and its reliance upon the media, both as a source of information and as a political actor.

### Summary

A variety of research methods will be utilized to examine the propositions set forth in Chapter II. Case studies supplemented by historical review, open-ended unstructured interviews, document analysis and newspaper content analysis should show many of the same types of issues and concerns extant in the community. Each source of information serves to build upon and verify previous findings in an iterative process which allows exploration of issues and a clearer definition of decision makers and constituents who impact on them.

Case studies and open-ended interviews have been criticized because they can be manipulated, or at least selectively winnowed, to build a strong case. Such problems are of special concern when the theory and theoretical outcome are clearly outlined. Check sheets, cross-verified using archival information, interviews, and newspaper content analysis, are developed in Chapter VII as one method of strengthening the study and avoiding such criticism.

To further narrow the research focus, Table 2 matches 8 Michigan mental health agencies along 15 organizational dimensions. Michigan Institute for Mental Health and Lafayette Clinic were found to be the most directly comparable. Yet, they differed along one crucial dimension. Michigan Institute for Mental Health closed soon after opening. Lafayette Clinic continues to serve mentally ill clients from the Detroit area. This critical difference provides the foundation for examining constituency support for the two agencies both before and after the crisis period.

It is acknowledged that public mental health policy in Michigan may not be representative of other sectors and issues. As a result, findings may have only limited generalizability. The purpose, however, is less to offer definitive theory than to validate the utility of a particular framework in the public sector.

## CHAPTER IV

### ENVIRONMENT, CULTURE AND TRADITION

#### The Background

Policy decisions are shaped by the milieu in which they are embedded. Decisions, particularly in the public sector, are constrained by a myriad of external contingencies including resource availability, organizational culture, history, tradition, legal and legislative mandates. As was noted in Chapter II, to be immersed in a system means, at least minimally, to be responsive to it.

While some might argue that decisions are results predictable by the weight of history, or that external forces can be selectively managed and tuned to fit organizational needs, Boulter (1983) offers a more dynamic approach. Critical historical periods, philosophical trends and environmental factors serve to shape current policy decisions.

In order to understand the evolution of decisions in the public mental health sector, we must begin by examining the influence of 150 years of institutional history within this larger framework. (See Chronology, Appendix B.)

Administrative issues concerning treatment and care of Michigan's mentally disabled population can generally be classified in four interrelated areas:

1. Organization, including coordination of a unified service system.
2. Laws and statutes.
3. Budget, allocated through the legislature and dependent upon the state's fiscal health and ability to generate revenue.
4. Personnel. With the exception of capital renovations, staffing requires the largest single expenditure of mental health resources. More than 80 percent of the operating cost of inpatient care is attributable to personal staff services.

In addition, personalities of such key actors as Department of Mental Health Directors, legislators and other central figures create impacts that ripple throughout the system.

Much of Michigan's early mental health history is available as a result of the Michigan Writer's Project, sponsored in 1941 by the State Administrative Board and Federal Works Project Administration. The Mentally Ill in Michigan traces the first years of what was to become a comprehensive state-wide system of institutional services.

In Michigan, as elsewhere, mental health programs began as a way of relieving communities and families from the pressures of coping with essentially uncontrollable and bizarre behavior. Out of necessity, the most violently insane were confined to poor houses or jails. Often mentally ill persons were intermixed with incorrigibles, addicts, senile elderly or those with such medical problems as epilepsy and tuberculosis.

Michigan's first institution was an outgrowth of increasing urban pressures. In 1834 a local ordinance was passed in Wayne County creating a Board of Superintendents for the Poor and converting the "Pest House" (established in 1832 for cholera victims) into a poor-house accepting "lunatic persons".

Conditions were barely humane and the concept of treatment unknown. Inmates were considered incurable. Cells and chains confined the most violent in a rude shelter known as the "crazy house". In 1841 the facility received the first person in Michigan adjudged legally insane. The Board of Superintendent's 1858 annual report showed 29 insane persons admitted during the year with 17 remaining, 12 in constant confinement.

One of the first advocates of the mentally ill was Dorothea Dix of Boston. Her concern about abuses of this vulnerable population was a new concept in the



mid-1800s. She contended that care of the hopelessly insane was a public responsibility. For the first time mental illness became a public, as opposed to family, problem.

Largely as a result of Dix's efforts, hospitals were established in many states, including Michigan. In 1848, the Michigan Legislature provided for establishment of a state asylum for the insane. However, because of the increasing costs of public programs and a limited tax base, no money was appropriated.

Institution opponents argued that there were insufficient numbers of people needing care to warrant "the expenditure of sums which the state could ill afford to raise for any purpose" (Michigan Writer's Project, 1941, p. 4).

Because of this opposition, the Legislature requested that the Secretary of State survey the population. The census showed that there were 120 insane in Michigan -- 24 from birth and ten described as idiotic. The board of trustees for the proposed institution estimated one insane person for every 1,000 population, or 426 insane or idiotic persons.

Despite continued budget pressures, inadequate appropriations and a destructive fire during construction, the Michigan Asylum for the Insane in Kalamazoo

finally accepted its first patient on April 29, 1859, eleven years after the enabling legislation. With an allowed bed capacity of 400, the facility was soon overcrowded, limiting admissions to "curable cases" only.

Like other facilities that followed, the Michigan Asylum (later to be known as Kalamazoo Regional Psychiatric Hospital) was an independent farm colony operated by a local board of trustees. It immediately began a massive building program that lasted ten years.

The increasing need for space was generally blamed on growing numbers of insane or defective immigrants arriving in the United States in the late 1840s and early 1850s. Between 1891 and 1924 a series of federal laws restricting immigrants helped curb the problem, although language difficulties, ill health, culture shock and poverty continued to exert pressures on immigrants and the public system.

In 1873 the legislature appropriated monies for the Eastern Michigan Asylum (Clinton Valley Center) at Pontiac. Five years later the building opened with a bed capacity of 400. By 1880, almost 1,100 patients were under care in the two Michigan facilities, with a waiting list of about 200.

As a result, the legislature authorized the Northern Michigan Asylum (Traverse City Regional Psychiatric Hospital) in 1881, with an appropriation of \$400,000. In November 1885, after several delays and further appropriations, the new facility admitted 445 patients. The governing board immediately began a construction program that ended in 1906 with 11 new patient buildings.

The year 1883 marked the first time thought was given to segregation of violent criminals and sexual offenders from the general mental health population. The concern was two-fold. Asylums were highly dependent upon labor performed by "inmates" who tended farms, cared for herds and performed other necessary duties of day-to-day operations. Unknowingly, through work programs, the way was being paved for more humane treatment and even some effort at "rehabilitation" of the mentally ill. Clearly, however, consensus was that the criminal needed to be locked up. Only secondarily was there a new awareness of the need for different types of services for different populations.

The Michigan Asylum for Insane Criminals (Ionia State Hospital) opened in 1885, two years after legislative authorization. The 100-bed facility immediately developed a waiting list.

The first facility for the "feeble-minded and epileptic", now known as Oakdale Regional Center for Developmental Disabilities, opened in Lapeer in 1895 with a capacity of 200. Within months the waiting list reached 600.

On November 1, 1895 the Upper Peninsula Asylum for Insane (Newberry Regional Mental Health Center) opened in Traverse City.

We can see that state institutions in Michigan were a response to growing community pressures, the 19th and 20th century creation of a rather curious coalition comprised of advocates of humanity-toward-all on the one hand, and segregationists on the other. Moved with compassion and sincerity the "humanists" witnessed the abuses of society toward the mentally handicapped and earnestly believed the disabled could obtain better care and acceptance in self-contained quasi-communities (institutions) with "their own kind". These advocates were motivated by their perception of what was best for the disabled individual.

The other side of this coalition consisted of segregationists who wanted the mentally handicapped removed from the community in the best interest of society. Thus, the institutional system was born and with it a philosophy of life-time care apart from

society at large. State hospitals were built to be self-contained communities, remote from the general population. Not only did patients live their lives within the confines of the hospital grounds, but so did many of the staff. It was generally believed that the local community could not, and would not, provide appropriate care.

Over the years, institutions have typically been the target of claims that minimal custodial care did not serve the needs of the populations residing in them. Reforms and suggestions for improved treatment began to occur.

According to the Michigan Writer's Project (1941), Michigan was the first state in the Union to provide special facilities for instruction of medical students in treating the mentally ill. In 1906 the State Psychopathic hospital at the University of Michigan (Ann Arbor Neuropsychiatric Institute) was established, specializing in research.

In 1906 mechanical restraints were abolished and in 1911 Michigan's legislature changed the name of asylums to state hospitals. However, each facility remained an autonomous state agency with a separate board of trustees and individually negotiated legislative appropriations.

In 1914 the Michigan Farm Colony for Epileptics was established in Wahjamega (Caro Regional Center). While additional building projects were halted until 1929, there were 7,448 patients in state institutions with a rated capacity of 6,254.

These overcrowded conditions were exacerbated by World War I, and increasing numbers of individuals "whose sanity had been shaken by wartime and postwar experiences. The tempo of social change was further accelerated by Michigan's rapid development as an industrial state" (Michigan Department of Mental Health (MDMH), 1962, p. 11).

Mental health services continued to lag and, in fact, worsened:

While the state's population mounted and mental problems multiplied, the number of beds per hundred thousand of population available in the state hospitals actually decreased. From 1915 to 1919 only 390 new beds were provided by additions made at Newberry, Kalamazoo and Pontiac. The state hospitals in 1920 were 17.5 percent overcrowded, according to space requirements accepted as most satisfactory by hospital superintendents the country over. (p. 12)

Because of increasing concerns regarding treatment of veterans and the resulting renewal of interest in mental health issues, three Michigan outpatient clinics were established in 1916. In the early 1920's Departments of Social Service were developed.

The first State Hospital Commission, an advisory board, was authorized within the Welfare Department in 1923. Public Act 151 of 1923 was the most comprehensive mental health legislation to date and was established to:

revise and consolidate the laws organizing hospitals for the insane, homes and schools for the feeble-minded and epileptic, institutions for the discovery and treatment of mental disorders; to regulate and provide for the care, management and use thereof; to provide for the licensing, visitation and supervision of privately owned hospitals, homes and institutions for the care and treatment of such mentally defective persons. (p. 218)

The law carefully laid out terms of voluntary and involuntary admissions and gave the Hospital Commission oversight control of all state institutions. In addition, it mandated that county Departments of Social Welfare care for senile persons not found to be psychotic. However, no funds were appropriated and the Commission was given no authority to hire staff.

In 1926, total bed capacity was 6,723. Admissions totalled 9,558. In 1928, approximately 213 patients out of every 100,000 of population were admitted and there was a waiting list of 2,050. In 1929, the seven admitting facilities provided 190 beds per 100,000 in population. There were 10,365 patients in facilities designed for 6,749.

With the onset of the Depression, overcrowding became even more severe:

The story of additions to the state hospital system had up to this time never been one of planning and preparing against need; each step was taken as a compulsory relief of conditions that had been neglected until they appalled an indifferent public and compelled action from legislators inclined to ignore a group made up of persons who were neither taxpayers or voters. (Michigan Department of Mental Health, 1962, p. 13)

In 1929 the Hartmann Act provided \$19,517,200 for hospital construction for the next four years. In 1931 the program was reviewed and funds subsequently cut.

Between 1915 and 1932 Michigan's population rose by 82 percent while state hospital capacity increased 42 percent. When the Hartmann Act was repealed in 1933, construction stopped.

There was no lack of critics, even within the system. "The first state-wide program launched by Michigan had not only failed to meet the new emergencies occasioned by the economic crisis but also fell short of meeting needs which had existed for thirty-five years" (Michigan Department of Mental Health, 1962, p. 14).

Two new facilities were opened in 1931 and 1935, Ypsilanti State Hospital (Ypsilanti Regional Psychiatric Hospital) and Coldwater State Home and Training School (Coldwater Regional Center for Developmental Disabilities).



By 1937, the number of people in state hospitals had risen to 14,842 while capacity remained at the 1934 figure of 8,885. Because of these conditions, Public Act 104 of 1937 separated the State Hospital Commission from the State Welfare Department. A Central Office, consisting of a director and clerical staff, was established with authority for operating the state hospitals.

The 1930's saw the beginning of a network of community clinics, partially in response to this renewed emphasis on mental health programs. There was growing recognition of the need to serve friends and neighbors coping with mounting economic pressures. But emphasis and funds remained focused on state institutions.

With the assistance of Federal Public Works Administration grants in 1938, 11.3 million dollars were made available for hospital construction. Total numbers of patients in either public or private facilities under the auspices of the Hospital Commission increased to 24,153 or a ratio of 474 for each 100,000 persons in the state's population. Included were psychotics, feeble-minded, epileptics, alcoholics, drug addicts, mal-adjusted and personality disorders. The number of people classified as psychotic and epileptic in Michigan's 8 state hospitals totaled 16,012 (2,768

epileptic). Private institutions accounted for another 515. Overcrowding exceeded 21.5 percent.

The next major administrative change occurred when Public Act 271 of 1945 abolished the State Hospital Commission. Instead, a Department of Mental Health (DMH) was created and an advisory commission, appointed by the Governor, established within the department. The Commission and Governor jointly appointed the Director of Mental Health for a six-year term, "who shall be the chief executive officer of the department and shall administer the policies, rules and regulations as established by the commission." The Director had to be a physician with ten years of psychiatric experience. He, in turn, appointed state hospital superintendents who were required to be physicians with three years of experience.

Among the new duties mandated to the Department was authority to undertake and encourage studies of the causes, nature and methods of care, treatment, and prevention of mental illness, mental deficiency and epilepsy; and to develop and conduct a state-wide mental hygiene program with emphasis on promoting mental health and preventing mental illness, mental deficiency and epilepsy. The Department was also given responsibility for licensing private hospitals for the mentally ill.

Michigan proved to be at the forefront of a growing national movement, and Central Office staff expanded dramatically. In 1946, partially as a result of increasing numbers of mental health issues arising out of World War II, the U.S. Congress passed the National Mental Health Act and offered federal assistance in supporting community services, research, and training of mental health professionals. For the first time, mental illness was acknowledged as a national public problem.

Michigan was one of the first states to recognize the importance of providing psychiatric clinic facilities:

It is evident that there is no problem with respect to the eagerness with which these facilities have been accepted. ...About one-quarter of all cases for which help was sought came from the parents, and another quarter from the schools. The remaining cases came from sources which indicate a widespread knowledge of the existence of the clinics and a well-distributed body of people willing to make use of their facilities. (Englischer, Lund, & Ricketts, 1956, p. 33)

Even with increasing community support, Michigan found itself chronically short of hospital beds for the mentally ill. Approximately one person out of every 180 was receiving some form of care from the department either in an institution, on extramural care, or under the auspices of a mental health clinic. Yet, according to a report for Senator Elmer A. Porter, Chairman of the Senate Appropriations Committee in 1953, there were

exactly twice as many patients per 1,000 occupying beds in public mental hospitals in New York as in Michigan.

In 1950, DMH Director Charles Wagg presented the legislature with a comprehensive plan for expanding facilities by more than 14,000 beds during the next ten years. Half the funds would be obtained through a \$60 million bond issue.

As the inpatient population continued to rise throughout the fifties, physical plants were improved and buildings added at existing facilities to meet what appeared to be a never-ending need. Despite continued construction, hospitals were chronically overcrowded and understaffed.

Northville State Hospital (Northville Regional Psychiatric Hospital) was the first institution to be financed by the bond issue. It opened in 1952 with 2,400 beds.

Between 1950 and 1955 total expenditures for the mentally ill in Michigan doubled. Expenditures per patient, per year, were \$1,271 in 1953, above average for the United States. In 1954, county payments toward the cost of hospital programs added more than \$3 million, with \$2.25 million collected from patients or relatives. In 1955 a total of \$58 million was spent for services for Michigan patients, with approximately 50

percent of residents discharged within a year of admission. Significantly, only about 13 percent of total admissions were voluntary.

Another set of statistics, however, tell a different type of story. Almost 21 percent of all patients in state hospitals on June 30, 1954 had spent 20 years or more in state institutions and 64 percent, or about 12,800 patients, had spent five or more years in a state hospital.

The Michigan Legislature met twice in extra sessions to authorize contractual hospitalization space in temporary facilities, including the Army Station Hospital at Fort Custer.

Nationwide, state hospital populations reached their peak in 1955. Approximately 559,000 people were institutionalized, occupying half of all hospital beds in the United States. At that time the U.S. Congress passed the Mental Health Study Act which formed a Joint Commission on Mental Illness and Health to examine the issues of institutional care.

1955 was an important year in other ways for services to the mentally ill. Psychotropic medications were introduced for the first time on a large scale. With increasing use of medications the need for physical restraint and seclusion dropped. These advances were

closely followed by a variety of new programs which encouraged community outreach. Such federal programs as Social Security provided the financial assistance:

The arrangement in mind is that which consists of encouraging, by technical assistance and money, the creation of facilities for out-patient clinics and acute in-patient care for mental illness in the general hospital. ...It (the small psychiatric clinic) is a place that he (the patient) may know about, he may have passed by several times a week on his way to work, he may even know some of the doctors who practice there. It is not a big, sprawling, distant and strange place that he is sent to. He is in an environment which is much more familiar to him and therefore less forbidding. (Englischer, et al., 1956, p. 34)

In response to these initiatives, Lafayette Clinic was established in Detroit as a research and training facility, jointly operated by the Department of Mental Health and Wayne State University. Admissions and length of stay in state hospitals began a gradual, steady decline.

In 1956, Central Office staff included 39 people. Four were assigned to the research section. Total appropriations for Central Office functions were approximately \$250,000.

That same year the legislature saw completion of the Hawthorn Center, Northville and appropriated funds for the Plymouth State Home and Training School, Northville (Plymouth Center for Human Development). Plymouth officially opened in 1960 with 1,000 beds. A smaller

unit, the Alpine Regional Center for Developmental Disabilities, Gaylord opened in 1960 as part of the state-wide planning process.

However, even in 1956 it was recognized that one implication of improved and increasingly successful treatment programs was a change in the distribution of the burden of costs from the state to the county:

As the number of long-term patients in state hospitals decreases and an accelerated discharge program based on effective treatment techniques succeeds in reducing the average length of hospital stay, the financial costs will begin to shift more and more to the county level. Since the type of care needed to effect such a change in the length of hospitalization is known and expected to be more expensive than a custodial care program, it must inevitably also push the per diem costs higher. (Englischer, et al., 1956, p. 32)

During 1956 there were 17 children's and 5 adult clinics, serving 8,000 persons. The cost to the state was approximately a million dollars, half contributed by communities. In addition, almost 20,000 people were being served in 6 large hospitals, all but 2 located in the lower part of the state, as defined by an east-west line through Lansing, Michigan. One hospital was in the Upper Peninsula.

A report to the head of the Senate Appropriations Committee ends with the following comment:

The State of Michigan ranks rather low among states ... in its efforts and success in preventing and treating mental illness. It is only in the expenditures per patient that Michigan ranks near the top, a position that would seem to indicate the presence of greater than average interest in the problems of mental illness and a willingness to match that interest with expenditures. At the same time, it is evident that, in terms of the number of persons served as measured by admissions and discharges, in proportion to patient population and general population, the record is poor.

This situation is attributable in part to less than fully satisfactory staff-patient ratios. Remedial action must include as a further major feature a greater degree of technical, professional, and administrative direction at the state level. Without such direction the hospitals will continue to be relatively autonomous and independent in character. (Englischer, et al., 1956, p. 83)

Between 1948 and 1958 admissions to state hospitals increased by 73 percent. From 1950 to 1962 about 7,000 additional beds were added to state hospitals, bringing total capacity to more than 35,000. With the bond issue and other legislative appropriations for capital outlay, \$96 million was allocated for construction, renovation and remodeling. The total departmental budget for 1961-62 (excluding capital outlay) was \$76 million, compared to \$36.4 million for fiscal year 1950-51. By 1972-73 that figure rose to \$218.9 million.

"One of the big issues I recognized personally," stated Joe Snyder (personal communication, February 4, 1985) a Michigan Representative for 12 years and Senator



for 4, "was the concept in the old days of institution-  
alization for any reason whatsoever." He went on to  
say:

It was the old "out of sight, out of mind" idea.  
That way the community could get out from under the  
financial burden of caring for these people. When  
these people were in the communities you had to  
take care of them. The institutions were a great  
alternative because then you could forget about  
them. There were an awful lot of people in  
institutions who didn't belong there.

In 1960 members of the Joint Commission on Mental  
Illness and Health released the findings of their six-  
year study. They called for greater utilization of  
community programs in response to humanitarian, clinical  
and economic concerns. President John F. Kennedy accep-  
ted the mandate and in a February 1963 speech before the  
United States Congress, urged a more comprehensive,  
community-based approach to care and treatment of the  
mentally disabled.

Kennedy's plan was to divide the country into  
catchment areas and establish, with federal funds, a  
national network of community mental health centers.  
The U.S. Congress responded by passing the Mental  
Retardation Facilities and Community Mental Health  
Centers Construction Act of 1963 (P.L. 88-164) which  
created a funding mechanism for such centers.

But the title of the Act ultimately proved more  
comprehensive than the funding. "I think the one thing I

worried about," added former DMH Director William A. Anderson, M.D. (personal communication, January 29, 1985), "and there's some evidence that it did happen, was that the Feds really put out seed money. They made these grants and got a lot of things started and they never had any intention, probably never had the ability, to fund them permanently."

In the 1960's the number of residents in mental hospitals and state schools began a precipitous drop as more and more people were placed in alternative community homes and programs.

New medications, increasing awareness of available sources of funds for patients (including Social Security, Veterans Administration, Railroad Retirement, Supplemental Security Income and Aid to the Disabled), and the diversion of funds from state to community programs left inordinate numbers of excess hospital beds classified for long-term care.

Available services were not 'suited to meet the needs of this changing population. Short-term intensive treatment required improved levels of psychiatric care and increased sophistication in medical and behavioral treatment. It also signalled a move away from the traditional medical model and toward greater reliance on mental health practitioners and counselors.

Ironically, as more and more of the burden of care was being accepted as a public mandate, responsibility was being shifted back to the local level.

Michigan P.A. 54 of 1963 provided the mechanism for concerted development of community mental health programs. The law allowed the Department of Mental Health to match local funds for city or county units to operate mental health services on a 75% state, 25% local basis.

Outpatient diagnosis, treatment, consultation, development of programs for prevention and education in cooperation with other public health groups would become available, in addition to local inpatient services. However, no program monies were appropriated. A year later (FY 1964-65) \$1.5 million was appropriated for the five established boards which met funding guidelines.

In that same year, the Michigan Department of Mental Health applied for, and was granted, National Institute of Mental Health funds for comprehensive mental health planning. Two reports were produced in collaboration with the Department of Health: Michigan State Plan for Construction of Community Mental Health Facilities, 1965-1966 and The Development of a Comprehensive Mental Health Program in Michigan.

Public Law 89-105 of 1965 provided matching funds for initial staffing of mental health centers. Medicaid

and Medicare programs offered another way to shift the burden of costs away from the state and on to the federal government by moving people out of state hospitals. By 1973 twenty-two communities in Michigan had received more than \$22 million in federal funds.

Nationwide between 1963 and 1976, census in state hospitals dropped from 504,000 to 216,000. It is argued that the majority of these patients were simply moved to general hospital beds or into nursing homes (Merwin & Orhberg, 1983, p. 102). The federal government would pay, through the Medicaid program, for patients in nursing homes but not for those in noninstitutionalized community placements.

Administratively, Michigan's Executive Organization Act of 1965, which implemented the Constitution of 1963, retained the Department of Mental Health without change. A 1970 amendment reinstated the State Advisory Council on Mental Health Services.

In 1966 the Michigan Society for Mental Health issued its second Directory of Michigan's Psychiatric Services. The study reported significant growth in public and private services for the mentally handicapped. In 1960, when the first directory was published, 61 agencies were listed. In 1966, 111 agencies were listed, providing 185 different services.

According to Norman W. Bully, President, and Harold G. Webster, Executive Director, perhaps most encouraging was the fact that 22 community general hospitals offered psychiatric services. "In 1960 this type of service was so little developed outside the metropolitan Detroit area that we did not include it in the directory" (Michigan Society for Mental Health, 1966, p. i).

### Crises

We have already defined four areas of environmental concern that ultimately impacted on Michigan's mental health system and which help us to delineate the crisis period, a critical component of Boulter's (1983) framework. Briefly these areas are:

1. Organization. The establishment of parallel public service systems -- state institutions and community mental health -- served to intensify the struggle over definitions of power and authority. It also highlighted fiscal issues and perceptions of resource scarcity.

2. Laws and Statutes. We have looked at a few of the laws, both Federal and State, that pertained to such philosophical issues as deinstitutionalization and the appropriate role for community mental health boards. These public acts continued to make an impact throughout

the 1970's and 1980's. In addition, new laws created their own repercussions.

3. Budget. It has been stated that when the rest of the country experiences recession, Michigan goes into depression. Governor William Milliken said in his 1981 State of the State message, "The national economy, with seemingly chronic double-digit inflation and a simultaneous recession, has caught the proverbial severe economic cold. As a result, Michigan, as has been the case through so much of our history, has caught economic pneumonia."

Fiscal crises and continuous budget reductions exacerbated struggles already occurring in the mental health field. It has been argued that a budget deficit was the single crisis that motivated mental health decisions. That explanation remains too simplistic. We will explore, nevertheless, how budget problems were intimately involved with both organizational and personnel issues.

4. Personnel. Michigan leaders impacted on the mental health system. The Governor and appointed heads of Executive Offices in their ongoing relationships with legislators, constituents and each other provide an interesting piece of the puzzle.

Crisis is most often defined by the people who live through it. Therefore, it is both more meaningful and insightful to look at these issues through the experiences and opinions of participants. At the same time, in examining the interplay of these four factors on decision making in Michigan, we will continue to lay the groundwork for a closer look at two specific facilities.

### Organization

For a time, scholarly literature and 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. In the late 1970's reports began to emerge which questioned whether the pendulum might have swung too far in the direction of community care (Halpern, Sackett, Binner & Kurtz, 1980).

New York and California were the first to experiment with community placement. Massive deinstitutionalization programs offered true horror stories of insufficient preplanning and inadequate service integration (Herman, 1979). Some observers felt that deinstitutionalization or community placement was not a bad idea, just poorly executed (Etzioni, 1975).

Many of these same problems occurred in Michigan. Little concern for coordinating local and state mental health services was evidenced by DMH decision makers. As community mental health centers began to establish their program components, much of this work occurred independently of state hospital efforts (Johnson, 1979). The focus was on funding, and local governments faced one budget crisis after another.

Johnson (1979), who was herself involved in treating Michigan's mentally ill population, would later add:

This lack of coordinated planning for the total provision of service contributed greatly to widening the gap between the two types of agencies and preventing the critical linkage essential for continuity of patient care. This mistake would later prove to be catastrophic as the concept of deinstitutionalization took shape and eventually prevailed as the new mental health principle.  
(p. 4)

Other Michigan practitioners supported this view:

One of the primary failures of the deinstitutionalization movement has been that it did not designate a point of authority and ultimate responsibility for the coordination of services to this population. Today, the needs of most deinstitutionalized and uninstitutionalized people are not being met in the communities. (Merwin & Ochberg, 1983, p. 105)

Former DMH Director, Frank Ochberg, M.D. (personal communication, January 17, 1985) calls this population in continued need the "unserved under-served."



From July 1967 to May 1969, psychiatric inpatient numbers continued to decline, from 14,505 to 12,667. Admissions and discharges both increased, with discharges exceeding admissions for the first time in 1968. Expressed as a function of population, bed utilization fell from 169/100,000 to 147/100,000, compared to a rate of 251/100,000 in 1957. Staffing was close to the national average of one employee for every 1.9 patients.

Stuart Lindzey (personal communication, February 21, 1985), Emergency Services Supervisor for a local mental health board, saw community services forced to change focus. Instead of providing outpatient programs for a broad range of community members, resources were redirected to "maintaining, stabilizing and housing the recovered or recovering person who was being deinstitutionalized."

In 1968, DMH Director Anderson (1969) presented Governor William Milliken with recommendations for a major legislative program to study and extensively rewrite Michigan's mental health laws. Existing law was archaic, a complex patchwork of amendments and statutory requirements. Four major departmental goals were identified:

1. To define state-wide clusters of services, including projection of program requirements from

demographic data in order to apply uniform standards in treatment, personnel and equipment.

2. To improve data collection and processing.

Little provision had been made for internal inspection and audits, "and the Director is in the position of having totally inadequate sources of information" (Anderson, 1969, p. 9).

3. To reorganize administrative services.

4. To modernize statutes and rules affecting the Department in order to bring commitment laws into conformity with existing theory; to provide better coordination between state and local programs; and to develop a financial structure which supports program objectives.

Anderson's (1969) concerns were 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. 9)

The Central Office of the Department of Mental Health was partially or totally responsible for 6 consultation centers, 7 state-local clinics, 11 residential facilities, 57 day training centers, 4 adult activity centers, and 503 family care homes throughout

the state. In addition, there were 18 institutions and 33 community mental health boards.

The Governor appointed a Mental Health Program and Statute Review Commission in May, 1969.

In that year, expenditures for mental health as a fraction of total state expenditures were declining.

But, according to Anderson (1969):

In absolute terms there have been consistent gains measured both in dollars and personnel ratios. The question is how much of this gain reaches the ward level in state hospitals where, except for a few islands of excellence, standards are far too low. Much of the new money goes into clinic activities, Act 54 (community mental health board) placement programs, new programs for children and employee benefits. (p. 14)

A year later, and seven years after the federal legislation, deinstitutionalization became a DMH program goal under Director E. Gordon Yudashkin, M.D. This formed the basis for systematic changes in mental health care delivery and, more significantly, reordered the thinking of relevant actors regarding how services should be provided and by whom.

According to one Michigan Legislative Fiscal Analyst, it "was a very haphazard approach, not terribly responsible. A lot of people were dumped out of institutions and into the street and suffered a great deal." His criticisms focused primarily on the lack of planning within the Department:

There wasn't the community support system, and there wasn't a lot of very good resources, even government resources. But, the time was ready. ...Federal monies had become available and psychotropic drugs were available, and these things made it more "doable" to achieve that transition. There were no licensing laws in effect at that time for adult foster care. We weren't really ready with after care and community based services to deinstitutionalize people. So a lot was done haphazardly and to the detriment of people.

"There were some good people in there who did some of the planning work," added a project director for Governor Milliken's Human Services Cabinet, "but when I got there it just seems as if planning never got carried through too many times:"

There was no uniform consensus that planning has a role in the overall function. ...I think in part that's because of the history of the Department, the history being that the facilities were always on their own. And I think the Department's still got a very hard time breaking away from where everybody does their own thing, even to this day.

State fund appropriations for establishment of mental health boards went from approximately \$7 million in 1967-68 to more than \$14 million in 1969-70. It was the Department's position that all budgeted services would be considered part of an integrated whole, subject to state-wide priorities. However, the community mental health boards, according to one Director, remained concerned: "There is a difference between community placement programs, putting clients in the community, and the willingness to transfer both the budget and

authority as well as the planning function to the local level for these services."

A Mental Health Program Budget Analyst for the Department of Management and Budget (DMB) during the past ten years, found that while it appeared communities were spending adequate funds for the mentally ill, "They were simply going for community mental health services for individuals needing crisis counseling, outpatient counseling ...There was an unwillingness on the part of the community mental health boards to serve the more severely impaired." This tendency was encouraged by the fact that "you can deliver outpatient services out of any hole in the wall, but if you're going to have day treatment programs and residential programs you have to get involved in some kind of capital outlay."

The Clinton-Eaton-Ingham Community Mental Health board, for instance, was primarily funded by a federal grant. The federal concept remained "more of a broad-based outpatient, consultation, education, kind of model" (B. Allen, personal communication, February 21, 1985).

Throughout this difficult period, Governor Milliken remained loyal to the concept of deinstitutionalization, according to his staff:

He was firm all along that community placement, having people in the community, was a much better method of care. He had enough political savvy so he didn't use it to kill himself politically. But, he never waivered. ...The administration itself had enough savvy to make sure that it got enough positive publicities through the press to offset any negatives that may be created by a few groups.

### Laws And Statutes

In 1972 the Mental Health Review Commission submitted to the Governor an integrated mental health code which would recognize patient rights, tighten admission restrictions and firmly establish community managed programs.

Passage of Michigan's Mandatory Special Education Law in 1973, further diffused state service responsibility by affirming a person's right to a public education until the age of 26. This meant that even the most severely mentally retarded individual had the right to receive schooling from the Department of Education. As a result, authority for day care centers for the developmentally disabled was transferred.

Sharon Miller (personal communication, March 19, 1985), Director of the Monroe County Community Mental Health Service Board, saw services for the developmentally disabled and mentally ill begin to diverge because of differences in advocacy regarding education:

The Associations for Retarded Children were very adamant that as many as possible of their population be served outside the facility. ...For the mentally ill, however, there was the insistence that educational services be part of milieu therapy. This meant that education was integrated into the total institutional program. ...I can say without much hesitancy that that difference has been a primary contributor to slowing down the development of community mental health services, particularly for the mentally ill population.

Given the increasing visibility of the mentally disabled in local communities, DMH Director E. Gordon Yudashkin found himself surrounded by controversy. His approach, according to one legislator, was confrontational: "I didn't like Yudashkin's methods, but I appreciated his results. He shoved patients out into the community, perhaps in a deliberate policy with the knowledge that once they were out there people would pay attention."

Many of Yudashkin's contemporaries felt that his resignation came as a result of increasing legislative opposition to deinstitutionalization and community placement movements. Some of his most vehement opponents were legislators in southeastern Michigan districts where state institutions remained large employers. At the same time, there were growing citizen complaints about ex-patients creating ghetto communities in downtown Detroit -- what experts would call institutions without walls.

One gubernatorial aide summarized the program by saying, "Probably, when all was said and done, they (the mentally ill) would have been far better off remaining in an institution than surrounded by people who were equally disturbed but on busy streets with no programs, no after care and no monitoring."

The final blow was struck by the courts, which declared Michigan's involuntary commitment laws illegal. At a minimum this meant that the state would have to release all involuntary clients or face legal action. While there was tacit agreement that the legislature would immediately pass a comprehensive Mental Health code to respond to this crisis, increasing pressures forced Yudashkin to resign.

Governor Milliken appointed an Executive Search Committee to recommend a new Director, chaired by Dr. Donald Smith, a pediatrician. "Unfortunately," said Governor Milliken's Special Assistant for Human Services, "the outcome of the committee was the recommendation that Smith was the best man for the job. ...At least in the first six months there was a lot of pressure from advocacy groups to get action from the Department of Mental Health and a lot of concern about Smith's appointment."



The State of Michigan legislature enacted the new Mental Health Code, Public Act 258 in 1974, two months after Smith's appointment. Admissions chapters 4, 5 and 8 took effect immediately. This comprehensive legislation embodied much of the contemporary thinking about treatment and strengthened standards of care for mentally ill and developmentally disabled individuals.

The code gives the Michigan Department of Mental Health statutory responsibility for public mental health services. The Department is directed to:

1. Provide care, treatment, and rehabilitation for seriously mentally handicapped individuals by promoting and maintaining a system of community mental health services throughout the state.

2. Shift the primary responsibility for direct delivery of public mental health programs from the state to the county whenever the county demonstrates willingness and the capability to provide such services.

Commenting on the new law, the DMH Director of the Office of Legislative Liaison, said:

Without question that brought in a lot of new direction, established very concretely the community mental health board system, gave authority to the Department to develop contracts and to ensure continuity of care in the community as well. ...I think it caught the Department by surprise, frankly. They had three months to implement a major, totally new codification of mental health statute and they were really caught by surprise.

While statutory responsibility for public mental health rested within the Department, statute also provided that county boards of commissioners determine applicable county procedures and regulations. According to Johnson (1979) this signalled additional problems for Michigan's mental health system:

The Department of Mental Health has responsibility for the service delivery and the funding, but cannot regulate (through policy and procedure) the implementation of that authority unless the county governing board is also in agreement. It is difficult to believe that the legislature intended to delegate responsibility to the Department without commensurate authority. (p. 6)

But, Milliken's special assistant felt that, although there was a service component to the code; Chapters 4 and 5 in particular:

implemented what was already a court edict, which was that institutions were warehouses, that the inmates who were there on an involuntary basis were inappropriately placed there. And so the Mental Health Code, even though there was a lot of political hue and cry about it and it was often the scapegoat for all the problems to come in the '70s, the Mental Health Code was really not much more than the implementation of what courts had already decided was the law of the land, not just in Michigan but every place else.

One Michigan Legislative Research Analyst, agrees with that assessment:

The Mental Health Code was a very ambitious undertaking. Unfortunately, it had to be kind of rushed through the legislature. They took their time writing it, but ordinarily it would have been quite a lengthy legislative process to adopt it.

But, because the court said, "Look, if you get this done in a hurry we won't tell you you can't commit anyone," the courts put pressure on the legislature because they felt our existing laws were unconstitutional.

As a result, she added, no one accurately estimated the cost of properly implementing the code.

The legislature continued its involvement in mental health issues. In addition to passing Michigan's first Adult Foster Care Licensing Act in 1974, a series of zoning acts in 1976, "really clearly spelled out the fact that people had the right to live in the community and that you do not need a Special Use Permit for homes if there are six or less individuals," according to State Representative Debbie Stabenow (personal communication, February 20, 1985), Chair of the House Mental Health Committee.

#### Budget

At the same time, the State was beginning to feel the first rumblings of recession. In order to comply with the constitutional requirement that the budget be balanced, Gerald Miller, State Budget Director, resorted to "creative financing". The 1975-76 Fiscal Year was extended to include a total of 15 months. The Fiscal Year began on June 30, 1975 and ended on September 30, 1976.

It was clear that Gerald Miller's hold on Michigan's budget was a strong one, according to a Milliken staff member:

What happened in the '70s was that DMB became a budget bureaucracy. ...What happened starting about '74-'75, which I think was a catastrophe, was that budget staff within DMB stayed on year after year doing the same programmatic budgets. After about three years what happened was that, both good and bad alike, the analysts thought they controlled the programmatic budgets of the Department. ...The Department Directors would go through the perfunctory exercise of saying, "Dr. Miller's wrong when he says this program can be cut back by \$10 million." But leaving the meeting Dr. Miller would whisper in the Governor's ear and the deal would be cut.

Another change that would profoundly effect Michigan's mental health budget and, therefore, program mix had its roots in the 1973 Social Security Act which established funds for patients in Intermediate Care Facilities for the Mentally Retarded (AIS-MR).

The final regulations went into effect on June 3, 1977. But, according to Ben Censoni (personal communication, March 4, 1985), DMH Director of the Office of Community Residential Services:

We actually began to get into the program in 1975. ...The regulations are very institutional-based, they really apply to state institutions. We accumulate a bill of charges for people who qualify who live in buildings of institutions that qualify and we bill Medicaid through the Medicaid system of DSS and are reimbursed for those services. It's just like the Medicaid system, we are the provider.

In 1976, during its first year of eligibility, the Michigan Department of Mental Health collected \$80

million for services to the developmentally disabled through the ICF-MR program.

There was some legitimate concern that this sudden influx of funds would create a disincentive for placing the mentally retarded in the community. "We argued, as some other states did finally successfully, that regulations did not preclude small community homes that were not on campus but rather on scattered sites throughout the communities. And that's what we call AIS-MR, Alternative Intermediate Services for the Mentally Retarded" (B. Censoni, personal communication, March 4, 1985).

Both the Mental Health Code and the ICF-MR program necessitated rapid system changes with little forewarning. Their implementation was symptomatic of a recurring inability on the part of providers, primarily the Department of Mental Health, to develop and implement plans. One DMH program director commented: "To say that we ever had the luxury of saying, 'Here's where we want to head'; 'Here's what we want to do'; 'Here's how we're going to get there'. ...It was just not in the cards. Somebody suddenly says, everything you're doing is illegal. So you've got to do something else."

In 1976 the Michigan deinstitutionalization program was still under fire. "It should come as no great surprise," a Detroit Free Press editorial stated, "that the Joint Legislative Committee that studied community

placement in Michigan found the program marred by confusion and lack of funding, and more concerned with cost-saving than patient welfare" ("Study Paints,..." 1976).

The Executive Office found itself embroiled in a battle over provision of services:

There was a ton of trauma, obviously, between the communities who felt they were being under funded, the Department which felt a rather hurried demand by state government to empty the institutions without adequate placement mechanisms available, and tension between DSS and Mental Health over who's responsible for after care.

Nor was Dr. Smith seen as much of an advocate for the Departmental budget by Milliken aides:

Dr. Miller found out early that he could severely cut the DMH budget and when he'd present that to the Governor, Smith would say, "well, I can live with that." I don't know whether he thought he could gain points by trying to work with what was offered or what. But sometimes Dr. Miller would offer tremendous cutbacks.

The DMH Director of the Office of Legislative Liaison seconded that opinion, "Under Governor Milliken, Gerry Miller was the driving force. And I know back then, Gerry Miller used to make some arbitrary decisions that this should die or this should stay and that sort of thing. We always had some problems with that."

What many people didn't understand, according to Miller (personal communication, March 19, 1985), was that "Milliken's budget function was his coordination function. He expected the Budget Director to make

integrative decisions. ...Milliken couldn't look at every line item. He had to depend on others that the budget all fit together and that services were thereby coordinated."

In partial answer to its critics, systematic regionalization of the mental health system was implemented according to a 1976 DMH reorganization plan. The state was divided into six geographic areas or regions, each managed by a mental health deputy director with line authority over state hospital superintendents. Joe Farrell (personal communication, February 11, 1985), DMH Chief Deputy was appointed Southeastern Regional Director: "The regions were the mechanism to facilitate the transition from a dual system where people were admitted either to a facility or were accepted in the community."

Sharon Miller (personal communication, March 19, 1985), DMH Planning Coordinator, saw the move as a way "to place high ranking, authoritative departmental people out in the regions and thereby place authority out in the fields. The regional offices would serve the Department by forcing integration of services at the community level, at least in planning."

At the same time the Department set forth three primary goals as outlined by the Michigan Mental Health code. They are:

1. Treatment appropriate to condition;
2. Unification and integration of mental health services; and
3. Quality patient care.

With this impetus, Department of Mental Health staff were encouraged to establish community-based inpatient treatment centers to complement local services. The first such agency was the natural outgrowth of a plan to transfer Ionia Riverside Center to the Department of Corrections for a prison. The Ionia institution had originally been built to handle a large forensic population and the move would alleviate serious overcrowding in the system. It would also pave the way for development of a small mental health program in its place. Michigan Institute for Mental Health, originally known as the New Riverside Treatment Center, opened in 1977 near Lansing with facilities for 100 acutely mentally ill clients.

The Governor's Committee on Unification of the Public Mental Health System called for a renewed commitment to an integrated state-wide program during its October, 1979 meeting. The concern was that every client be served by a single agency which would accept responsibility for assuring that all needs basic to that person's welfare and development were met. The organi-



zation would be supported by interagency agreements and other coordinating mechanisms.

### Personnel

Horrifying allegations of physical and sexual abuse of mentally retarded children at Plymouth Center for Developmental Disabilities rocked the mental health system in February, 1978. According to a Milliken aide:

I think it would be most honest to say that the triggering mechanism was the Free Press series. But there had been some undercurrents that should have been red flags to the problem. There were letters that we discovered in the files of the Department after the investigation began from citizen's groups. ...My guess is that they felt, "Let's go public. Let's go to the Free Press or the News or some other media vehicle and bring some public attention to this terrible problem."

Vern Stehman (personal communication, February 27, 1985), who earlier served as Acting DMH Director, said the two Detroit Free Press reporters, Paul Magnuson and Susan Watson, "weren't looking for any prize. They felt quite concerned, felt that the Department was very lax in moving vigorously and finally broke the story."

Governor Milliken had just survived another political scandal prior to elections, when PBB was accidentally mixed into animal feed and began to appear in Michigan's food chain. He could not afford any further evidence of inaction on the part of the Executive Office according to staff aides:

One of the problems with Dr. Smith was that he was very reluctant to do anything. The more serious the problem became, the more he would deny that there was a problem. ...So, in this case, Smith was a direct appointee and although the Governor supported him as long as he possibly could, it became obvious that Smith was not part of the solution that needed to come out of the whole mess.

Although Director of the Department of Labor at the time, C. Patrick Babcock (personal communication, March 25, 1985) remained a gubernatorial advisor:

What happened at Plymouth was the Governor got caught by surprise. ...I think the worse thing happened to him that could happen to any Governor or any political person -- that is that his appointees were not being candid. That happened to us in PBB, but we had also staffed that issue so well that we knew where problems were occurring and you could anticipate them. Plymouth hit us -- totally blind sided. Plus, we were so preoccupied with PBB at that point.

The DMH Legislative Liaison, offers a somewhat different perspective:

There was a problem at Plymouth and the Department recognized that. The Department's funding was not the best at the time. ...At first they thought maybe this would be a good opportunity because they can present this sort of thing to the Appropriations people. But it just backfired is what happened. Ya, just blew up. Really once the press ran with it, well, we would have to say that the Department appeared in the newspapers to be an adversary.

Because of the apparent lack of Department of Mental Health action, the Governor appointed a task force headed by Wilbur Cohen to investigate the allegations. Dr. Vern Stehman was asked to step in as Acting DMH Director.

If the 1970's could be considered a time of value clarification, improvement of services and quality of care for the mentally ill; the 1980's were characterized as a time of retrenchment by one gubernatorial aide:

The changes in the mental health system did not take place necessarily because of Oakdale (Oakdale Center for the Developmentally Disabled, Lapeer came under investigation regarding allegations of patient abuse in November, 1977), because of Plymouth, because of unification. The changes took place because the budget and the environment at that time forced these changes to be made. ...What really broke the dam and changed the system was the cutbacks in state budget and the change in budget. ...You reduce staff by 5,000, your levels of care went from 90 to 100% standard down to 60% of standard. Those were the things that really forced changes in the system.

After a comprehensive, nation-wide search, Dr. Frank Ochberg was appointed Department of Mental Health Director. A reporter from the Booth Newspapers Capitol Bureau found him to be articulate and charming:

He was, I think, an attempt on Governor Milliken's part to bring in somebody that had that combination that the legislature, and probably the Governor really likes too, of being very bright, excellent professional credentials, a good administrator and somebody who could also relate well to the legislature and get along with them.

The DMH Legislative Liaison characterized Ochberg as naive and in trouble with the legislature from the very beginning:

I think Dr. Ochberg got off to a bad start because he'd only been here a very few weeks and came charging over one night to the legislature because there was some legislation, budget-type stuff, that was coming up and he went sailing right out onto the floor of the House. I was there, and it was

simply a matter of he misjudged. ...You know, here was the Director of a major State Department out here, glad handing right on the floor certain key legislators. And they thought that was a no-no. And so they ordered him off the floor. And as a result of him having to be escorted off, it was a little embarrassing for him because he didn't understand the process. ...It appeared to be a very egotistical thing to do.

One of Governor Milliken's staff members thought that, "part of Frank's problem was that he came out of the Washington hierarchy system. ...He didn't know and he came off looking foolish at times. And he would try to cover up with a soft shoe which just made them (the legislature) more angry really."

#### The Budget Crisis

Ochberg was not reticent about bringing the issues directly to the public. For example, in the case of a controversial referendum, he exhibited little concern for the legislative supporters: "One of the proposals on the ballot, usually identified as the Tisch amendment, would radically alter the way state government is conducted, and its effect on mental health services would be devastating" ("Mental Health Cuts Set," October 3, 1980).

Under the Department of Management and Budget plan, funds for mental health would be cut by 48 percent, representing a \$243 million budget reduction. According to Ochberg this would force the Department to close most

state hospitals, return 7,000 of the 9,600 people in state facilities to the community, and lay off an estimated 9,000 employees (Parks, 1981).

The former DMH Planning Coordinator later would say about Ochberg, "He was a lover of crises, many of which he created himself". She went on to say:

I can remember him meeting with CVC (Clinton Valley Center) people and telling them, out of the blue, that he was going to be closing the place. It was incredible because we had never talked about it. And worse, I had just met the day before with the CVC people and we had talked strategies and policies and there just was never any indication that such a thing might happen. As staff we felt brutalized by that style.

Others would agree with that assessment, with the same types of problems occurring in relationships with the Governor's Office. A former DMB Budget Director added, "There was more than a little bit of the Washington in him, which gave him the feeling he could create a coup on the Executive Office through the legislature. Of course in Michigan it's too visible to work and Milliken and his staff didn't operate that way so it didn't work at all."

For the 1979-80 fiscal year, the Michigan Legislature appropriated \$494 million for mental health services. Economic conditions required reductions during the year to \$470 million, and \$7 million was transferred to the Department of Social Services for nursing home care for mentally retarded persons.

During this period four pilot community mental health clinics were established in Washtenaw, Marquette/Alger, Kent and St. Clair counties:

We saw those four pilot programs as pilots for what a full management board should be like, what types of services it should offer, budgetary arrangements ... defining standards to be evaluated for the establishment of other full management boards. The pilot program began in 1979 and was intended to last three years. But in 1980 there was a concerted effort to extend the contractual process to make other boards full management. There was also an intention to put pressures on communities to develop full contract boards through establishment of funding mechanisms that appropriated operating monies to the boards instead of institutions. (S. Miller, personal communication, March 19, 1985)

In 1980 \$479 million was allocated by the legislature to the Department of Mental Health. However, this included \$10.8 million for unemployment benefits and worker compensation, budget items which had not previously been part of the mental health appropriation; \$30 million for mandatory pay increases, negotiated by public employee unions; and \$20 million for full-year continuation of community programs started the year before. The budget also included a general inflation factor of approximately 10 percent. Ochberg (1981a) expressed concern that the appropriation was at least \$60 million short of the funding necessary for continuation of the 1979-80 level of mental health services.

There were also concerns within the legislature, but they tended to center around treatment priorities.

According to one legislator, "In '80-'81 the funding shifts were very dramatic: more to the community, the push for contract boards with the community mental health system, full management boards. It was mainly legislated through the budget."

She went on to say that, regardless of philosophical differences, legislators appreciated ongoing gubernatorial involvement in mental health issues:

I think in general the Governor was very supportive. I don't think Management and Budget was that supportive and that's the problem. And Gerry Miller had the Governor's ear, much more than Frank Ochberg did. So that's where mental health lost in that process, was Management and Budget.

Planning a comprehensive state-wide program is difficult at best. The Department's problems were highlighted by budget deficits and exacerbated by the massiveness of the system in which it was entrenched:

The growing constraints placed upon the mental health system by escalating costs, antiquated physical plants, a shrinking inpatient population, tougher building accreditation standards and the demand for expanded community services pose a variety of major, and at times conflicting, planning problems for the state mental health authorities in shaping public policy on mental disability. (Provost, 1980, p. 7)

During such times, leadership styles and skills become important. One useful strategy is to call upon the support of other leaders, especially those responsible for budget allocations. As seen by one Legislative Fiscal Analyst, however, Ochberg's relationship

with the legislature remained poor:

I think that it took a while to catch up with him, but it did. He seemed to completely misread Michigan's political scene. He thought that everyone would follow him without a second thought, perhaps because of his articulateness, perhaps because of his personal charisma. But, in actuality, he alienated more than he won his constituency.

That opinion was seconded by legislators. "In terms of the State legislative process he was a neophyte. He was a good man, competent in many areas. He just didn't know. ...But unfortunately he interacted with some pretty big egos that didn't care that he didn't know."

Another gubernatorial staff member would later comment:

Mental Health was a recurring set of pressures from the Community Mental Health Association, the board members of community mental health boards, from the protection and advocacy groups. Generally it was a fight for more dollars. But to some extent, it also was a fight for more local accountability and responsibility and protection from this state department which was viewed by the locals as an octopus attempting to extend itself too far into the community.

The Director of a Michigan mental health association found considerable friction between community mental health boards and the Department, mostly as a result of funding and control issues. She calls it "a spoken battle" caused by local boards asked to take on growing responsibilities without adequately improved funding:



The Department of Mental Health is still hanging on to the budget, which limits the system. More and more boards are becoming full management but they remain dependent on the Department. The money should be allocated directly to the local level. Such changes are needed to let us grow up. There still remains so much political wrangling, trying to sort out who does what. I don't think the legislature would want to take that job on.

Babcock (personal communication, March 25, 1985)

sees many of the same problems, but places them in a different perspective. When asked what some major mental health issues are, his reply was:

Instability has always been a key issue from a management point of view and I've tracked the system back to the late '60s when Anderson was Director. The frequent change of Directorships and the inability of the leadership of the Department to relate with the reality of trying to run a volatile agency in a very political sense.

In 1979 there were 613 Central Office employees responsible for rights services, training, data collection, money collection and quality control. In 1980 the Office of Recipient Rights increased its staff by 39 to a total of 124, under a legislative mandate to expand services.

As cutbacks in the state's budget forced layoffs, the American Federation of State, County and Municipal Employees (AFSCME) charged that Michigan's 23 mental health institutions were becoming increasingly dangerous: "Reports have steadily increased of aggressive acts among the facilities' 10,000 residents and

charges that insufficient care violate their rights. Employees are more frequently seeking psychiatric counseling." ("Cutbacks,..." 1980).

Ochberg proposed the idea of "domiciles" to help reduce populations in the state's 15 institutions for adult mentally ill. He suggested moving 300 to 400 patients out of hospitals and into facilities (some on the grounds of state institutions), where they would be housed, not treated. Because of massive layoffs throughout the system, Ochberg felt the state could no longer maintain adequate standards of care in hospitals: "We have in the facilities for the adult mentally ill a lot of patients who will receive shelter rather than hospital services. ...It's an alternative to discharging people into the community" (Cote, 1981, p. A18).

The Kalamazoo Gazette described the proposal by saying, "Michigan's mental health system, plunged into crisis by deep budget cuts, is using controversial and innovative policies to keep above water -- and proceed with 'deinstitutionalization'. ...Persistent rumors that some institutions soon will be shut circulate through the approximately 15,000-member mental health workforce" (Cote, 1981, p. A18).

One of the first casualties of this ongoing fiscal crisis was Michigan Institute for Mental Health (MIMH). Although money was appropriated for MIMH operating

expenses, the legislature recessed prior to finalizing the State budget. This gave Governor William Milliken unprecedented spending powers and responsibility for balancing the total budget. During a televised address urging voters to reject the Tisch amendment which would cut funds even more, Milliken announced the closing of MIMH as a cost-saving measure. Chapter V examines this period by detailing the Institute's history.

Added to this budget controversy was a report by the Office of the Auditor General (1981) that mismanagement and possible fraud in the community placement program could cost the state up to \$35 million a year. According to the report, the program lacked accountability, used favoritism, and encouraged potential conflicts of interest by permitting state employees to operate homes leased by the state.

The real problem, however, according to Chris Parks (1981) of the Petosky News Review, was Ochberg's high-profile support for developing neighborhood homes for patients able to live outside of institutions.

The program ran up against a growing siege mentality among state residents determined to hang on to what they have and increasing hostile demands that they share it with minorities, the poor and other disadvantaged groups.

A recent audit uncovering a number of miscues in community placement merely provided ammunition for lawmakers eager for an excuse to attack the unpopular program.

...The recent audits of community placement and travel are damaging, not because they uncover shocking abuses but because they depict a department seeming adrift and neglected.

Travel by department officials actually increased at a time when the governor was pleading for restraint, and the auditor general's office detected a "general attitude" of laxness toward such expenses. (p. 4)

The current DMH Director, C. Patrick Babcock (personal communication, March 25, 1985), mentions that these concerns brought him back to accept what he saw as a challenging position:

We were getting killed on the tangents, on community notice, on contracting policy, leasing. We had opened ourselves up so that people who couldn't take on the issue of community placement, (it was a damn hard thing to take on because it works) could take us on on mismanagement questions.

Babcock went on to explain Ochberg's resignation, "He just got aced out of the action because of his lack of credibility with the front office and the legislature. ...And in those days DMB was a very omnipresent force, much more than it is today."

Milliken appointed Babcock Acting DMH Director. Babcock had served on the Governor's Executive staff, headed the Department of Labor and had an excellent working relationship with the legislature. He offered the stabilizing influence in coping with a volatile department that Milliken was seeking. Snyder (personal communication, February 4, 1985) calls Babcock one of the finest advocates for the mentally ill, "primarily

because he knows the system and developed a tremendous following in the legislature."

While it is clear that treatment issues were gaining the public eye, budget matters continued to be the dominant issue. In March, 1982 Babcock stated that state budget cutbacks made it difficult to provide adequate institutional care, outpatient care, or community mental health services. He added that the "department is hanging on by its fingernails, dependent on the willingness of the staff to go the extra mile to help people who desperately need it" ("Breaking Point,..." 1982). "At the present funding levels," he continued, "the department cannot meet all of its legislated responsibilities. The governor and legislature are aware of that, but they are trapped between the agonizing need of the mental health system's clients and the agonizing reality of the state deficit."

In total, the Department reduced its work force from 17,314 persons on January 5, 1980 to 11,772 on July 3, 1982, almost the same figure as 17 years earlier. In November 1965, Department facilities employed 11,157 persons. The comparable figure for July 1982, was 11,230. Babcock observed that:

The loss of 5,542 men and women from our work force has seriously damaged the state's ability to provide appropriate care for those who look to us for help. The big losers are our patients. However, the impact on employees cannot, and should

not be minimized. ("Mentally Handicapped,..." 1982).

Populations in state-operated facilities reached a high point of over 30,000 people in 1960, as can be seen in Table 3. Of that group, approximately 19,000 resided in psychiatric hospitals and 11,000 in centers for the developmentally disabled.

Between 1970 and 1975, the number of residents in psychiatric hospitals was cut in half. This is partially attributable to new treatment programs, following the introduction of psychotropic medications, in conjunction with the nationwide emphasis on deinstitutionalization.

As of September 30 1982, total facility population was reduced to 7,205, including 3,038 persons in centers for the developmentally disabled, 3,683 adult mentally ill and 484 mentally ill children. In addition, it is estimated by the Michigan Department of Mental Health that 5,700 persons reside in specialized homes; approximately 7,000 developmentally disabled and 6,500 mentally ill adults live in general foster care homes; and another 1,039 mentally disabled live in specialized nursing facilities.

While the patient population in Michigan has continued to decline, staffing has remained fairly stable. Total employees in state facilities in 1982 was 10,799,

Table 3

Patients and residents in state of Michigan facilities  
with number of employees, FY 1955 through 1983

End of Fiscal Year	Patients in State Psychiatric Hospitals	Employees in State Psychiatric Hospitals	Residents in Centers for Developmental Disabilities	Employees in Centers for Developmental Disabilities	Total Patients and Residents	Total Employees in State Facilities	Staff to Patient Ratio
1955	17,075	4,997	9,025	2,475	26,100	7,472	.286
1960	19,059	5,656	11,261	3,913	30,320	9,569	.316
1965	17,053	6,275	12,516	4,882	29,569	11,157	.377
1970	11,134	7,698	11,844	6,338	22,978	14,036	.611
1975	4,925	7,399	6,537	5,902	11,462	13,301	1.16
1976	4,354	6,620	6,191	6,434	10,545	13,054	1.24
1977	4,405	7,098	6,047	7,196	10,452	14,294	1.37
1978	4,779	7,657	5,728	7,850	10,507	15,507	1.48
1979	4,712	7,904	5,142	8,474	9,854	16,378	1.66
1980	4,527	7,803	4,371	7,153	8,898	14,956	1.68
1981	4,481	6,113	3,574	5,561	8,055	11,674	1.45
1982	4,383	6,158	2,973	4,641	7,356	10,799	1.47
1983	4,235	6,481	2,594	4,330	6,829	10,811	1.58

about the same as in 1960 (9,569). There were 30,320 patients in 1960, and 7,356 in 1982. When only psychiatric programs are considered, there were 19,059 patients and 5,656 employees in state psychiatric hospitals in 1960; in 1982 there were 4,383 patients and 6,158 employees. Thus, we see an increase in the staff-to-patient ratio without a significant increase in total staffing costs.

Currently in Michigan there are 55 community mental health boards and 25 state hospitals divided into six geographic regions. By statute, the boards may receive up to 90 percent of the cost of programs from the Department of Mental Health. It is estimated that community mental health agencies provided services for nearly 150,000 people in 1982.

Yet, organizational issues continue to surface between the state funded and locally operated programs. The Supervisor of Community Placement Services for the Clinton-Eaton-Ingham Community Mental Health Board (C-E-I CMH), says:

I don't think the Department does a very good job right now in terms of process. I think there is a big gap between people in Central Office and community mental health boards. I don't think it's on purpose, but sort of like divide and conquer. You've got all of these mental health boards scattered around and there isn't any formal mechanisms for them to get together and plan together, to process decisions, to set priorities.



## Discussion

In one sense, Michigan's mental health system seems to have come full circle. A century ago people who did not fit into the community, who were unable to live independently or were considered unmanageable, were moved into institutions. The first asylums served the function their names implied. They offered shelter, food and security. Domiciliary care is much the same concept. The increasing costs of intensive treatment programs and the demonstrated lack of benefits for some patients have forced mental health officials to explore alternatives to institutionalization.

One-hundred-and-fifty years ago mental illness was considered a private problem. Services, when available, were offered at home. Today mental illness is a public issue. In fact, it has been argued that increasing criticism of mental health programs comes less from the lack of funding -- since shortages of money, space and staff remain a chronic problem -- than from increased visibility of the mentally disabled in the community.

Traditionally policy was developed slowly, in response to legislative mandates or constituency pressures. The need for a comprehensive, unified system was recognized. The problem was implementation exacerbated by budgetary deficits.

During the past century there have been innumerable advances in the care and treatment of the mentally disabled. While the numbers of people receiving services have stabilized, the type of patient is changing. Individuals in state psychiatric hospitals today can generally be divided into two distinct groups. First, there is the acute care patient who needs immediate assistance during a crisis period. Such individuals generally remain within their communities but need emergency or short-term, intensive treatment. The second group of patients is unable to live independently, perhaps because of disabilities such as retardation, physical handicaps, senility or medical problems. These are the new chronic patients.

At one time individuals admitted to mental health hospitals would be expected to live out their lives there. That is no longer an expectation. Yet, some people, unable to handle independent living, move from one treatment program to another in a "revolving door" syndrome. They spend more time in institutions than out.

Clearly Michigan's in-house psychiatric population, as well as that of other states, consists more and more of the latter type of individual. This "new chronic" patient uses more resources, costs more to serve, and generally requires longer hospitalization in a variety

of settings. This population is more often characterized by slow turnover and multiple admissions.

### Summary

Decisions are shaped by the milieu which surrounds them. This chapter examined the forces at Level IV of Boulter's (1983) policy ladder. The two facilities to be studied, Michigan Institute for Mental Health and Lafayette Clinic, were embedded within a unique culture and environment. Historical data provides a key to the reactions of decision makers toward the agencies, particularly during a time of crisis.

The crisis period has been defined. A state-wide recession caused budgetary cutbacks throughout the mental health system. Management problems, including allegations of institutional abuse, community placement issues and uncoordinated deinstitutionalization programs, exacerbated the crisis.

The history of mental health in Michigan parallels experiences in other states, with some critical differences. With the acceptance of mental illness as a public problem, a massive service industry was established. Advances in psychotropic medications, new treatment concepts and evidence of the crippling effects of "institutionalization" added a second layer of service providers -- community mental health. The Mich-

igan Department of Mental Health has, over the years, tried to pull this dual system together with limited success.

Fiscal issues heightened concerns about institutional priorities and the ability to provide adequate treatment within a complex, multi-layered system. State-funded agencies were coming under increasing scrutiny regarding quality of care. Allegations of abuse only served to spotlight these problems.

Public programs for the developmentally disabled and mentally ill were often a limited response to pressures that were building to a level of intolerance. Some of those pressures were economic; some were the force of constituency concern. This turbulent, complex environment clearly impacted on types of mental health institutions and programs developed, as well as on services provided.

In order to understand this process more fully, let us move on to examine other levels of Boulter's decision-making ladder in relationship to two specific Michigan mental health institutions.

## CHAPTER V

### A COMPARATIVE CASE STUDY

Boulter (1983) tells us that decisions are made by politicians and bureaucrats. But, they are influenced by interest groups and the media; attentives and the general public; and are ultimately shaped by the environment, institutions, culture and the traditions in which they are embedded.

Elected officials are expected to be representatives of the people they serve. The implication is that, while there are some issues of conscience rather than consensus, most often legislators serve as delegates of the public interest rather than trustees of the public good. It was proposed in Chapter II that, by the very nature of their jobs, public decision makers are attuned to the concerns of their constituents and ultimately base decisions on what they perceive as the sum of support for a given outcome.

Two different decisions occurred in much the same context. Michigan Institute for Mental Health was a state operated, acute-care facility for the mentally ill. It opened in 1977. The decision was to close it four years later, ostensibly because of the need to economize during a recessionary period. Lafayette

Clinic is also a state operated, acute-care facility for the mentally ill. It opened in 1955. Despite a serious setback in achieving its mandate, the decision was to continue allocating operating funds.

By using Boulter's (1983) framework to explore each level of decision processes within the agency context, it becomes possible to trace these different outcomes.

Traditionally case studies have attempted to provide insight into the workings of a program through details about daily operations. The approach here is somewhat different. System dynamics, rather than organizational operations, are of primary interest. Examination of specific events and their impact on the program and its constituency will clarify the focus of decision-maker attention.

Chapter IV provided the historical context, delineating crises and the crisis period as perceived by relevant actors. This chapter builds upon that base by further developing Boulter's (1983) policy ladder for two specific institutions. It will look at various levels of agency operations, as well as interactions among key individuals, their stakes and stands. Chapter VI goes on to examine more closely media attention and influence.

Each of these pieces, in conjunction with document analysis and interviews, serves as the basis for completing check sheets in Chapter VII that will help to clarify the decision outcome. While it is possible to fill in the check sheet and weigh the balance of constituency support less rigorously, ratings should also be based upon available, documented data. Admittedly, it is difficult to tread that narrow line between an intrinsically interesting case study presented for its own merits and the urge finally to weigh the sum of constituency support (including political and bureaucratic) based on known outcomes. Cross verification of data and careful explication of important factors at each level should serve to counteract these inherent biases.

### Lafayette Clinic

#### Politicians and Bureaucrats: The Legislature

Lafayette Clinic is a 128-bed psychiatric treatment center located in downtown Detroit. Act 217 of 1954 provided for the establishment of a facility under the jurisdiction and control of the Michigan Department of Mental Health. As the last enacted law of the session, P.A. 217 passed only after considerable negotiation, in part because of some unusual provisions. While the

Clinic was authorized as a combined psychiatric hospital and outpatient clinic for inner city Detroit, the program was:

especially designed to train personnel for the field of mental health, including such specialties as psychiatry, psychiatric social work, clinical psychology, psychiatric nursing and others; and to conduct studies and research into the nature and cause as well as methods of care, treatment and prevention of emotional and mental disorders and disturbances. (State of Michigan Public Act 217, 1954, p. 595)

The Act went on to reiterate that "such inpatient service shall at no time be used for the care of long term custodial cases, and no patient shall remain in continuous residence for more than two years."

One other provision was added that served to emphasize the program's unique charge:

To more fully implement the objectives of said clinic and to provide an effective utilization of the combined resources of the department and Wayne university, the department of mental health and Wayne university shall jointly appoint and control a director of the Lafayette clinic who shall be a qualified psychiatrist with demonstrated ability as a teacher and administrator, who shall have complete supervision and control of the operation and personnel of the clinic. (State of Michigan Public Act 217, 1954, p. 597)

#### Wayne State University

Although Lafayette Clinic was established as a State-funded program, Wayne State University had an early vested interest. As part of its commitment, the



University agreed to provide land, space and initial staffing. In addition, all operating money was to filter through the University, strengthening faculty involvement in program success and guaranteeing initial acceptance by DMH officials of the clinical teaching component. A total of \$100,000 was appropriated for the fiscal year ending June 30, 1954 of which \$75,000 was designated for salaries and wages.

The enabling legislation, as well as original position papers, established that Clinic research would focus on schizophrenia and the new "miracle" drugs that promised alleviation of symptoms, if not a cure. There was widespread conviction within the Department of Mental Health, directed by Charles F. Wagg, and Wayne State University faculty that schizophrenia had a biological base.

With this argument Lafayette received strong support, not only from the Executive and Legislative branches of government, but also from local advocacy groups. According to a Detroit area legislator in a 1954 letter to colleague Joe Snyder (personal communication, February 4, 1985), "It is only a matter of time, patience and money before we will see an end to this devastating disease. And that time will come because of our support of this facility."

### Interest Groups

The Michigan Society for Mental Health, a client advocacy group, helped to finance and pass a bond issue to raise the initial operating funds. Beth Leeson (personal communication, February 4, 1985), Director of the Mental Health Association in Michigan (formerly the Michigan Society for Mental Health), adds, "There was tremendous local interest in the agency. When Lafayette was being built and developed our Mental Health Association was 100% behind the effort. We pushed the bonds and helped develop the financing and concepts of Lafayette Clinic." She went on to say that the Clinic was initially conceived as a training and research center, not a treatment facility:

There was a lot of community involvement, partly because of the nature of the Detroit area itself. I think Detroit prided itself on being in the forefront and there were some tremendously powerful legislators who saw it as a feather in their caps. It was a natural -- prestige, money and an important social problem. As far as elected officials were concerned, nothing but good could come of supporting it. (B. Leeson, personal communication, February 4, 1985)

Lafayette Clinic could be characterized as a second generation mental health facility. First generation programs were the large, specialty institutions that isolated clients from the community for the majority of their lives. Not only were patients divorced from the

community, but so were staff who generally lived on the grounds.

This new program was being developed in one of the most populous areas of the country and was dedicated to an era of research and prevention in the field of mental health. Evangeline Sheibley, Chair of the Mental Health Commission, commented during opening ceremonies:

We have founded this Lafayette Clinic because we know that the answer lies in two major fields: one, research into the causes, treatment and prevention of mental illness, and secondly, training of personnel to care for the afflicted so that we may look towards rapid discharge of patients from our existing hospitals and clinics. (Lafayette Clinic, 1956, p. 4)

Lafayette was one of the first facilities of its kind, oriented not toward rehabilitation or isolation of a disturbed population, but to a "cure" for mental illness.

Location was an important component of the facility and contributed to the perception of its value held by decision makers. Adjacent to Wayne State University's School of Medicine and part of the Detroit Medical Center Complex, the Clinic joined a tight knit community of mental health services and professionals in an urban and cosmopolitan setting.

Two other sets of relationships served to shape the Clinic, as well as its internal and external linkages: leadership and mandate. Each was a distinct aspect of

the organization that Selznick (1957) would characterize as critical to its institutional core.

Location: The Environment

Interactions with the community, clients and other service providers were deeply affected by the immediate environment.

The facility was next door to the Detroit Receiving Hospital and the Health Care Institute. Staff from these other hospitals comprised the teaching faculty of Wayne State University's School of Medicine and served as Lafayette Clinic consultants. Many senior Clinic professionals also held joint faculty appointments with the University.

According to a June 20, 1954 recruitment letter, Lafayette would "serve as a focal point for the total training program of the Michigan Department of Mental Health and ... include a broad program of instruction and training at all professional levels."

Legislative intent was that the Clinic would augment and amplify training already occurring at various state hospitals of the Department, as well as develop its own educational programs for residents in psychiatry, interns in psychology, students in social work, psychiatric nurses and occupational therapy students.

The first Annual Report for 1955-56 mentions that:

Integration of the professional staff of the Lafayette Clinic with Wayne State University has proceeded without difficulty because of the excellent cooperation of Dr. Clarence B. Hilberry, President of the University, Dr. Gordon H. Scott, Dean of the College of Medicine and many other administrative officers. (Lafayette Clinic, 1956, p. 1)

In addition to relationships with affiliated state programs, close teaching ties were established with the Department of Psychiatry of the University of Michigan and its clinical facilities. "Key linkages" also occurred with the Schools of Nursing and Social Work at both the University of Michigan and Wayne State University in order to develop "social work and psychiatric nursing programs designed to focus on underserved and unserved populations" (Lafayette Clinic, 1980, p. 71).

Two general hospitals in metropolitan Detroit, Detroit Memorial and Sinai, began to assign residents in internal medicine to Lafayette for training in psychiatry. Since 1957, resident physicians from Pontiac, Traverse City and Northville State Hospitals have rotated through the Clinic's services in child psychiatry and neurology. Even dental students from the University of Detroit were incorporated into the program.

Educational programs were further strengthened by rotating Clinic physicians through the Children's Center of Wayne County, the psychiatric services of Detroit Memorial Hospital, and Harper Hospital.

John F. Myett, the Clinic's first Business Manager, said, "Because the Lafayette Clinic intends to become a significant center for both research and training in the area of mental health for the state of Michigan, we feel very keenly our obligations with respect to community participation and support" (Lafayette Clinic, 1956, p. 12). Annual Continuing Medical Education sessions were developed for general practitioners in the community who wished to improve their knowledge and skills in psychiatry.

Along with the newly established Lafayette program, four other public agencies continued to provide adult inpatient psychiatric services to residents in Wayne County. They are Detroit Psychiatric Institute (DPI - Herman Keifer Hospital), Northville State Hospital, Wayne County General Hospital and Ypsilanti State Hospital. Only Wayne County General was not fully supported by State funds. (See Figure 5.)

#### Community and Interest Groups

A physical location near other medical services, and the unique relationship this engendered, proved

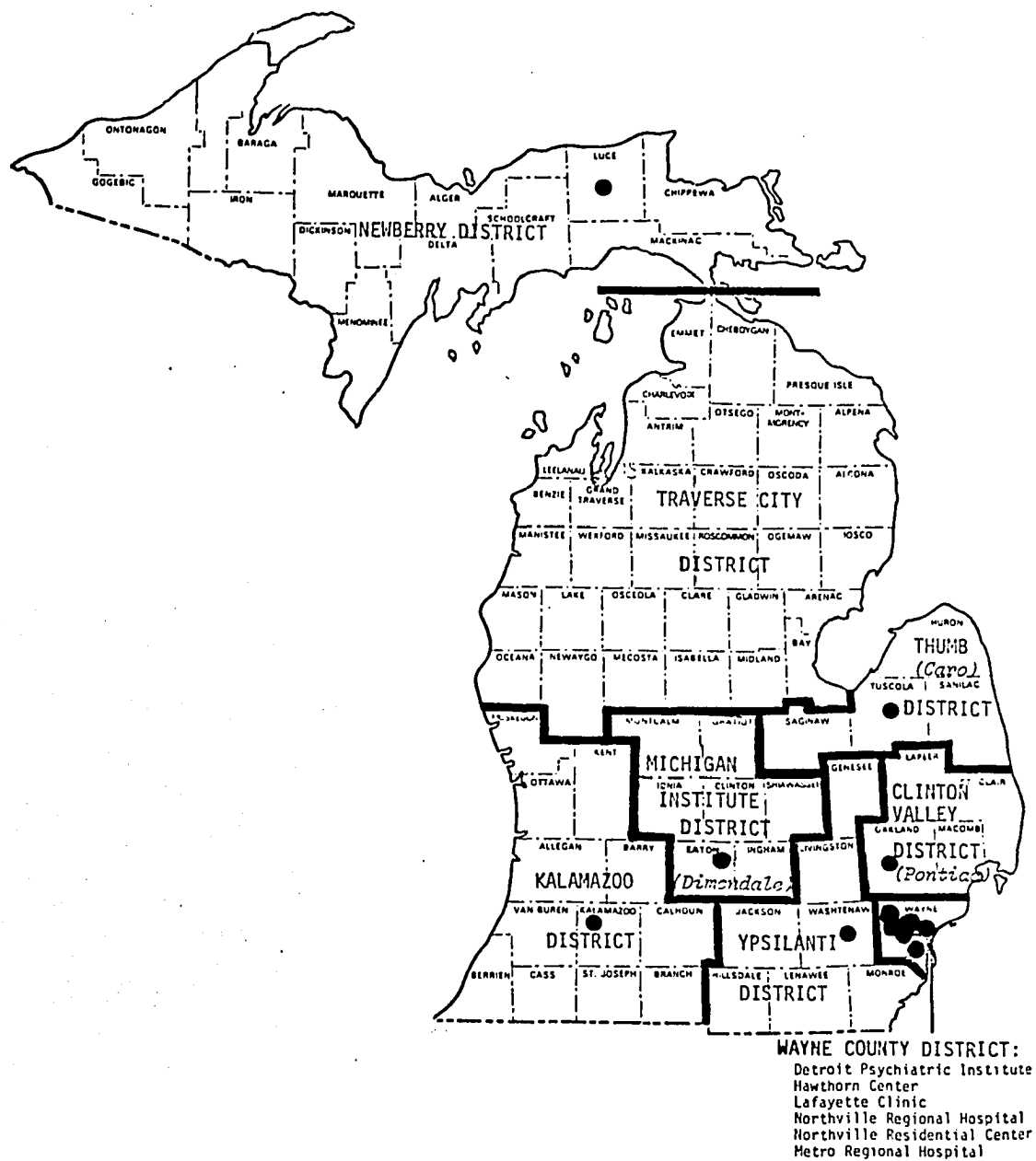


Figure 5. County map showing Michigan psychiatric hospital service districts.

advantageous to Lafayette Clinic. Not only was there ready access to a variety of experts and special programs, but the downtown location in a medical complex mitigated many of the concerns such a facility might ordinarily encounter in a rural or suburban setting.

Insertion in an existing medical community serves a protective function. The Clinic's neighbors were all health care providers. Local officials and other interest groups found that even if Lafayette was not the appropriate admission unit for an individual, other programs in the immediate vicinity might be.

The Clinic staffs a Community Mental Health team. Team members may refer callers to other treatment centers, may make outpatient appointments, or admit to an inpatient unit. The team functions as both an intake screening unit and an intermediate stage of treatment between complete hospitalization and total independence.

According to Ann White (personal communication, February 23, 1985), former President of the Community Mental Health Boards Association:

We realized, and are starting to develop the services behind the conceptualization, that what is required is a whole continuum of services because there certainly is a whole continuum of patients. You just don't find all the needed services in any institution, no matter how good or how comprehensive.

This philosophy has further integrated Lafayette into the community.



By 1961, 1,325 new outpatients were examined at the Clinic, making Lafayette the twelfth largest psychiatric outpatient service in the United States in terms of patient treatment time. By 1971, the Clinic was one of the three most active outpatient centers in the midwest. While it appears that Lafayette Clinic managed to fit itself into its environment rather thoroughly, partially as a result of its location in the heart of one of Michigan's most populous counties, there were questions about whether it was actually serving the population in need.

A research report by Karl Kish, M.D. and Paul Lowinger, M.D. (1971) used a demographic analysis to study whether university programs in psychiatry actually served the inner city. They found, at least for Lafayette, that the answer was "no":

The focus of psychiatry has in recent years shifted to prevention, therapy and rehabilitation within the community. This study asks to what extent a public psychiatric teaching hospital acts as a community mental health center. Do the demographic characteristics of the population using the services of the outpatient clinic reflect the characteristics of the local community? Does a typical university program serve the poor, the black, the very young and very old? (Kish & Lowinger, 1971, p. 276)

The report notes that Lafayette Clinic is located in the city's central poverty area, across the freeway from Detroit General Hospital, the emergency and treatment center for much of Detroit's indigent population.

In 1968 the ten mile area around the Clinic was an economically disadvantaged community containing eight percent of the city's people, 54 percent black and 46 percent white. Forty-seven percent of household incomes fell below \$3,000, then the poverty level.

Yet, the results of the authors' survey showed that "the Clinic does not adequately serve the needs of the blacks, poor, and aged of the inner city" (Kish & Lowinger, 1971, p. 278). In the sample only one patient was over 60 years of age. In the area, 12 percent of the population was over 65. New clients were 77 percent white. Returning patients were 86 percent white.

While it could be a problem of mobility, inner city poor seemed able to reach clinics at Detroit General Hospital in large numbers:

Anyone who has worked at Detroit General for any period of time will be struck by how many poor, black people regard it as "their" hospital, though it too is a medical school teaching hospital which is open to any city resident. (Kish & Lowinger, 1971, p. 279)

The study added that 38 percent of the referrals to Lafayette Clinic were from private doctors or hospitals. As a result, only rarely were people served who existed outside the mainstream of general health care. A scant two percent of the people admitted to Lafayette were referred by courts, attorneys, police, clergy or churches. As will be discussed later, this meshes well

with Lafayette's perception of its mandate and the specific roles chosen by its leaders to assure survival. After all, poverty stricken, inner city dwellers are least likely to exercise their franchise, tend to be less concerned about social issues, and, as a result, exert the least amount of pressure on decision makers, including legislators.

#### Mental Health Services: Detroit and Wayne County

The Michigan Department of Mental Health assumed state operation and control of the Detroit Psychiatric Institute in 1972, expanding the number of adult inpatient beds from 60 to 205. In that same year Northville State Hospital had 650 beds; Lafayette had 80 specifically designated for Detroit and Wayne County patients; and Wayne County General had 450 beds for clients who could be admitted for as long as one year.

An expanded emergency psychiatric service at Detroit General Hospital added 10 beds for short-term admissions, funded by the Detroit and Wayne County Community Mental Health Services Board. A Mental Health Drug Abuse Center established with state funds supported 17 beds, and Cities Center had another 25.

By 1972 there were 1,412 beds for inpatient treatment of mentally ill individuals from Wayne County and Detroit:

Table 4

Agencies Providing Inpatient Psychiatric Treatment  
For Wayne County and Detroit Area Residents

AGENCY	CHILDREN	YOUNG ADULT	ADULT
Lafayette (state)	60 beds		80
Detroit Psychiatric (state)	50	60 beds	180
Detroit General (county)			10
Mental Health Drug Abuse (state)			17
Cities Center (federal/state)			25
Northville (state)		80	650
Wayne County General (state/ county)			450
		TOTAL:	1412

While this may seem like an abundance of public services in a relatively small area, there are some interesting statistics that show both the atypicality and need of this district.

Wayne is the third most populous county in the United States behind Cook County, Illinois and Los Angeles County, California. Of the 11,731 persons admitted to Michigan's state psychiatric hospitals in

1977 (the year Michigan Institute for Mental Health opened), 5,000 came from Wayne County and 1,400 from Oakland. One third of all the admissions (nearly 3,700) were between the ages of 22 and 30. More than half were between 22 and 40 years of age.

In 1972 Dr. E. Gordon Yudashkin, Mental Health Director said:

The mentally ill and mentally retarded from Wayne County and Detroit have been shunted to far-off institutions. There has been a dearth of local services, especially in the inner city. Mental Health services for this highly concentrated population area are grossly inadequate to meet the needs of its 2.7 million people. ("Services Expanding in Wayne-Detroit," 1972, p. 1)

At the same time, Dr. Joseph Denniston, M.D. was appointed DMH Deputy Director for Detroit and Wayne County, with an office at Northville State Hospital. James Hunt, Metro Regional Mental Health Executive and Mark Cavanaugh, DMH liaison officer with the Department of Social Services were also added to the staff. While under contract to DMH, Cavanaugh was responsible for assuring that placements in the community were prompt, effective and appropriate.

Two issues were already evident. There were enough DMH concerns about the Detroit and Wayne County district and the difficulties of serving this public that regional staff were appointed four years before regionalization occurred throughout the rest of Michigan. In

addition, there was increasing awareness of placement issues that would continue to impact on citizens state-wide.

As mentioned in Chapter IV, Yudashkin's placement program created considerable community stress. The legislature and House Mental Health Committee were particularly concerned about over-concentration of foster and group homes in the Detroit area. Prior to its June recess, Representative Dave Hollister, Chairman of the Mental Health Committee, stated that he would ask for a total investigation into the community placement program if it was not being carried out properly and according to the law (Michigan House of Representatives Mental Health Committee, personal communication, June 16, 1977).

During the same meeting, Sue Stine speaking for the Department of Social Services, commented that adult foster care placements had only been in existence since 1975 and there was no home finder program in the Department. Yet, deinstitutionalization was already putting pressure on the Detroit area, and as a result, on the Lafayette Clinic.

Specifically, discharged residents were generally placed into the Wayne County metropolitan region, since that was where the Clinic was located. This meant a buildup of dependent care homes and former mental

patients in that county. (See Figure 6.) Added to the issue of proximity was one of zoning. "In the Detroit metropolitan area, where more than 60 percent of all the state's former mental patients are placed, zoning is a particular problem because it restricts most of the placement facilities to inner-city locations" (W. Mitchell, 1974).

As Lafayette Clinic's treatment program improved, discharges increased. The results were growing numbers of displaced persons in Wayne County, despite efforts to develop appropriate community living situations outside the metropolitan area.

At a meeting among community mental health boards, the House Mental Health Committee and the Department of Mental Health, one board member stated:

The practice, going back a number of years, was to place former patients into foster care, close to the state facility. This was done because the facility provided many of the follow-up and support services to the residents. Also, if the person needed to be rehospitalized, it was convenient to have them close by. As a result of this practice a thriving foster-care industry has sprung up in inner-city Detroit. (Michigan House, personal communication, June 12, 1980)

The effect was to develop a ghetto of former and current patients that served to further isolate them from the community. "Lafayette was sometimes seen as an ivory tower kind of program that really kind of used people to get what they wanted," explained a Wayne





County Community Mental Health worker. "When they didn't want them any more then we got them."

Community mental health services were forced to offer ongoing programs to an ever-increasing number of people who were non-residents and non-tax payers. In addition to impacting on community mental health services and hence local costs, this influx of the mentally ill also affected the probate court system in those counties, the police, jail system and the Department of Social Services. Perhaps because of these pressures, the Wayne County Circuit Court and the U.S. District Court, Detroit were at the forefront of several critical mental health decisions.

Joe Dulka (1979) an M.D. from the Crisis Center at the Detroit Receiving Hospital, said DMH responded to these problems by:

developing the now-infamous "Management Plan" of 1975 which outlined an on-going reduction in hospital beds and staff. This resulted in large numbers of patients who were previously being followed by State hospital clinics being transferred to community mental health clinics. These clinics became flooded making them less responsive to their communities, diminishing their ability to perform preventive services and intervene in the deterioration of their clients. At the same time, the Department requested what amounted to a budget reduction and provided no funding to Community Mental Health to support the increased load of patients. (personal communication to the House Mental Health Committee, June 5, 1979)

"So, while we wanted to do a good job and serve as many people as possible," added an intake worker, "the

more people we placed out, the more difficult our job became when those non-residents went back into the hospital." Since counties bear the local share of institution costs when a person is rehospitalized, this further penalized an already financially struggling system. These difficulties were exacerbated by state-wide budget reductions.

Although placement efforts were a DMH program priority, trying to accomplish those goals did not endear service providers to citizens. Mitchell (1975) reported:

More than 3,000 mentally ill and retarded patients would be released from Michigan institutions by mid-1976 under a budget-cutting plan adopted by the state Mental Health Department.

At the same time, the plan postpones for at least six months the spending of some \$1.8 million budgeted to provide community care for the released patients.

"It's a paradox within a paradox," said former Detroit Common Council President Mel Ravitz, who now heads the Detroit-Wayne County Community Mental Health Board. (p. A3)

#### Department of Mental Health

The 1976 Michigan State Plan for Comprehensive Mental Health Services underscored the problems of serving the Detroit area. The plan was a U.S. Department of Health, Education and Welfare requirement under the National Health Planning and Resources Development

Act of 1974, PL 93-641. According to Ron Uken (1977), Administrator of the Planning and Evaluation system of the Michigan Department of Mental Health, the Act was intended "to facilitate the development of a national health planning policy, to augment area-wide and state planning for health services, manpower and facilities, and to authorize financial assistance for the development of resources to further national health planning policy" (personal communication to the House Mental Health Committee, June 23, 1977).

Each state facility was required to provide emergency services. Michigan's plan mentioned that:

while a board may apply to the department for waiver of any of the other service categories, emergency services may not be waived by the department. Emergency services provide immediate access to mental health services to anyone who is experiencing an emergent mental dysfunction. (Michigan Department of Mental Health, 1976b, p. 11)

The plan also implemented a survey of need in order to develop state-wide priorities for mental health programs. A social indicators matrix, using the National Institute for Mental Health Demographic Profile System was adopted. The five dimensions studied were employment status, economic status, family status, neighborhood structure, and ethnicity.

Catchment areas were ranked on the basis of each dimension score. In addition, the number of acute

inpatient beds, residential beds, partial day slots and outpatient case loads were used in ranking catchment areas by resource capacity. Eastside Detroit was ranked 60th in need, indicating it had the greatest need for mental health services of any area in the state.

The two rankings (need and resources) were added together to create a summary score indicating net need. Southwest Detroit scored 57, Central Detroit 58, Inner Cities 59, and Eastside Detroit 60. For comparison, Lansing South and Lansing North were ranked 26 and 28 respectively.

One DMH planner stated:

There was no doubt that the Detroit/Wayne metropolitan area was taking more of our money and receiving fewer services than any other area in the state. We kept pouring money down the hole to try to keep things together. It was no help that the area also tended to be a hotbed of controversy. A lot of landmark decisions came out of courts there and a lot of trouble was brewing, what with community placement programs, big institutions with allegations of abuse and other such.

In the Metropolitan region (see Figure 6) there were a total of 8,750 admissions to state facilities in FY 1977-78. This is from a state total of 12,546. In comparison, the Southeastern region (MIMH area) saw 1,123 admissions, mostly to the Ypsilanti Regional Psychiatric Center.

DMH Clinical Director Vern Stehman, in a February 8, 1979 hearing before the House Mental Health Commit-

tee, stated that readmission rates to state hospitals remained fairly stable. In fact, they "had always been around 30 percent across the country." He added that he felt it was better to have clients out of institutions for six months and back in for six weeks than for people to be institutionalized all the time. He also added, however, that the Detroit metropolitan area remained the major exception regarding readmissions. It continued to have a 50 percent rate, the highest in Michigan. Half of all the people discharged from Detroit state-operated facilities, including Lafayette Clinic, were readmitted within a year.

In 1978 the Department of Mental Health opened a new 172-bed agency, the Metropolitan Regional Hospital in Wayne County. This institution replaced the psychiatric beds previously available in the Wayne County General Hospital, thus dropping the number of beds for adults in Wayne County by 278.

FY 1979-1980 allocation figures continued to demonstrate ongoing service concerns. Community mental health programs in the Metropolitan region received almost \$26 million. Facilities were allocated an additional \$78 million. The next highest grant went to the Western region where community mental health receive \$13.6 million and facilities \$11.9. In comparison, the Southeastern region community mental health programs

received \$1.7 million. Facilities (the Michigan Institute for Mental Health) received \$4.8.

Given the level of need for services in the Detroit area, the dearth of adequate inpatient programs, and Lafayette's entrenchment in the medical community, it would have been difficult to justify program cutbacks in the early years.

#### Leadership: Bureaucrats and DMH Officials

Lafayette was not immune to the political byplay occurring around it, but it had several distinct advantages. One was that it was essentially a second generation facility, with the opportunity to settle into the community before the crisis period began. Unlike the large first generation institutions, local involvement was encouraged. This position was solidified by the skill brought to the role of Director by Jacques Gottlieb, M.D. Gottlieb helped to establish the Clinic and remained its Director for 20 years. During most of that time, he was also Chairman of the Department of Psychiatry at Wayne State University.

Gottlieb's appointment was the result of a nationwide search by a selection committee that consisted of top decision makers in Michigan's medical community. According to June 20, 1954 recruitment materials, the committee was looking for "a person with the highest of

qualifications in the psychiatric field, including demonstrated administrative ability, proven teaching capacity and outstanding recognition in psychiatric circles" (Lafayette Clinic, 1954). Pay for the new position would "be in line with the highest salaries paid for comparable positions."

Gottlieb was the unanimous choice. He was a professor of psychiatry and Chairman of the Department of Psychiatry and Neurology at the University of Miami. Prior to that he had been Director of the Psychiatric Institute at the Jackson Memorial Hospital, Miami.

Gottlieb was also well respected by Department of Mental Health officials who recruited him. "Jack and I worked very well together, explained William Anderson, M. D. (personal communication, January 29, 1985). "He was Director there when I was Director of the Department and I think we accomplished a lot together."

In fact, Gottlieb worked with DMH Directors Wagg, Kimmich, Stehman, Anderson, Yudashkin and Smith. Each of the former Directors interviewed had high praise for the man, although relationships with the Department of Mental Health deteriorated somewhat in the 1970s following Yudashkin's resignation.

Gottlieb's political skills were an important aspect of agency survival, according to one former DMH Chief Deputy Director:

Lafayette started off with a very powerful figure as its head. And this person had enormous influence in the Department, in DMB, in the Legislature. He was able to haul millions and millions of dollars into the budget and get great acceptance for it. Gottlieb did a great job with legislators. He would have them there. He would have members of their family who were in trouble come there and give them the treatment, and they were always pleased. They always walked away feeling satisfied.

An observer commented, "While it is somewhat of an oversimplification, it is generally true that these superintendents ran a sort of fiefdom, answerable in only a general way to a central authority" (McCauley, 1974, p. 6). This was evidenced most clearly in the budget process. Gottlieb and other facility directors solicited support and funds directly from legislators on appropriation committees. Hearings were held at institutions and testimony received from superintendents with little direct input from Department of Mental Health or Department of Management and Budget staff.

Lafayette Clinic's relationship with key bureaucrats and politicians began to slip a little following Gottlieb's retirement, but the residue remained. This was especially true since, although technically retired, Gottlieb continued his teaching and consultation duties. He also continued to serve as agency spokesperson.

#### Facility Staff

It would be unfair to characterize Gottlieb's



tenure as completely without problems. Lafayette Clinic weathered many of the same staff difficulties that other agencies experienced in integrating clinicians with direct-care personnel and academicians with state workers. But, one of the most difficult aspects of such a relationship had been clarified by the legislature and accepted by both the Department of Mental Health and Wayne State University -- the clinical chain of command.

A former Administrative Officer and Acting Director following Gottlieb's retirement, stated:

From my perspective, the relationship among and between staff has always been relatively smooth. There are always some conflicts around administration, but at least at Lafayette we consider ourselves a Civil Service organization with Civil Service employees. That's even the professional staff. No serious problems at all. They are considered Civil Service staff with joint appointments and I think they have fully accepted that role.

One concept developed at Lafayette, and relatively unique to work situations, was that of the milieu team. An individualized treatment team was assigned to each patient. Generally it consisted of a psychiatrist, psychiatric nurse and attendant, psychologist, social worker, occupational therapist, recreational therapist, work therapist, special education teacher and vocational rehabilitation counselor.

The unusual aspect was the carry-over of this treatment concept to staff relationships. Peter

Beckett, M.D., (Lafayette Clinic, 1971, p. 9) said, "The patient's progress -- the measure of success -- depends heavily upon total communication within the milieu team and elimination of attitudes in staff which might slow the patient's progress." To accomplish this, teams adapted many of the techniques of psychotherapy within their daily work relationships, including "freely and openly expressing their opinions and feelings, and challenging and probing harmful attitudes in team members" (Lafayette Clinic, 1971, p. 9).

Only rarely are such intensive relationships completely trouble free. A Lafayette Human Relations Council was established in 1965 during what was termed "a racial crisis in our society". But minutes of the July 17, 1965 meeting revealed that there was "a greater gap between the managerial sector and employee sector of the Clinic" which prompted an ongoing staff council to moderate interactions between direct-care workers and administrators.

During that same period there was some concern among personnel about a proposed transfer of Lafayette Clinic from the Department of Mental Health to University jurisdiction. On November 28, 1967 Mrs. Cornelia Wright, a Lafayette staff member, wrote a letter to Dr. Anderson, DMH Director, enclosing a letter/petition signed by 61 employees. In the letter she asked, "Why

is Lafayette Clinic being cut off from Mental Health and Civil Service and handed over to Wayne University?" She went on to ask, "Can anything be done by the employees of Lafayette Clinic to prevent this severance? This is a stupefying shock to be suddenly cut off from security many of us had planned on."

Anderson's reply, dated December 1, 1967 states, "The Department of Mental Health has made no request to transfer Lafayette to Wayne State University and has not been asked to take any official position on any proposal initiated last year."

A letter from Gottlieb to Anderson adds:

I presented your attitude of firm support for the continuation of the Lafayette Clinic as a unit in the Department of Mental Health. This assuaged their (staff) concern over our survival as they see us essential to the teaching and research programs of the university.

With the feeling of assurance that you also were interested in our adequate survival, they had no hesitancy in canceling all of their study committees concerned with the problem of our transfer. They assured me that they were in no way interested in raising any issue or controversy as our function in the past as a Division of the Department of Mental Health has been extremely satisfactory to them. They were only concerned in assisting us in receiving adequate support so we could meet our obligations efficiently. (December 21, 1967)

Concerns about DMH support of the Clinic were not completely ameliorated. By August, Gottlieb felt compelled to write Anderson again, telling him:

Without question, the 1967-68 year that we are now in is the most difficult that we have ever faced at

Lafayette Clinic. The funds from the State are completely inadequate, and made no provisions for initiating support of our research wing. ...In order to keep our staff intact, and to maintain morale, it has been necessary to use every expediency possible.

Monies were slowly being filtered from research programs to direct care and community placements. Already there was evidence of a very real difference in priorities between the Department and Lafayette Clinic administrators.

#### Decision Makers

A major decision point, demonstrating Gottlieb's strength as institutional leader, occurred in the early 1970's. In the midst of crisis Gottlieb not only managed to salvage Lafayette programs and receive additional funding, but he further anchored the facility within the system.

The story was one that inherently appealed to newspapers. It had every element of sensationalism. A 37-year-old mental patient, committed to Ionia State Hospital after raping and killing a student nurse 18 years earlier, was considered an excellent candidate for experimental brain surgery to curb his aggressive impulses: "Last year, doctors at Detroit's Lafayette Clinic said they believed there is hope for the man. They offered him a chance for brain surgery, and he

agreed" ("Brain Surgery Case Opens," 1973).

Dr. Ernst Rodin, a neurologist at Lafayette, had planned experimental brain surgery on Smith and surgical and chemical experiments on 23 other involuntarily committed patients, in an effort to control their aggression. Suit was filed by Gabe Kaimowitz of Michigan Legal Services to halt the experimentation. Charles R. Halpern, of the National Mental Health Law Project, representing the American Ortho Psychopsychiatric Association, and University of Michigan law professors Francis A. Allen and Robert A. Burt were Smith's court appointed attorneys. Representing Rodin and Gottlieb was Samuel I. Shuman, Wayne State University Professor of Law and Psychiatry, and Assistant Attorney General Thomas Wheeler, representing the Department of Mental Health.

According to client Louis Smith, who was known as John Doe to the public during much of the court case, "Dr. Yudashkin (DMH Director) told me last May that the surgery would not hurt or impair my emotional abilities. I was surprised by him asking me. I don't think too many people in institutional life approached me one-to-one like Dr. Yudashkin" (Caine, 1973, p. A1). It is interesting to note that the Director of the Department of Mental Health became directly involved in obtaining client permission for a facility research program.

The press immediately took advantage of a sensational story. The Detroit News ran a weekly series, including a five page Sunday News Magazine article by "John Doe" (1973) entitled, "Can You Cut Out Hate With A Knife?: The Story of a Tortured Mind." Kaimowitz argued that, "We must refuse to let the state of Michigan become a playground for the type of experimentation which has troubled man since Nurenberg." ("Brain Research,..." 1973).

Newspaper articles traced the history of psychosurgery from its beginnings in 1936 and talked about doctors using ice picks to perform lobotomies. They cited Dr. Walter Freeman as the "father of American lobotomy" since he performed 3,000 to 4,000 operations in this manner.

A three-judge Wayne County Circuit Court panel consisting of Horace W. Gilmore, John D. O'Hara and George E. Bowles was asked to decide whether involuntarily confined mental patients could participate in experimental psychosurgery. Not only did they rule that surgery would be illegal, but they added that Smith's rights had been violated by his indefinite hospitalization following the rape-murder. On Friday, April 6, 1973 they ordered him released by Monday, April 9, after ruling that his confinement was unconstitutional and hearing testimony that he was a good risk for freedom.

The result threatened to devastate Michigan's mental health system. Essentially the court had stated that the majority of involuntarily committed patients residing in state hospitals were being illegally confined. This related specifically to the criminal population of mental institutions, including all of the criminal sexual psychopaths at Ionia State Hospital who had never been tried for their crimes, but were institutionalized instead. While a murder trial was being urged for Smith, DMH officials were contending with the necessity of having to free thousands of the mentally ill.

A compromise was reached. The Department agreed to immediately present the legislature with a comprehensive mental health code, including new admission and discharge criteria. The code was described as "an act to modernize, add to, revise, consolidate and codify the statutes relating to mental health" (Act 258, 1974). It also directed the Department to establish effective coordination and integration of all public mental health services for the purpose of providing a unified system of state-wide mental health care (Section 116(g)).

As an activist for services in the metropolitan area, and a confidante of DMH Director Yudashkin, Gottlieb successfully lobbied the Department of Mental Health and legislature to include a separate chapter in

the new Mental Health code pertaining specifically to Lafayette Clinic.

This was a masterful stroke because it came at a time when both Lafayette's mandate and relationship with the Department and legislature were at their most tenuous. As mentioned previously, placement programs, particularly those in the Detroit area, were being roundly criticized. Yudashkin was under pressure by Detroit-area legislators who argued that "the man's approach was irresponsible and inexcusable. He was in the process of destroying some good programs by developing some bad ones with little thought to how they would be implemented or what the final results would be." Furthermore, Lafayette Clinic was directly involved in the court case that declared current admission statutes unconstitutional, throwing Michigan's mental health system into turmoil.

Gottlieb gained concessions from a DMH Director who was under fire from the same legislators who were supporting the Clinic, despite the fact that the Clinic could be considered directly responsible for creating many of the problems with which the Department was being forced to contend. The fact that Gottlieb did accomplish his goals is a tribute to the man and the strength of Lafayette's support within the bureaucratic and legislative hierarchy.



Inclusion of the Clinic in a separate chapter of the code meant considerable last-minute work and negotiation, but the effort was supported by other bureaucrats and gave Lafayette a charter, written into law. It also clarified clinical supervision, a potentially troublesome area. Finally, it reiterated the relationship between the Clinic and Wayne State University.

Chapter 9 of Public Act 258 of 1974, states that:

The department and Wayne state university shall jointly appoint and control a director of the Lafayette clinic who shall be a qualified psychiatrist with demonstrated ability as a teacher and administrator. The director shall have complete supervision and control of the operation and personnel of the clinic.

As DMH Chief of Clinical Services from 1977 until 1983 when he retired, Stehman (personal communication, February 27, 1985) commented, "A University is in business to educate, not to treat patients. Through the University every doctor becomes an independent contractor. University involvement is great but it is important to get the rules established before you sit down." Gottlieb got the rules established.

### Bureaucrats

The period between Gottlieb's retirement and the appointment of Samuel Gershon, M.D., to head Lafayette Clinic five years later was characterized by a reduction in activities, although the facility continued to

receive renewed accreditation from the Joint Commission on Accreditation of Hospitals. Gershon acknowledges that the Clinic's prestigious reputation became tarnished as a series of acting directors took over while four separate search committees looked for a permanent chief who could satisfy the duties of Clinic Director and Psychiatry Department Chairman (Covert, 1980, p. C1). "We've had acting directors for six years -- an astonishing length of time," Gershon stated. He went on to say:

Any institution that doesn't have someone running it for that long has all sorts of problems created in it. You lose staff, can't recruit new good people. The legislative support for budgets dwindles over time with no one to make the needs known and justify them. The budget problems we have now are much worse than we've ever had before. (Covert, 1980, C1)

The Clinic received its first research grant since 1974 during the first year of Gershon's appointment. One grant in six years is not an impressive record for what was once a pioneering institution, Gershon admits. "Lafayette Clinic originally was funded through bond sales," Gershon said. "The public felt a commitment to mental health when the facility opened. It's a question of reawakening that commitment" (Covert, 1980, C1).

Gershon continued to work toward re-establishment of a close working relationship with Wayne State University and considered it an ongoing effort. Shortly after

becoming Director, he successfully formalized his own position. The Director of Lafayette Clinic is now simultaneously appointed Chairman of the Department of Psychiatry at Wayne State University.

Over the last several years the relationship between Lafayette Clinic and the Department of Psychiatry at the School of Medicine has undergone a major revision with the development of close ties and integration of programs. ...Lafayette Clinic can now function as the Neuropsychiatric Institute of the Department of Psychiatry (Lafayette Clinic, 1983, p. i).

#### The Mandate

Gershon perceived Lafayette Clinic as providing a "consultative and referral source for problems of clinical concern within the state system" (Lafayette, 1983, p. i).

Broadly stated, he considered the Clinic's four major goals as:

- 1) Advancing research for greater understanding and improved treatment of mental illness.
- 2) Providing a high standard of training for workers specializing in the mental health disciplines and for others concerned with mental health problems.
- 3) Providing modern psychiatric services for the citizens of Michigan.
- 4) Being a leader in extending the techniques of mental health care in the community.

But the facility's goals and mandate have evolved over the years to meet the exigencies of the times. Lafayette's first annual report stated that the agency's primary goal was to serve as an acute psychiatric treatment resource for patients. Only secondarily was it expected to supplement and augment educational and clinical psychiatric resources in the community. Finally, the Clinic was expected to initiate, assist and amplify training and research programs.

In discussing the research component, the report went on to say:

It was decided that the major research efforts of the Lafayette Clinic would be directed towards the most devastating illness that fills mental hospitals ... schizophrenia. ... This illness is primarily one of young people and of a chronic nature, even having its initiation in the young child at times. (Lafayette Clinic, 1956, p. 8)

Initially, research centered on discovering the causes of schizophrenia. Thomas Sullivan, Lafayette Assistant Director, noted that Clinic faculty were also at the forefront of brain research within the United States (Covert, 1980, p. C1).

One of the most interesting characteristics of the agency, however, has been its ability to adapt with the times, to change focus to meet perceived community and Department of Mental Health needs. As Covert (1980, p. C1) would add, "Since Lafayette was founded in 1955, its researchers often displayed a keen eye for hot topics in

psychology, and their studies were underwritten by frequent federal research grants."

For instance, in the late 1950's, Clinic staff probed the relationship between dietary deficiencies and mental retardation. In the early '60s, they conducted human stress tests for NASA and, at the end of the decade, were deep in research on methadone and marijuana for treatment of narcotics addiction. Today, staff are involved in sexual dysfunction and sleep research, as well as gerontological studies.

These changes in focus were partly a response to ongoing budgetary difficulties created by chronic underfunding. In the 1961-62 Fiscal Year progress report, it was stated that:

In spite of the fact that the research program of the Lafayette Clinic has been making excellent progress the funds allocated by the State of Michigan for the support of this institution cover only service function and part of training. Only 6% of the total appropriation to the Lafayette Clinic is used for the support of research. (Lafayette Clinic, 1962, p. 2)

According to Wayne State University administrators, this lack of funding for research was less an indication of belief in Lafayette's ability to garner grant support than an expression of DMH's lack of interest in research. The highest DMH priority, and the one for which funds were provided, was ongoing care of patients.

Yet, as early as 1965, an audit by Peter A. Martin,

M.D. (personal communication to the Department of Mental Health, September 9, 1965) acknowledged that without Lafayette Clinic's grant base, services would collapse: "Here, as throughout the mental health institutions in Michigan, the line item budget ties the Director's hands and promotes inefficiency instead of efficiency of operations."

Despite these difficulties, staff were able to gain substantial funds from outside sources, enough to keep research programs viable. One example of this ability to garner support by perceiving and attempting to meet community needs occurred following the Detroit riots of 1967. Gottlieb was able to obtain a research grant of \$130,000 for the study of the "Detroit Disaster".

One Lafayette (1971, p. 33) summary states, "Even before the Detroit riot of July, 1967, had ended, a team from the Lafayette Clinic, Wayne State University and the University of Michigan began to explore its causes and its likely consequences." Citizens, including those arrested, along with officers from the Detroit Police Department, were interviewed. The report concludes that, "this study and similar ones done elsewhere have increased comprehension of the nature of urban disturbance, may have corrected misconceptions, and have had at least an indirect effect on public policy" (Lafayette Clinic, 1971, p. 33).

While some might question how appropriate this role was for a mental health institution, according to the Clinic's twelve year report published in 1967, a major facility goal was to:

minimize the long-standing barriers between the psychiatric hospital and the community. Lafayette Clinic's attacks on these barriers include its own urban location, simplified admission procedures, accessible drop-in clinic, day-care and night-care facilities, community education activities and use of newer modes of Social Insurance like Medicare, and UAW-Blue Cross health insurance coverage.  
(p. 6)

A study by Kish and Lowinger (1971), however, questioned whether the "black uprising in Detroit and the following well-publicized Lafayette Clinic civil disorder studies" may have been significant in decreasing clinic referrals, particularly for low income, inner city residents. Given the program's economic straits, any source of funds was welcomed and the money was interaccounted into the operational budget for personnel.

It appears that Lafayette Clinic administrators were forced to compare the value of support gained from community and university decision makers to that withdrawn by an already isolated and essentially disenfranchised group of potential clients. The 1971 Lafayette Clinic progress report further delineated the administrative philosophy behind increasing involvement in locally funded projects. It argued that:

Like most institutions, a hospital can assume the aspect of a little world of its own. In these times, however, society cannot afford to have its institutions isolated unto themselves. The resources of the Lafayette Clinic and the knowledge generated through its programs have a direct bearing upon our awesome social problems. Society must have ready access to our resources and information. (p. 13)

### The Legislature

By 1973, support, most notably in the form of legislative funds and research grants, was drifting elsewhere. For Fiscal Year 1973, ending June 30, 1974, the University of Michigan was actually allocated more money than Lafayette Clinic for "Administration and operation of the neuropsychiatric institute and children's psychiatric hospital -- \$7,879,800 and mental health research institute - \$2,097,100" (Public Act 118, 1973, p. 461). The University of Michigan was also offered \$732,800 in federal funds.

Lafayette Clinic, the larger, older, state-established and funded program received \$6,004,600, including \$445,300 in federal funds. Of this amount, 10 positions and \$221,900 was allocated for establishment of data processing services.

Another example of astute management occurred during that critical year, 1974. Concerns had been raised about psychosurgery on involuntarily committed adults who may not have the ability to consent. The



ensuing lawsuit embroiled Lafayette Clinic in legal issues that would continue to impact on the system for years to come. Yet, the Clinic managed to receive special funding from the legislature in 1974, along with an appropriation of \$6,435,800 for an average patient population of 135. This included authorization for 342 staff positions.

A report of the Special Senate Committee on Mental Health, authored by Senator John E. McCauley (1974), explained that "A drug has been synthesized by Doctor Frohman of this Clinic, which he claims and Doctor Hendrie backs up, will cure schizophrenia partially or in total. This drug is now in the process of being patented for the State of Michigan by Governor William G. Milliken."

The miracle drug had been developed. "If successful, the medicine could restore millions of patients to normal life," Gottlieb (McCarthy, 1976, p. A1) told reporters. Developed over a period of nearly 20 years, the medicine was being isolated and synthesized at the Clinic. Staff were only awaiting approval for human testing. "Researchers at Lafayette Clinic for years have worked on the premise that schizophrenia had a biochemical cause," read one newspaper account.

"Through years of painstaking investigation, they now feel they have nailed it down" (McCarthy, 1976, p. A1).

Clinicians mentioned that approximately half of Michigan's 5,000 mentally ill patients in state hospitals suffered from the disease (occupying one quarter of all hospital beds). The medication would cure most of these clients, greatly reducing the need for public mental health services. The legislature allocated \$690,500 for an "accelerated schizophrenia research program" (Act 233, 1974, p. 632).

Public Act 257 of 1975 directed the Department of Management and Budget to reduce the general fund amount appropriated to the Department of Mental Health by 1.5% "in order to equal the amount of estimated revenue as reflected in House Bill No. 4439 of the 1975 regular session of the legislature" (p. 870). Despite this, the same act authorizes \$710,700 to Lafayette for accelerated schizophrenia research (not to exceed 31.2 positions).

Although Lafayette's operational fund allocation increased slightly during 1975 to \$7,058,400, with federal monies subtracted (\$1,332,300) and a 1.5% reduction (\$85,891), actual funds totalled \$5,640,209 for an approved population of 115 and staff of 289.1. An additional \$1,048,730 and 58.1 positions were approved for a 20-bed children's center.

Money was also allocated to the Ionia Probate Court to help offset the unanticipated jump in court costs

resulting from petitions on behalf of Ionia State Hospital patients. Without court involvement these inmates would have been discharged en masse as a result of earlier rulings regarding involuntary confinement of criminal sexual psychopaths.

The following year, 1976, was an odd appropriation year because it ended on September 30, 1976 instead of June 30, 1976. Despite budgetary juggling, the legislature requested another \$753,300 for Lafayette's accelerated schizophrenic research program (Act 251, 1976). Governor William Milliken vetoed it. The legislature submitted a special supplemental appropriation (Act 309 of 1976) for the full \$753,300, along with a request for an additional \$212,100 to reopen a closed ward at the Clinic.

While the Governor had vetoed other mental health appropriations, including \$463,500 for a depression research project at the University of Michigan's Mental Health Research Institute, only Lafayette's request was reinstated. Negotiations included projected reductions in Ionia Riverside Center costs as programs were down-phased. Act 309 took immediate effect on October 28, 1976, approximately a month after the start of the fiscal year.

Unfortunately, no further information was ever released about the miracle drug and the promises of 1974

gradually faded away. With that unacknowledged failure, it became imperative that Clinic research focus on other contemporary issues.

During FY 1975 Lafayette Clinic received another special appropriation of \$251,300 to develop a substance abuse service, with a staff of 9.7 people. The legislature wanted to launch a strong offensive against drug abuse and allocated a total of \$17,830,700 to 5 Executive departments. The largest sum went to the Department of Public Health (\$16,353,600) with Education receiving \$695,300; Social Services \$385,700 and Corrections \$144,800. Lafayette was the only Department of Mental Health drug abuse program to be funded.

#### The General Public

Community placement and Mental Health Code issues continued to be two of the primary concerns impacting on the Detroit area and Lafayette Clinic. Citizens were upset by the thousands of former mental patients living in urban communities, especially inner city Detroit.

"What we're dealing with are society's discards," said a Wayne County Department of Social Services worker:

You can call them schizophrenics, or you can call them bums. It doesn't matter. What matters is that they come to us because nobody else can deal with them. And when we're done with them, do you think society really wants them back? (Hart & Watson, 1977, p. A1)

Staff did not perceive these issues as caused by neglect or lack of interest. A Lafayette Clinic employee clarified their view: "The sense that I got was a concern for increasing the quality of care within the mental health system. There was a lot of involvement in what kind of programs we were providing. This relates both internally (facility treatment) and externally (to the community)." However, services continued to be hampered by lack of funds.

#### The Legislature

In 1977 Lafayette Clinic received an appropriation of \$8,517,400 for 306 staff positions. Of this amount \$1,157,500 was received from federal funds. Only \$650,000 was allocated for research. Interestingly enough, in that same mental health appropriation bill (Public Act 106 of 1977), the legislature inserted an unusual last paragraph:

Sec. 49. It is the intention of the legislature that the close collaborative relationship which has existed since the establishment of Lafayette Clinic between the department of mental health and Wayne state university shall continue in the programs as established in section 904 of Act No. 258 of the Public Acts of 1974, being section 330.1904 of the Michigan Compiled Laws. (p. 550)

Although there is little evidence of what elicited this reaction, there must have been some perception of threat to this "close collaborative relationship" that

necessitated a legislative response. Smith was then DMH Director and one former staff member clarified what happened:

Smith was very, very supportive of university affiliated research, but there was increasing dissatisfaction as money began to go toward other projects. I might even say that there was some resentment that the Department was beginning to develop new programs without adequately supporting existing ones.

It was during this fiscal year that Michigan Institute for Mental Health, with Michigan State University (MSU) assistance, opened.

Lafayette continued to make compromises in reaction to increasing budget reductions throughout the state. The Administrative Officer at that time said, "We tried to do some early downphasing before the really big stuff hit. After taking care of the inpatients, then we had to examine how best to allocate money to maintain as much as possible of the research component."

Joe Snyder was an extremely powerful legislator in both Michigan chambers and on both the Mental Health and Appropriations Committees. He was elected from the Detroit area and, before retiring in 1979, remained a strong advocate for the Clinic. "There's just no doubt," said one of Governor Milliken's aides, "the history of the politics of mental health in the '70s are thoroughly intertwined with Joe Snyder. He was the activist."

A Lafayette Clinic staff member mentioned that  
Snyder:

went out of his way to assure that the hospital was supported. When we had to close the ward, we had interested legislators down here to tour the ward and visit the Clinic. I think the Clinic did have solid legislative support; even the Governor came to visit.

#### Michigan Department of Mental Health

The next several years were turbulent. Public attention focused on another Wayne County facility, Plymouth Center, where allegations of abuse created system-wide repercussions. A former Clinic psychiatrist said, "I think that caused more changes than the Mental Health Code. I know that mostly our reaction (at Lafayette Clinic) and the reaction of most of the other service providers in the area, was just to lay low."

Two DMH Directors, Smith and Stehman, resigned under pressure. In the meantime, search committees had finally agreed on a Lafayette Clinic Director.

When Gershon accepted the position in 1979, he found that state budget cuts had left the center under-financed by \$2.5 million, a full third of its \$7.5 million 1979 budget (Covert, 1980, p. C1). He also found a facility that was generally demoralized by staff losses, lacked strong leadership, and was under close scrutiny for potential human rights violations.

Given the unusual circumstances in Wayne County, the Department of Mental Health could not afford to eliminate any program serving the poverty area, but it could insist on operational research, according to a former DMH Director who went on to say, "It didn't matter a hill of beans to the powers that be that a program was meeting community or consumer needs, what mattered was the budget."

The DMH 1979-1980 update to the 1976 Michigan State Plan for Comprehensive Mental Health Services clarified the Department's position:

Research to be supported must be broadly defined as operational research. The research should be seen to have an impact on treatment provided in the public mental health system in Michigan. It must have a relevance to the current overall goals and concerns of the Department of Mental Health. The Department of Mental Health will not support research of a more basic investigational type (p. 109).

During Fiscal Year 1980, the Clinic had 354 employees and received \$10,491,900 of which \$953,700 was allocated for research (20 positions). \$122,000 of this amount came from federal funds. Cutbacks caused the closing of two wings (the adolescent and neurology units) in 1982. One of the empty wards has since been reopened to serve what is perceived to be a growing community population in need, the geriatric mentally ill.



However, there remain some serious differences in opinion, both within the legislature and the Department of Management and Budget, regarding facility programs.

Department of Management and Budget Staff

Legislative involvement in agency services began to erode in later years. One Michigan Representative on the House Mental Health Committee states:

I've toured the facility. I'm aware of some of the research things that have gone on. It's high cost. I think whenever you want a very intensive program like that, it's always going to be a higher cost. The professional ratio to patients is so low compared to regular hospitals. Now the question is, are they getting their money's worth? I don't know. ...The cost may not be justified.

The 1974 legislative mandate offered some sense of security. But, according to a former Department of Mental Health Director, "A very liberal legislature, back in the earlier days, gave them (Lafayette Clinic) some very special rights, special conditions and I suppose many of them don't like that now."

Concern about Clinic programs was also expressed by the Legislative Research Analyst who handled the Department of Mental Health budget during the past ten years:

There have always been legislators who have questioned some of the things that have happened at Lafayette Clinic. ...Of course in the last few years we've had to have so many budget cuts, or threatened budget cuts that never happened, and each time the Department of Mental Health is always asked by the Governor, "What can you give up?" ...And the legislature asks itself ... "now what

can be cut?" And Lafayette Clinic always comes up. Now we can't cut it because it is required by law.

When asked whether the idea to cut the Lafayette budget is brought up by the Department of Mental Health, her answer is "No, by everyone. Because it is always felt that, my gosh, if we can't afford to treat people, what the heck are we doing spending money on research?"

Among those who questioned research during a time of growing patient care costs were Department of Management and Budget fiscal analysts. Lafayette was increasingly forced to depend on outside grant monies to fund research. However, since it was one of the few accredited state-operated inpatient programs, third-party reimbursements covered a substantial portion of direct-care costs.

That did not completely ameliorate concerns according to one analyst:

For a number of years, I can't remember how many years, there was one research project going on at Lafayette Clinic, research into the cause of schizophrenia and the treatment of schizophrenia. They got into this peptide thing that after much hoop-de-do turned out to be absolutely nothing -- nothing. And the state put millions of dollars into it. Now that's the research game of course. You fund research. Maybe it comes up with something, maybe it doesn't. But, if we have to cut \$50 million.

#### University Officials -- Wayne State Faculty

While the Department of Mental Health continued to

urge fast, efficient patient care, Lafayette faculty attempted to maintain support for ongoing research projects. Increasing budget constraints and differences in expenditure priorities between DMH and Lafayette administrators renewed interest in a transfer of authority from the Department of Mental Health to Wayne State University. This time, staff were more supportive of the proposal that had initially been presented in 1967.

One legislative research analyst, interviewed in January 1985, mentioned that, "Right now there's a project going on aimed at transferring the facility to Wayne State." When asked if that is a legislative initiative, she replied, "No, it's an Executive branch initiative. But I think there are some legislators who support it." She added that it was not a budget issue, "not as far as the Executive branch is concerned because they expect to continue funding. But, if the transfers do happen they feel that third-party payments or federal funds, or research grants, etc. will be forthcoming."

Such a change in status would also protect Lafayette from budgetary, philosophical and political uncertainties extant within the Department of Mental Health.

In discussing his opinions about the Clinic, however, the DMH Director of the Office of Legislative

Liaison, said:

Super nice facility, has outstanding talent down there. ...Probably one of the best in their specialties, probably the best research centers in the midwest. ...The only difference is when we had the lean years, why they suffered a bit and I think they prefer to be a part of the Wayne State University than a part of the Department of Mental Health. But I definitely see support within the Department and Legislature for Lafayette Clinic.

The long-term disposition of Lafayette Clinic, thus, remains uncertain.

#### Media

As will be mentioned in Chapter VI, Lafayette has received only limited media attention during the past years. The Clinic's Acting Director following Gottlieb's retirement pointed out that "Lafayette kept a low profile with the media. Gottlieb really preferred a low-keyed approach. He wanted to prevent any possible misunderstanding."

#### Attentives

It is difficult to know whether this attitude toward the media was helpful or harmful. During interviews, advocacy group members and leaders from several types of organizations generally expressed ignorance of Lafayette Clinic programs. Several were hesitant to refer clients. When asked about the Clinic, the Executive Director of one consumer group stated:

I never refer anyone. I wish I had more knowledge about Lafayette, that's one reason. Another reason is what people tell me, and people are people who have been there. That's a guinea pig place. That's an experimental -- and children, that's another issue with Lafayette. ...They have to show me some proof that their program's effective. And I don't see anything.

The Secretary/Treasurer of a more militant client advocacy program was vehement in his opposition:

Lafayette represents the greatest danger of all the institutions. It is the closest thing to Nazi medicine you will ever find. It is experimental and they use people for guinea pigs. They don't have to tell anyone what they're doing and they get tons of money to perform experiments that most of the time don't have any results.

But an entirely different viewpoint was offered by the Director of a mental health association working with both families and service providers:

It does not have the national prominence that it once did, partially because of funding, probably some political pressures throughout the years. We just really have not attracted the kinds of funds and staff that keep a location as prominent as it once was. But, there's a director there, Gershon, who came in about five years ago and has done a good job of rebuilding Lafayette Clinic.

Lafayette Clinic staff generally agree that these next years will be characterized by rebuilding. In the past there have been ongoing discussions regarding transferring the facility to Wayne State University, serious setbacks in achieving funding which necessitated reinterpretation of the mandate, as well as some suggestion that at least the research component should be discontinued. However, a unique legislative charge,

reiterated over the years, along with personal involvement by several DMH directors and legislators, has solidified the institution's position within the system.

It is worthwhile to contrast this program with another, similar facility that also appeared to have such support, at least initially.

### Michigan Institute for Mental Health

#### The Beginnings

##### Tradition, Culture and Institutions

Michigan Institute for Mental Health (MIMH) was a third generation facility. It evolved from the Ionia State Hospital (a large, first generation institution), which opened on September 7, 1885 as the Michigan Asylum for the Criminally Insane.

At its peak Ionia State Hospital housed 1,500 people including forensic clients (under criminal court charges) of whom almost 200 were criminal sexual psychopaths. A maximum security institution, the primary concern was isolation from society of a dangerous criminal element. Seventy years later in 1955, there were 329 employees and 1,400 patients.

By the 1960's there was increased understanding of the difference between criminal sexual psychopaths, insane criminals and mentally ill persons. Service

areas for the mentally ill had been clarified by the Department of Mental Health and persons admitted directly to the Ionia State Hospital were, for the first time, treated separately from the criminal population.

The new Ionia Riverside unit (a second generation facility) was housed in a renovated building on the grounds. It was designed to be a short-term hospitalization program providing emergency inpatient psychiatric treatment for residents of Clinton, Ionia, Gratiot and Montcalm counties. Persons could be committed to the Ionia Riverside unit either voluntarily or by probate court. Bed capacity was 250, and the unit averaged 215 inpatients.

However, most Ionia patients were still committed to the Center for Forensic Psychiatry in order to determine competency to stand trial; for treatment because of incompetency to stand trial or acquittal by reason of insanity; or as mentally ill convicts transferred from correctional institutions.

Changes in the criminal code, including repeal of the Criminal Sexual Psychopath Act, the plea "guilty but mentally ill" and the new Mental Health Code began to impact on the types of programs and treatment available within both the mental health and correctional systems during the late sixties and early seventies.

As early as 1967, executives from the Departments

of Mental Health and Corrections were meeting in an attempt to clarify custody and treatment boundaries. Gus Harrison, Committee Chairman and Director of the Department of Corrections, sent a January 2, 1968 letter to Glenn S. Allen, Jr., State Budget Director, requesting release of planning funds for a "corrections medical facility" based on authorization contained in Public Act 124 of 1965.

The study committee urged authorization to build a shared institution at Ypsilanti for the criminally insane and criminal sexual psychopaths. Costs were projected at one million dollars. Ionia would then become a general mental health institution.

A Lansing State Journal article by Jerry Moskal (1967) interpreted the report as saying, "key officials are requesting permission to build a joint facility at Ypsilanti and for an almost immediate phase-out of troubled Ionia State Hospital." The article added that "Gradual phase-out of Ionia had been urged previously by a House Committee, which also recommended criminally insane patients be treated at other state mental health hospitals." Moskal (1967) went on to cite escapes, improper parole practices, inadequate treatment and alleged brutality of patients.

Some of these same study recommendations had been made a year earlier by Robert A. Kimmich, M.D., then



Director of the Department of Mental Health, following review by a six-member Medical Audit Committee. While that report, which was sent to Governor George Romney and members of the Legislature, mentioned phasing out specialized services performed at Ionia, it also recommended that the facility be converted to a general regional mental hospital.

In response to the Kimmich report, the Legislature authorized a Center for Forensic Psychiatry through Public Act 175 of 1966. According to the Act, the facility would handle "diagnosis, evaluation and treatment of patients committed to the Department by criminal courts."

In 1968 P.A. 143, the Goodrich Act, repealed the criminal sexual psychopath law.

As a result of continued efforts by DMH and Corrections officials, a residential unit of the new forensic center opened in a building on the grounds of Ypsilanti State Hospital in September 1969. But the new program did little to ease the tensions caused by population pressures at Ionia State Hospital. A March 5, 1970 letter to Dr. William Anderson, DMH Director, from Dr. George Birzgalis, Ionia Medical Superintendent, revealed some of his concerns:

The public image of the Ionia State Hospital is very vulnerable to severe criticism in the news media because of the concentration of dangerous

patients at this institution. If a patient after his discharge from this hospital commits a new offense, articles with large headings appear on the front pages of newspapers. On the other hand some dangerous patients who cannot be released into the community write to news media, letters with complaints of alleged abuse and mistreatment of patients. ...A few newspapers publish these unfounded allegations again with large headings on the front pages. Instigated by these news articles, other articles with severe criticism of the Ionia State Hospital follow in the newspapers. Usually they are written by persons who have never been at this institution and who have no factual and objective information on the operation of this hospital.

Birzgalis (personal communication, March 5, 1970)

went on to mention an anonymous group organized by inmates called the "Committee on Patient Welfare" which mailed letters to relatives of inmates with "malicious charges of abuse and mistreatment of patients."

In April, 1973 Department of Mental Health officials again discussed phasing out Ionia's forensic program during Senate Appropriations Committee hearings. Patient census had been reduced to about 300. As a result, approximately \$1.5 million was transferred from Ionia State Hospital accounts to the Center for Forensic Psychiatry in Ypsilanti.

Senator Robert VanderLaan of Grand Rapids was vigorously opposed to this approach. He was concerned about opening a new facility in temporary quarters while underutilizing existing resources. He urged the Department of Mental Health to designate Ionia State Hospital

as a forensic treatment center. To ensure consideration of his proposal, VanderLaan introduced Senate Concurrent Resolution 23 in February, 1975.

The resolution called for a reexamination and reevaluation of all departmental policies regarding forensic services, noting that "recent news stories and editorials throughout the State have focused public attention on the problems inherent in housing mentally ill offenders in the Wayne County jail." With the "modern facilities" at Ionia containing over 500 empty beds and increasing demands for treatment and evaluation of mental patients, "it seems shocking that such a situation exists."

In response, Acting DMH Director Donald Smith, M.D. named a panel to work with a larger advisory task force established at the same time to advise the Department on integrating correctional and mental health services. The panel focused specifically on development of forensic services in Michigan and alternatives, including the feasibility of Ionia and the Center for Forensic Psychiatry jointly meeting state-wide needs.

Smith submitted his report to the Secretary of the Senate in July, 1975. His recommendation was that Riverside Center, Ionia would best serve the state by continuing as a regional mental health facility for mid-state counties. He also suggested that mental

health diagnostic and treatment services be strengthened at the center.

Department of Management and Budget

Two months later (September 19, 1975) Gerald Miller, DMB Director, issued a press release stating that he would recommend to the legislature that the Ionia facility be transferred to the Department of Corrections. He stated that "While the prison inmate population has been growing, the development of community-based mental health programs has made possible increased treatment of mentally ill persons outside state institutions." Miller drafted a transfer bill which included cost figures and suggested language for a supplemental appropriation to implement transferring mentally ill clients from the Ionia Riverside unit.

In a November 26, 1975 letter to Jerome Hart, Chairman of the Senate Appropriations Committee and Dominic Jacobetti, Chairman of the House Appropriations Committee, Miller cited the escalating inmate population stating that "The buildings at Riverside Center are maximum security buildings of recent vintage which are easily adaptable to correctional use. ...In addition, the facility at Riverside is not accredited which means that the State is losing Federal funds." In conclusion Miller found that savings to taxpayers would amount to

\$15,000,000. Attached to his letter were drafts of the proposed bills.

Ionia Superintendent, David Ethridge, M.D. provided an informational update for employees on September 26, 1975: "Press releases on both sides of the issue have begun to appear and it is obvious the controversy has now entered into the political realm." He went on to say:

Many of you will no doubt find it gratifying that the local community mental health clinics, probate judges, county prosecutors, and many of our former residents and their families have written letters to the Governor, Acting Director of the Department of Mental Health, Director of Management and Budget and their own legislators attesting to the high quality of services they have received from us and objecting to the plan to discontinue psychiatric services here at Riverside Center. At this point in time, only a very few individuals have come out in support of the proposed transfer. (Ethridge, 1975)

#### Politicians and Bureaucrats

There was a state-wide need for more prison space. In 1976 Michigan prisons had already exceeded their rated inmate capacity by 11,500, and the population was rising. However, in the first Michigan State Plan for Comprehensive Mental Health Services, published in 1976, there is no mention of the transfer or a new facility.

An interesting discussion, however, is recorded in the minutes of the Michigan House of Representatives, Mental Health Committee meeting of November 20, 1975.

Ethridge met with the committee to discuss plans for Riverside patients if the Ionia State Hospital were to be closed. The minutes read:

Dr. Ethridge had toured Kent Community Hospital as a possible site for the installation of mental health patients. He stated that the second floor of the hospital could possibly be utilized for this purpose, and that intensive remodeling would have to be done.

...Dr. Ethridge noted that there are approximately 50 to 60 patients currently scheduled for transfer who are long-term chronic patients, but feels that acute intensive admissions would be a problem.

Joe Farrell (DMH Southeastern Regional Director) estimated it would cost approximately \$70 per day for a chronic patient at Kent Hospital which is higher than the rate at Kalamazoo. Dr. Ethridge stated that the majority of patients at Riverside now come from the tri-county area of Eaton, Clinton and Ingham counties.

John Baggott of Kent County Mental Health Services told the committee that the Kent Hospital area was being considered for a CMH alcohol unit, and that "plans (for the Riverside transfer) are developing so rapidly that no one knows exactly what the problems or costs will be."

Ethridge clarified that the Department was planning to release 86 patients to the tri-county area. He added that the biggest problem in the Lansing area was acute emergency care, but current efforts to use St. Lawrence to fill those needs were coming along well.

Gail Harris, Ed.D. of the Tri-County Community

Mental Health Service (C-E-I CMH) opposed moving patients to Kent county because of the distance. She stated that the tri-county board was hoping to build a 100-bed facility in Lansing which would also serve children.

The discussion ended with Ethridge promising to defer additional work toward development of a Kent facility until DMH could determine if similar facilities were obtainable in the Lansing area.

On February 22, 1976 an advertisement appeared in the Wanted to Rent section of the Lansing State Journal. It said:

THE STATE OF MICHIGAN-Desires to lease for 5 years with standard legislative cancellation clause and renewal option in the Lansing area, a hospital facility of approximately 100 bed capacity to include 7,000 sq. ft. of office space. Facility to be operated by the Department of Mental Health, have access to parking for 150 cars and be available as soon as possible.

#### The Legislature

That same week Representative Ernest Nash (R-Dimondale) introduced Michigan Public Act 58 of 1976, mandating transfer of Ionia State Hospital to the Department of Corrections. The bill directed the Department of Mental Health and the Department of Management and Budget jointly to submit to House and Senate Appropriations Committees a comprehensive plan

and budget for "the provision of institutional and community-based mental health care for residents of the Riverside region." It also authorized some \$3.5 million in state expenditures: \$1.3 for the Department of Corrections to hire new staff, \$2 million for construction and \$159,000 for relocating the Department of Mental Health program.

It was estimated that the State would save \$15 million by moving mental health patients to a new facility. The bill passed 34-0 in the Senate and 102-0 in the House and took effect on March 24. There was no pre-vote debate.

A February, 1976 Huron Daily Tribune article reported:

State officials, forced earlier this year to juggle funds to balance the state budget, have resorted to a similar tactic to reduce critical prison overcrowding.

...The state resorted to juggling patients and prisoners in the face of a rapidly expanding prison population which currently has forced corrections officials to lodge inmates in hallways at some institutions.

...Miller (Budget Director) had asked the committee to approve the plan on an emergency basis, and some members complained they were being forced to write a blank check for prison building. ("State Changing,..." 1976).

Senator Jerome Hart (D-Saginaw), Chairman of the Senate Appropriations Subcommittee on Mental Health stated there was little resistance to the action in



mental health circles, "We want assurances that it will be as good or better for the patients involved. It may be a step ahead, in phasing out an old facility" ("State Changing,..." 1976).

Norbert Enzer, M.D. (personal communication, February 22, 1985), Chairman of the Michigan State University (MSU) Department of Psychiatry, was a personal friend of DMH Director Smith:

I was interested in training and education of professionals, obviously particularly psychiatrists, and in research opportunities. The latter was of some personal interest to Smith, but not at the time a high priority institutionally because they looked to Lafayette to do that.

Enzer (personal communication, February 22, 1985) broached the subject of a combined research/teaching mental health facility. His approach was:

Lafayette Clinic's down there in Wayne and at least in the past the Department of Mental Health substantially supported the Department of Psychiatry at Michigan. How about doing something for us? And one of the things he and I talked about was the possibility of creating something not unlike the Lafayette Clinic here, namely a research and training institute.

Harris (personal communication, April, 7, 1976) continued to insist that the Clinton-Eaton-Ingham Community Mental Health Services Board be considered an active partner in planning for Riverside patients. She estimated that 70 percent of the residents were from the tri-county service area. "Thus, it is urgent that we plan for comprehensive community services," she stated

in calling for an April, 1976 meeting. The C-E-I Board, along with St. Lawrence Hospital, submitted a proposal to DMH that offered 80 beds at St. Lawrence (20 acute care) as well as 80 partial hospitalization beds (20 at St. Lawrence and 60 in Ingham county).

Michigan Department of Mental Health

DMH officials, however, showed little interest in coordinating services with community mental health. No state officials attended the tri-county planning meetings. The October 1976 program statement, submitted by DMH Director Donald C. Smith to meet legislative requirements for the transfer, offered an analysis of regional and statewide needs in planning for a permanent replacement facility for Riverside Center. It drew heavily on DMH's 1976 plan without including C-E-I and St. Lawrence's recommendations.

While it appears that an assumption had already been made by chief executives that the facility would be Lansing-based, the report added other recommendations. It was estimated that 120 adult beds would meet the inpatient psychiatric treatment needs of the Riverside catchment area and Shiawassee county. The study also mentioned that "there is a definite need for a residential treatment center to serve children in the catchment area" (Michigan Department of Mental Health, 1976c,

p. i). A 40-bed unit was suggested, 20 for short-term diagnostic programs and 20 in cottage-like units for the severely disturbed.

The following program components were discussed:

1. Occupational and vocational therapy to serve community-based aftercare or outpatient clients on a fee-for-service.
2. A 36-bed unit for the chronically mentally ill.
3. Provision of comprehensive training for mental health personnel.
4. A commitment to operational research.

The summary concludes that "the design of the new facility should be committed to flexibility so that future changes in service delivery needs can be accommodated with programming or residential space that can be used for other purposes" (MDMH, 1976c, p. 11).

In Smith's November 18, 1976 letter distributing the report for review and comments to community mental health boards, probate courts, legislators and other interested parties, he adds, "If approved in fiscal year 1977, it is expected the facility would be completed by 1981."

In that same year (1976) DMH initiated a new methodology in the planning and budgetary process. Program Policy Guidelines (PPG) were issued, to be used in formulating service requirements for the 1977-78

Fiscal Year. Each PPG for subsequent years was expected to build upon policy and program foundations of the past.

According to the Department, these guidelines were intended to serve two related functions: 1. To delineate, on a multi-year basis, the priorities of the Department for planning, development, management and evaluation of mental health programs; and 2. To provide guidance to state-operated facilities and community mental health boards for review of current programs and preparation of program budget requests for the following fiscal year (MDMH, 1976a).

For the mentally ill, top priority was given to offering treatment in the least restrictive environment. The question of where best to relocate Riverside Center patients was being addressed as part of this process.

The Department had unsuccessfully explored placing patients in two apartment complexes; a Provincial House facility; the Michigan School for the Blind, Lansing; the VFW home, Grand Ledge; the Great Lakes Bible School; space at Michigan State University; Edmore Hospital, Mount Pleasant Center for Human Development and Kent County Community Hospital, Grand Rapids. With no other possibilities immediately available, the Department proposed an interim plan. Officials suggested using other state hospitals until such time as a "Lansing-

based, community-oriented, university-affiliated facility which could serve as a model for other areas of comprehensive service delivery" could be built (MDMH, 1975, p. 4).

Before that plan could be more fully explored, a better solution was offered.

### Environment

In Eaton county, eight miles south of the State Capitol, but isolated enough to be practicable, the Jarvis Acres Christian Retirement Center was going into receivership. It was a familiar story of the private church-related nursing center selling life estates, bonds and debentures, then finding itself unable to meet debts.

Jarvis Acres, opened March 1972, had been placed into receivership November 1975 for default of Mortgage bonds. The company owed \$150,000 in back taxes and was behind more than \$750,000 in mortgage payments. The bank holding the \$4 million mortgage on the facilities and 70 acres of grounds indicated it would pursue foreclosure unless Jarvis found a way out of its one million dollar debt.

Fully half of the building was unoccupied. Yet, there was an imperative need to sustain the home because of the elderly who had invested so heavily in the

venture. New Riverside Center would be housed in two wings adjacent to, but isolated from, Jarvis Acres. Considerable remodeling would have to take place to bring the rented wings up to state standards, an extra plus for the Jarvis Acres Corporation.

#### Interest Groups and the Media

On June 2 the Windsor Township Planning Commission met to receive the request from the State of Michigan for a special use permit.

As Davis (1978) makes clear, there is another side to innovation that those in the business of promoting change processes should confront: "All change is not free-spirited onwardness and upwardness. Much of it can be wearisome, forceful adaptation" (p. 651).

The first public hearing to discuss DMH plans accomplished little. A June 16, 1976 Eaton County Journal article revealed that after the May 3 meeting, "Rumors have included such items as: criminally insane patients to be moved in; dope addicts; a stone wall between the State facility and remaining Jarvis Acres portions of the building; bars on windows and mismanagement of funds" ("Jarvis Acres, area resident," 1976).

At the June 23 Windsor Township Board public hearing to discuss issuance of the Special Use Permit,

Mrs. Warner, a local resident, presented a petition signed by 700 area residents opposing the facility. She and two other housewives had visited Riverside Center in Ionia. What they saw were "young people 18-25 years of age, very dirty, hair matted, no socks and with spaced out looks" (Elkins, 1976).

The appropriations bill for funding had passed the Senate Appropriations Committee on May 12 and the House Committee on May 13. The official transfer would occur on January 12, 1977. According to Mrs. Warner, "this was done very quickly, no chance for the public to be informed" (Elkins, 1976).

The main concerns, as expressed at the hearing, were that "the presence of mental patients would depreciate property values and the future of Jarvis would again be in jeopardy after the lease expired" ("State Use,..." 1976).

Trustee Fred Smith argued vehemently against the conversion, saying people did not want it, "They built their homes in the area, then learned a facility for the mentally ill would be a neighbor. It isn't fair. When you move an institution into a settled area, that isn't the choice of the people already there" ("Jarvis Acres Controversy,..." 1976).

Representative Ernest Nash (R-Dimondale), sponsor of the transfer bill and a Jarvis neighbor, sent a

letter supporting the proposed facility to all registered Windsor Township voters. This is despite the fact that Nash (personal communication, February 25, 1985) felt:

In the community the overwhelming opinion was they didn't want it. It's like many other things such as prisons or institutions, any kind of institution almost. "We don't want it in our neighborhood. We want it someplace else." And a lot of it's based on the fear of the unknown.

In early July, area residents and township board members received anonymous clippings of two Eaton Rapids Journal articles, printed July 5 and 6. A 66-year old mother received multiple stab wounds in the back. She and a 22 year-old, who had also been knifed, were taken to St. Lawrence Hospital. Police arrested the woman's 32 year-old son who was later taken to Riverside Hospital in Ionia, where he was under observation ("Nash Checks,..." 1976).

The Windsor Township Planning Commission voted to recommend granting a lease during its July 7 meeting. According to one report on the meeting:

Voting to issue the special use permit (5 to 2) followed a lively discussion by trustees before less than 20 spectators -- a meager turnout compared with the hundreds who turned out for earlier public hearings where opponents to the permit said the change would reduce property values. ("Planners OK,..." 1976)

Smith adhered to his stance that the board had to answer to the dictates of its voters and should not



listen to "political interests and moneyed interests" ("Planners OK,..." 1976). But the prevailing voice was that of City Council member Gordon Cornwell who told the planning board, "society is going to have to deal with the care of these people in some way" ("Planning Board,..." 1976). The knifing incident, "along with concerns of Windsor Township residents plus some local mistrust of state government," led to several conditions being attached to the Special Use Permit according to Windsor Township Supervisor Garry Marsh ("Planners OK,..." 1976).

In order to be admitted to a State facility, patients have to meet one of three criteria under Chapter 4 of the Michigan Mental Health Code (Public Act 254 of 1974):

1. Dangerous to themselves.
2. Dangerous to others.
3. Unable to take care of basic physical needs.

In addition, a person would have to be certified mentally ill by a licensed psychiatrist.

The Special Use Permit specified that the New Riverside Center could not accept people with the following diagnoses, even though they met all other criteria for voluntary or involuntary admission:

1. Any patients under criminal court charges.
2. Anyone under the age of 18.

3. Drug abusers.
4. Alcoholics.
5. The mentally retarded.

Local politicians were dependent on constituency support; yet, they were also bound to honor legal ordinances and regulations. The compromise was a restrictive special use permit. According to Nash (personal communication, February 25, 1985):

By that time I think they felt the pressure was gone. They felt that they were in a position of not being able to deny it no matter what the public feeling was, that all the rules and all the laws had been met and they just weren't in a position to deny.

On July 8, a petition against the transfer was signed by 73 of 99 Jarvis Acres residents. On August 11 the Township Board of Supervisors approved the Planning Commission recommendation.

With Township Board and City Council approvals, the Department of Mental Health was able to lease 54,300 square feet of Jarvis Acres space, effective July 31, 1976. Properties included the first and second floors of the east and south wings, the main dining area and surrounding grounds. Payments would be \$556,442 annually, with adjustments for taxes, insurance and maintenance.

### Michigan Department of Mental Health Bureaucrats

It was acknowledged by both the Department of Mental Health and Michigan State University staff that the new agency was of particular interest to DMH Director Don Smith. A former MIMH clinician noted:

It was always my understanding that Don Smith, who had a very close relationship with the MSU Department of Psychiatry, developed this concept and then hammered it out with the University people. It was a very personal conceptualization that he envisioned, a top quality facility.

Ivan Estes (1976), Personnel Director for the Department of Mental Health, talked about DMH projections for the new agency during a September 8 meeting with Jack Boyett, Personnel Director for the Department of Corrections; William Abshire, Superintendent of Riverside Correctional Facility; and Jon McNeil, Department of Civil Service:

Riverside Center - Dimondale will be a training facility for the Department of Mental Health. Jarvis Acres is just an interim facility. In about five years we expect a new facility will be built in the Lansing area and will then become a renowned training facility.

### New Riverside (MIMH) - the First Years

#### Facility Staff

Charles Pearson, a DMH Special Projects Coordinator responsible for general administrative services, was appointed New Riverside Director. Pearson received his

Bachelor of Arts degree from Michigan State University in Business and Public Service and was reaching retirement age. The law requiring that hospital superintendents be physicians had recently been changed.

William Anderson, M.D., also nearing retirement, agreed to serve as the Clinical Director on contract from Michigan State University. With Anderson's past involvement as Department of Mental Health Director, it was felt that the link between DMH and the University had been carefully forged. Joseph Farrell would continue to serve as Chief Deputy Director of the Southeastern Region.

Ionia employees were given the option of transferring to New Riverside, the Department of Corrections or taking a layoff. Since many direct-care staff did not meet the physical requirements to become guards, there was considerable concern. Additionally, a number of older employees had neither high school diplomas nor GEDs, a Department of Mental Health and Civil Service requirement.

The first 15 patients to be admitted to The New Riverside Treatment Center (NRTC) came with Ionia staff on March 6, 1977, although personnel transfers to the Department of Corrections had been occurring since November. Other Ionia Riverside patients were being released to nursing homes, their families and community

living situations.

In addition, approximately 110 residents were transferred from the Ionia Riverside facility to Ypsilanti, Kalamazoo, Traverse City and Clinton Valley Center with the expectation that chronic patients from the New Riverside catchment area would eventually transfer back into the new facility. Ypsilanti opened 30 bed ward to handle transfers and direct admissions in the interim.

By October 1 there were 38 in-house clients, although bed capacity was 50. By December, remodeling was finished and bed capacity rose to 80. At about the same time the tri-county community mental health board established a nine bed respite care center that offered overnight lodging for mentally ill persons.

### Institutions

The New Riverside Treatment Center was designed to fill many of the community needs that Riverside, Ionia had worked toward, including treatment of acutely mentally ill adults in a small crisis-oriented center. However, NRTC had the additional advantages of being closer to the population in need, operating in a new building offering modern accommodations in a suburban area. As a State of Michigan agency, it served a six-county area of Clinton, Eaton, Gratiot, Montcalm and

Ionia with a total population of 503,177. On January 1, 1978 Shiawassee county was also added to the catchment area.

At the same time, the program's name was changed to Michigan Institute for Mental Health (MIMH) to reflect a transition from traditional mental health facilities and, more specifically, a breaking away from Ionia State Hospital and the Riverside Correctional Center. MIMH was a third generation program.

Joseph Farrell (personal communication, February 11, 1985), then DMH's Southeastern Regional Director, commented that:

The whole idea of MIMH was that it was to be novel, experimental in concept if not in treatment, and that it would represent a partnership of the state, community mental health boards and University. So, from the very beginning we had discussions with MSU about us contracting with them for psychiatric care as well as research.

The agency had 136 employees with Michigan State University faculty responsible for clinical services. Under a unique agreement, the Director of Clinical Affairs was on contract from MSU's Department of Psychiatry, as were Unit Directors and psychiatrists. Clinical professionals such as psychologists, physicians, social workers, and nurses were jointly recruited by the University and DMH. Although paid by the State, they received appointments to the MSU Department of Psychiatry faculty. Audiovisual specialists, library

consultants and other medical services were provided by MSU under contract. However, most employees were civil servants, generally reporting to MSU contractual staff.

This organizational model, despite some unique aspects, was fairly traditional. Departments such as Pharmacy and Activity Therapy provided centralized services. Each discipline had an appointed department head who in some instances had little or no clinical responsibility as, for example, in the case of the Director of Nursing and Clinical Director, while others, such as the Directors of Social Work and Psychology, carried a full-time case load.

MIMH was conceived (at least by the University faculty) as a teaching program. It provided the only psychiatric in-hospital training site in the area. On the average, there were three to four psychiatric residents, an equal number of physicians in residence as well as psychologists, social workers, pharmacy and student nurses in training.

Each MIMH patient received an individual treatment plan designed by an interdisciplinary team consisting of a psychiatrist, social worker, psychologist, activity therapist, educational coordinator (if appropriate), pharmacist, and direct-care and other adjunctive staff.

Treatment was planned and supervised by team members during twice weekly meetings and centered around

individual combinations of four modalities: psychotherapy (group and individual); milieu, use of the environment in normalization and behavior modification; recreational/educational/music therapy; and chemotherapy, the use of psychotropic medication to ameliorate symptoms.

Therapy, team discussion and client records were problem-oriented, with progress on each of a number of problem areas noted after careful observation. Direct-care staff were part of the teaching milieu. They participated completely in team meetings and implemented the greatest portion of treatment plans.

A placement unit was developed later in facility operation. Serving chronic patients, it offered specialized treatment for individuals who were no longer considered actively psychotic but for whom placement was difficult or who had, over the years, become "institutionalized". In many instances, clients were placed directly on this unit when they did not fit into any other community program. Most attended some form of day care or vocational training.

#### Community Mental Health

A mentally ill person considered suitable for admission was first seen at the Central Admitting Point



at Ingham Community Mental Health Center, where a physician performed a preliminary examination. The physician's admission orders evaluated the patient's level of functioning, the least restrictive level of movement possible for the individual, as well as an estimate of the risk of harm to self or others, and the level of psychiatric and nursing care required. Generally, those admitted were either actively psychotic or suicidal.

According to MIMH Social Worker James Austin (1980), by negotiating with Community Mental Health for screening at a central admission point located in the community and jointly staffed, many of the usual admission problems were solved. For instance, all new admissions were first seen by a trained mental health therapist who assisted the psychiatrist or psychiatric resident to gather information, interview the client and family, and made recommendations.

If the client was not suitable for admission, community mental health staff could assist with transportation, accommodations, and referrals to appropriate services. Austin (1980) adds, "for the first time the Community Mental Health Agency was able to observe directly the problems that individuals present when they are being hospitalized, which assisted

them in planning" for discharge and outpatient services (pp. 29-30).

Release plans were implemented by the unit social worker. If readmitted, patients were placed back on the same unit. Although each client was assigned a social worker, the facility provided no after-care, outpatient or respite services. The burden of responsibility for this aspect of treatment, including some day programming, fell on local community mental health staff.

In fact, most services other than direct care were provided within the community or by community consultants. Recreational, barber/beauty, dental and medical needs could be met in the city, so there was little reason to duplicate these same programs in an institutional setting. Whenever possible, patients were encouraged to continue to use family providers, thereby maintaining contacts for after-care support.

#### Institutions -- Efficiency and Effectiveness

Approximately 450 patients received services at MIMH each year, with another 120-150 sent to Ypsilanti Regional Psychiatric Hospital. Between 30 and 50 clients were admitted monthly, with an average length of stay computed for in-house patients at the end of each month and for those discharged each month. Figure 7 shows admission and discharge rates, depicting monthly

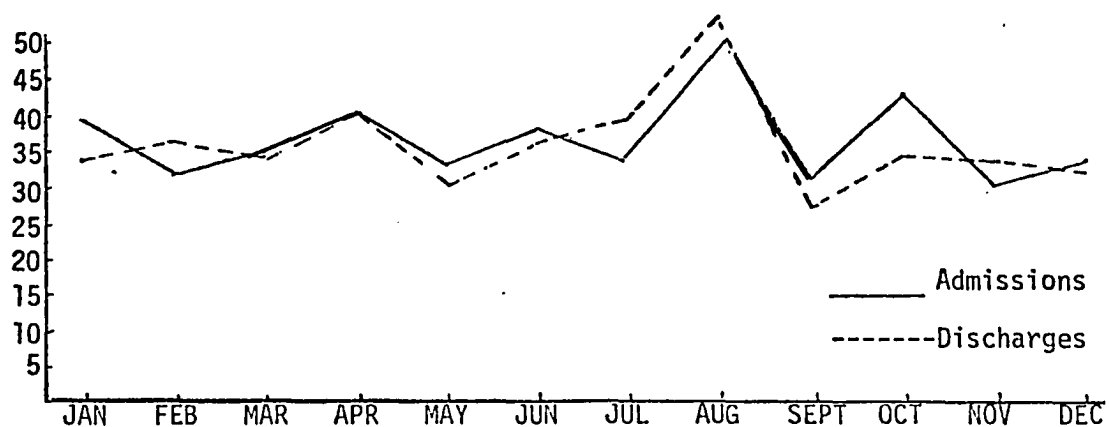


Figure 7. Michigan Institute for Mental Health admission and discharge rates in 1979.

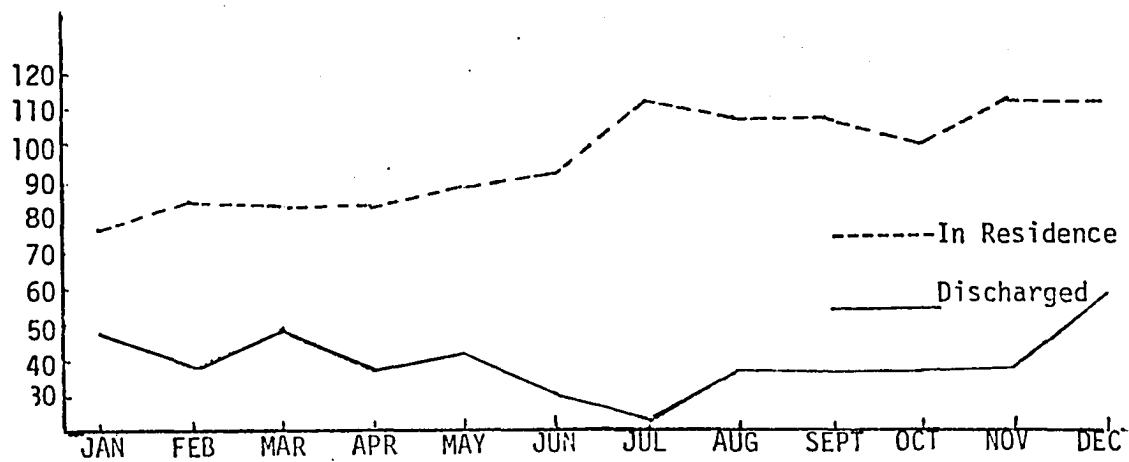


Figure 8. Michigan Institute for Mental Health length of stay comparing in-house patients to those discharged each month in 1979.

statistics for 1979. Figure 8 shows that length of stay for in-house patients remained almost twice as high as for those discharged each month. For the most part, these were individuals on the placement unit who represented the agency's "chronic" population. Figures 9 and 10 provide the same information for 1980.

About ten percent of the patients on this placement unit were discharged to dependent living situations such as foster care homes, residential facilities and nursing homes.

With a university-based evaluation and research unit assigned to the facility, data about clients and assessments of patient improvement in relation to other agency variables was more complete than might normally be expected.

The average length of stay at MIMH was four to six weeks. Some critics felt that MIMH's increasingly rapid turnover of patients would result in higher admissions to other area services, including alcohol units and jails. However, recidivism of MIMH patients to any area facility remained at a low 25%, compared to Ypsilanti's 74% and Lafayette Clinic's 50%.

Joe Farrell (personal communication, February 11, 1985), DMH Chief Deputy Director and Southeastern Regional Director, considered the facility to be efficient, adequately serving the population in need, ful-

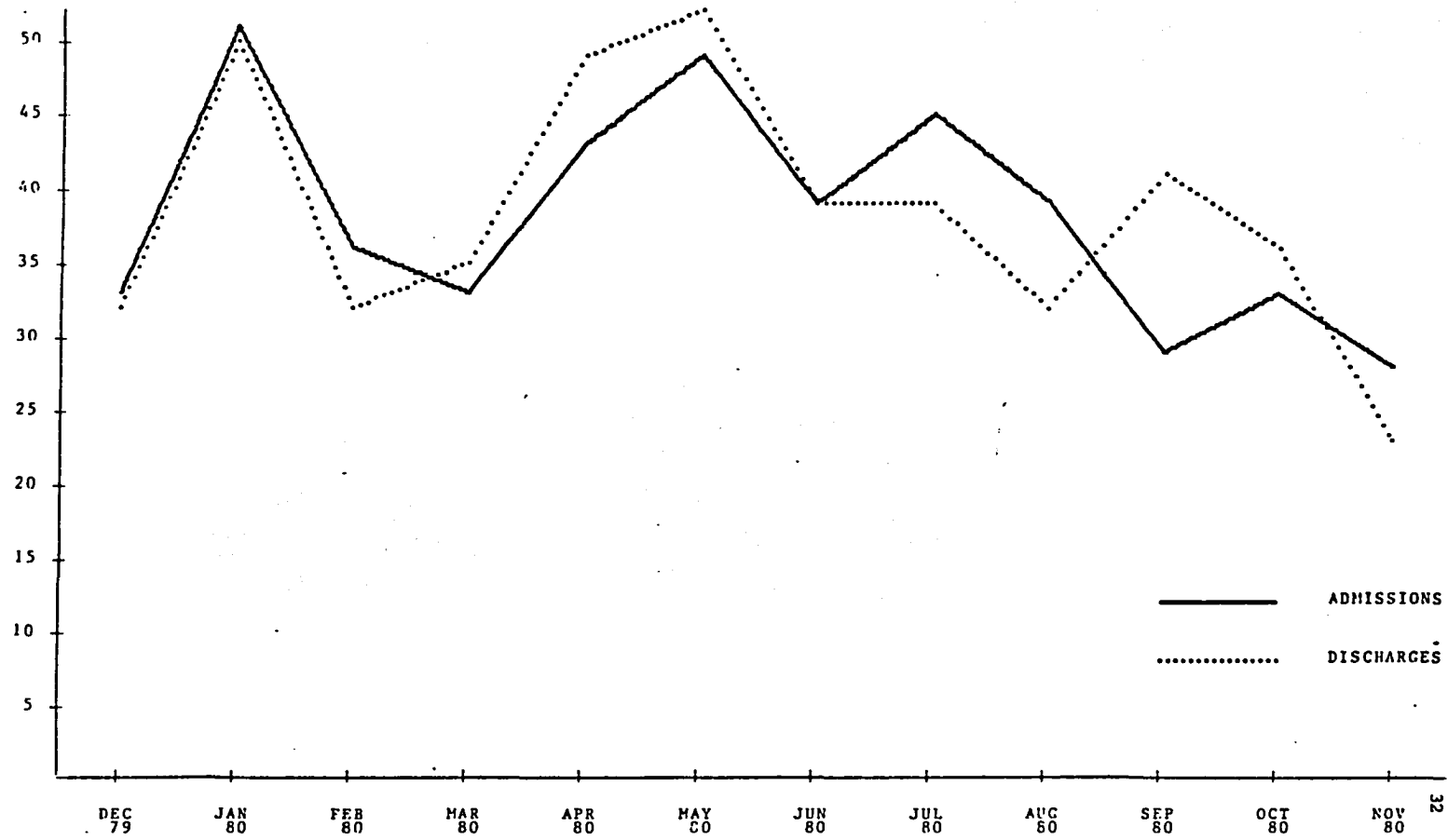


Figure 9. Michigan Institute for Mental Health admission and discharge rates for 1980.

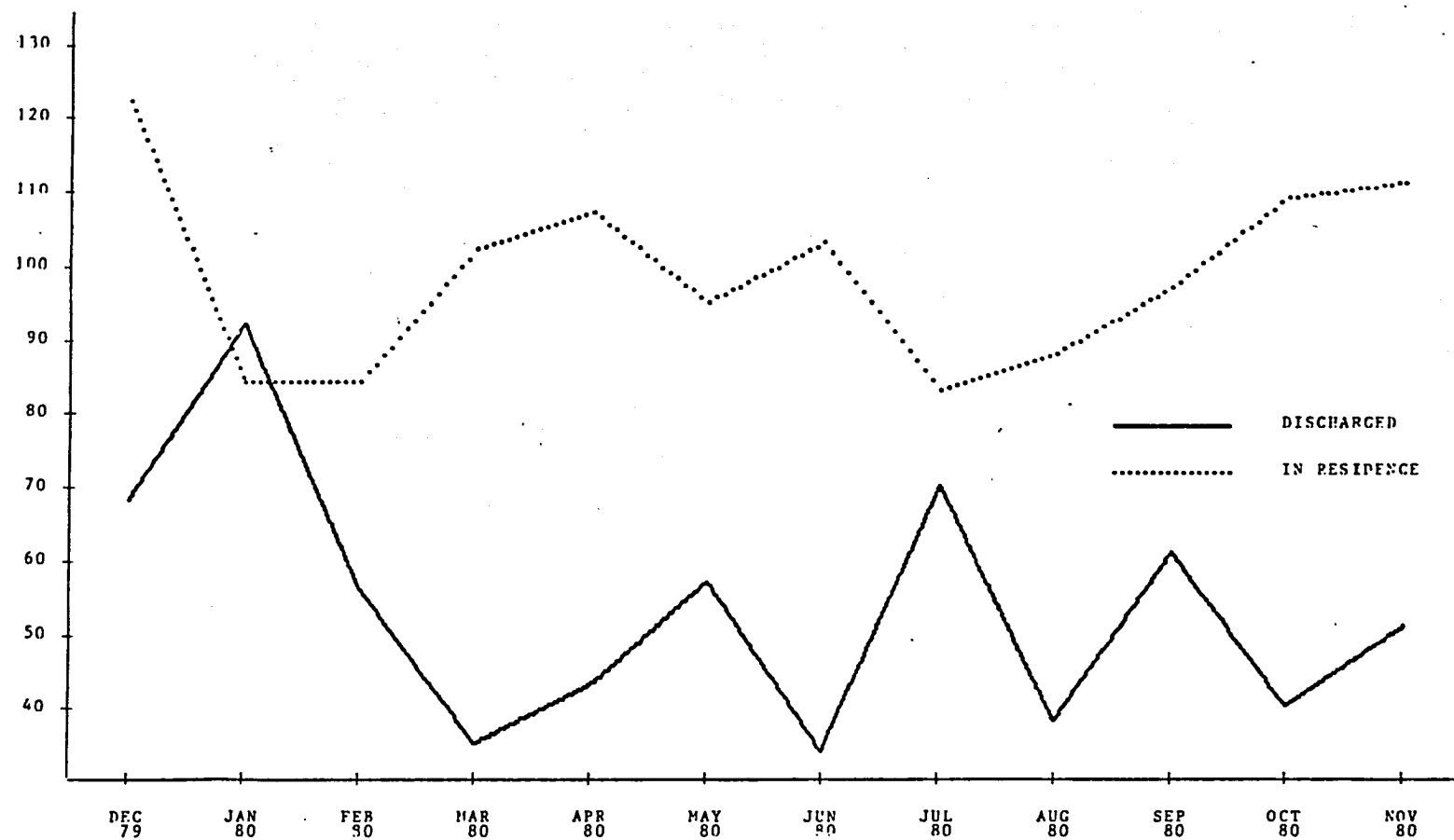


Figure 10. Michigan Institute for Mental Health length of stay for 1980.

filling its mandate as established by the Department of Mental Health:

There was generally agreement that the treatment was good. The facility was accredited. I mean, if you're going to close a facility, why would you close the one accredited facility? We have very few accredited facilities. So, in any objective measure, if you didn't look inside at the dynamics of the facility, you'd have to say that it was a star performer.

### Economy

In Chapter I it was mentioned that we cannot automatically discount obvious reasons for closing a facility. Among possible factors are mismanagement, poor operating procedures, extraordinarily high costs, inefficiency, ineffectiveness or fraud. As will be noted later, costs did become an agency issue, partially as a result of crises identified in Chapter IV, including budget reductions and staff cutbacks within the mental health system.

According to one MIMH staff member, "In the early '80s budget issues became more prominent, finance issues began to enter into concerns about providing quality care. ...Budget became more closely tied to treatment with growing concerns about economy and efficiency".

Perhaps the single most discriminating criterion between a state psychiatric facility and a private hospital is the client's ability to pay. If clients

and/or families have the money, their first inclination is to seek private care. Since the majority of patients in a state mental hospital are indigent, a large proportion of expenses are borne by the state.

At least half of MIMH operating costs were reimbursed, because of licensure and accreditation, through federal programs such as Supplemental Security Income (SSI) and Medicaid. MIMH was one of the few accredited state facilities for mentally ill, the only one, other than Lafayette Clinic, for adults. Therefore, costs could be charged to third party payees such as insurance companies. In addition, the agency received three federal grants. According to Farrell (personal communication, February 11, 1985): "We were able to reduce the cost per day by third party insurance where virtually no other facility in the system could do that. So it made our net state cost less than any other place."

Roughly one-third of the Center's total budget paid for direct-care staff. This is typical of most institutions and includes personnel for three shifts, seven days a week; direct-care staff supervisors; and cost of coverage for vacations, holidays and sick days. The six psychiatrists and Chief of Clinical Affairs were Michigan State University faculty and paid on contract. The first agreement was for \$597,000 and gave MSU responsibility for patient care. The only ongoing building



expense was for rent paid to Jarvis Acres corporation.

Most other costs were standard, and similar to those of other facilities. Interestingly, drug and pharmacy costs at MIMH were less than at most other DMH agencies, even though MIMH used a unit dose system which is generally more expensive than bulk dispensing. Instead of a pharmacist or nurse counting out pills in small cups three times a day, pills came individually wrapped so they could be handled by non-pharmaceutical staff. The intention was to teach clients responsibility for taking their own medication and free charge nurses from dispensing duties.

While MIMH programs appeared to be expensive when looking at cost-per-day figures, knowledgeable argued that the opposite was true when costs-per-episode of illness were discussed:

Even though MIMH's per diem rate was high, comparatively speaking and considering the length of treatment, the length of each episode of illness combined with readmissions was extremely low and was not reflected in the rate per day. Our patients were treated in a matter of days, not months. So the figures we had said far different things than those presented by the Department.

The prime concern was final cost to the patient. When expenses were considered in light of recidivism rates and compared to other facilities, it became less costly for a patient to be admitted to MIMH than other institutions.

This appeared to be a position supported by the Department of Mental Health, even up until the time the facility was ordered closed. In March, 1981 three months before MIMH's closure, DMH Director Ochberg told the Communications Council:

It's easier to do it (provide services) in large mental hospitals, jails, concentration camps. Is it more expensive to do it in the community? No. I think it is much more expensive to do it well in an institution. We want to run an institution really well so that you'd be privileged to go there. ...That institution is going to cost a lot. (Michigan Department of Mental Health Communications Council, personal communication, March, 1981)

A month before MIMH was closed, Ochberg told the Michigan Psychiatric Society:

Responsible deinstitutionalization means reduction of dependence as a society on large, old-fashioned institutions as the bulwark of treatment for chronic mental illness. ...It does not connote opposition to psychiatric hospitalization.

On the contrary, the mental system would be incomplete and ineffective without the ready availability of well-funded, accredited, psychiatric hospitals. There must be small, active treatment hospitals which serve limited geographic areas, where psychiatrists can participate enthusiastically in treatment programs. (Ochberg, personal communication, March 18, 1981b)

#### Michigan Department of Mental Health

It can be argued that the daily operations of institutions are relatively insulated from the Director of the Department and state policy issues. But as early as 1974, it was recognized in a report by the Special

Senate Committee on Mental Health that the Director had considerable impact on local services. The Committee, established by Senate Resolution 353 of 1973 and chaired by Senator John E. McCauley (1974), studied the programs and policies of the Department of Mental Health. One of McCauley's strongest criticisms was that:

The rapid turnover in the Director's position undoubtedly has contributed to the failure of the Department to develop and establish procedures and arrangements for the effective coordination and integration of all public mental health services. ...If the individual who has all the executive authority of and within the Mental Health Department; in other words, the Director; changes an average of every two and a half years, as has been Michigan's experience for the past decade, then it follows that failure to accomplish meaningful overall policy is understandable. (p. 8)

He went on to say that, "Throughout the investigation of the mental health program by the staff, there have been striking incidences of a lack of leadership from middle management upward" (p. 21).

This situation did not improve in the ensuing years. The MIMH Office of Research and Evaluation (1980) noted that, "While changes which occurred at MIMH are not directly attributable to leadership changes within DMH, nevertheless these changes had a subtle effect on the ambiance surrounding the project."

An "easy" relationship between Donald Smith, DMH Director and Norbert Enzer, Chairman of the MSU Department of Psychiatry, is described in a draft of agency

history. Enzer (personal communication, February 22, 1985) commented, "There was a pretty high level of trust, of candor, and of personal good feeling and a sense that, ultimately, what we had dreamed of was worth arguing about."

But, with Smith gone and Vern Stehman, M.D., as Acting Director, many projects were stalled. "Because Stehman was an interim director," the MIMH Office of Research and Evaluation (1980) history observed, "the attitude was to adopt a wait-and-see stance until a new director was in office."

Beyond that issue, one MSU psychiatrist said, "I didn't see him (Stehman) as having the same interest in issues of education and training and research that I saw in Smith."

Perhaps for those reasons Stehman was not considered a supporter of agency programs. According to an MIMH clinician:

He stated many times that "we couldn't continue to afford to drive this Cadillac". ...You have to remember that most of these DMH lieutenants had been brought up in the old warehouse system. It was the system they were comfortable with and could understand. ...We seemed to be affluent in an austere time. So, the thought was that we couldn't afford the luxury of that program.

When Ochberg was appointed Director, there was renewed optimism regarding DMH involvement in the facility. Another MSU Department of Psychiatry faculty

member mentioned that:

I had these grand blue sky dreams that here's going to come this guy who was a very sophisticated academic-type psychiatrist, undergraduate school at Harvard and medical school at Johns Hopkins, psychiatric residency at Stanford. All the best. And that he would certainly understand what we were about and he would see the importance of the training and the research. ...He never really got actively involved. And then, in '79, when the budgets began to be tough and things looked ominous, we began to feel we were in jeopardy.

The Dean of the MSU Department of Psychiatry at that time, agreed with this assessment. He felt that Department of Mental Health administrators "didn't have the same appreciation for research and education (as University staff), so it always became a hassle. They (DMH) had money set aside for research but as the budget crunch came, the first money to go would be the research money."

#### Michigan Institute for Mental Health Staff

According to Selznick (1957), management of conflict is a critical decision area. In particular, the problem of organizational rivalry is aggravated in special purpose enterprises because aims are more sharply defined, and therefore more vulnerable to divisive activity (p. 9).

At MIMH there were several sets of factions that served to shape the agency. The most visible conflicts were those between clinical and administrative staff,

and between DMH Civil Service and MSU clinical personnel.

MIMH Civil Service Staff

As a group, Ionia Riverside employees were considerably older than MIMH employees (the average age was 38, compared to 23 for MIMH staff), with a lower average educational level. For the most part, they also had considerable seniority in the State system and thus were able to choose both their work site (MIMH) and shift. All had worked with the criminally insane at Ionia where crimes were particularly heinous and mental illness generally chronic. Typically, direct-care staff did not interact much with patients and treatment was minimal. Everyone wore uniforms.

Newly hired MIMH direct-care staff were young, idealistic and had at least a high school education. Six had college degrees. Prior to unit assignments they were placed in an intensive training program that emphasized human rights, short-term treatment and the role of all staff members as treatment-oriented care givers.

No one wore uniforms. This was sometimes distressful for Ionia workers who not only found themselves initially unable to tell staff from patients, but who occasionally found themselves misidentified. Few were used to the demands of active, continuous treatment of

very mobile patients. One MSU clinician considered part of the problem the fact that:

We were moving in the direction of much more supervision and the inclusion of research and education as major activities along with patient care. And I think a lot of those people really had very little interest in that kind of thing. Some of them felt it was an intrusion, and aside from their own personal dislocation and all of that, they were in a sense a little out of water.

Sometimes overtly hostile, as well as covertly subversive, it was this "hard-core" group that most inhibited administrative changes.

Administrative responses to such resistance included selective hiring of new employees, intensive training and the conscious split of factions by shift and unit assignments. Agency values and philosophies were gradually strengthened as the Ionia Riverside employees found themselves outnumbered. Many were eventually co-opted when they joined the direct-care versus professional battle.

Clinical professionals were the elite. Yet, direct-care workers implemented the greatest portion of treatment plans. Facility operations were based more on a democratic process than the medical model. Decisions regarding patient treatment were part of a group process in the form of a treatment team, rather than the sole purview of a psychiatrist. Not even chemotherapy was sacrosanct. Direct-care staff were expected to document

instances when patients appeared to be receiving too much, or not enough, medication.

The result was a form of leveling. While the organizational chart was hierarchical, the unit and team concepts lead to a non-traditional approach. Such democracy generated innovative treatment solutions and esprit de corps within the direct-care faction. It was also hard on professional egos and potentially destructive of agency discipline.

#### MSU Staff and Faculty

MSU faculty were responsible for psychiatric treatment. The Clinical and Unit Directors owed primary allegiance to Michigan State University as their employer. However, all other employees were civil servants.

This clinical-administrative schism manifested itself most often in attempts by clinicians to define agency divisions of labor. In the professional hierarchy, power resides in expertise; one has influence by virtue of one's knowledge and skills (Mintzberg, 1979). Many MSU staff felt that administrators should be responsible for "political" decisions such as budgeting, building maintenance, service agreements for day care or foster care. MSU faculty were to handle the medical decisions, the front-line treatment of patients.



An MIMH clinician characterized the schism as:

a split between clinical administration and administrative staff simply because Michigan State University staff were most closely tied to the clinical program which created inherent allegiances in various areas of the hospital. These problems ended up manifesting themselves ultimately in quality of care to patients.

Now don't get me wrong, care at MIMH was clearly superior, comparatively speaking. The services provided there were head and shoulders above most other state-provided services, whether institutional or in the community. I think the program had a much greater impact than most such facilities. But that kind of in-fighting had to impact on care and facility programs. Indirectly it affected morale and operations.

There appeared to be a basic disagreement over both ends and means. "State administrators" wanted an efficient, cost-effective operation, with patients moving swiftly through the system. Means were orthodox, carefully defined by DMH manuals, operational guidelines and one hundred years of institutional practice. For MSU staff, research and teaching were also important with precedents, as defined by previous institutional operations or civil service policies, perceived as irrelevant in this context.

Mintzberg (1979) tells us that professionals in these structures do not consider themselves part of the team. "To many," he writes, "the organization is almost incidental, a convenient place to practice their skills. They are loyal to their profession, not to the place where they happen to practice it" (p.360).

Although professional clinicians have a strong aversion to administrative "experts" muddling in treatment, the very intimacy of the agency precluded strict divisions of labor. Offices were on wards; staff interacted with most patients daily; and the therapeutic milieu was maintained by clinical and administrative staff alike.

University support was even hard to obtain for clinicians "out in the field", according to one MSU program coordinator, partially because of distance. "The faculty always perceived the faculty that was located there (MIMH) as second class citizens, more practitioners and less academicians."

#### The University and the Department

However, the division between Michigan State University and the Department of Mental Health went deeper and was more difficult to resolve. One of the first skirmishes occurred when it came time to renew the MSU clinical services contract. The original contract covered an 18 month period and would expire at the beginning of the next fiscal year (October 1, 1978). It provided for negotiations 90 days in advance.

Charles Pearson, MIMH Director, was concerned about several issues, including slow recruitment of psychiatrists by the University and MSU's failure to appoint a

permanent Director of Clinical Affairs. However, the critical problem area lay in definition of chain of command.

According to the contract, "The Director of Clinical Affairs will report regarding the day-to-day operation of the clinical services to the facility administrator and will be responsible to the Chairman of the Department of Psychiatry for the quality of service provided" (MDMH, "Clinical Services,..." 1977).

In his June 7, 1978 letter to Joe Farrell, Pearson explained:

This sentence creates the greatest operational difficulty for the facility director. Some clarification is necessary if the Department wishes to maintain operational control. The key word here is "quality". Dr. Enzer assumes, as you can see in his memorandum of June 1, 1978, that the university controls all programmatic aspects including bed occupancy and utilization, total service area and operations, etc. Directives of the Department of Mental Health to the facility director have not been carried out or have been appealed to Dr. Enzer by university staff assigned to the facility. At this time the university seems to assume that the chain of command places Dr. Enzer and the Director of the Department of Mental Health on a coequal level and that information comes from Dr. Enzer to the Director of Clinical Affairs to the Director of Michigan Institute for Mental Health and on to the Regional Director. This certainly creates confusion as any change in direction can be stalled for months.

Joe Farrell reiterated his own concerns in a June 13 letter to Vern Stehman, DMH Director, "Michigan State University has not operationalized the contract to our expectations" although "the Department has provided the

funds, facilities and supports as promised." He then proposed that the position of Chief of Clinical Affairs be shifted to the Department, "This will clarify that the clinical responsibility lies with the facility director." Farrell also recommended reducing the number of staff psychiatrists on contract from the University to two, which would allow the Department to hire the remainder. Pearson predicted in a June 19 follow-up memorandum that such contract changes could cause some resignations in professional staff, but "I think the problems created by this will be minimal."

The Department moved ahead to update the contract adding, "the Director of Clinical Affairs will be hired by the Director of the Michigan Institute for Mental Health and shall be a regular Civil Service employee of the Department of Mental Health."

About a month later (July 28) Farrell outlined the proposed contract changes for Pearson, with copies to the DMH Director, Personnel Director and Enzer. "General agreement was subsequently reached within the Department that the Chief of Clinical Affairs should be a psychiatrist employed directly by DMH," he wrote. "This action would make clear that clinical responsibility (as well as administrative) rests with the facility director."

Farrell went on to mention that there were additional contract issues that needed to be discussed when

Norbert Enzer, M.D., Chairman of the MSU Department of Psychiatry, returned from his vacation in mid-August:

While most of these matters can await that time, the appointment of the Chief of Clinical Affairs has been decided upon. Accordingly, due to the time constraints imposed by the October 1 contract year, I am directing that you commence recruitment efforts immediately to identify candidates for this important position. (J. Farrell, personal communication, July 28, 1978)

Enzer interrupted his vacation to reply on August 4, 1978:

I am generally concerned that you did not hear my comments to you over the phone on Thursday, July 27th, and my prior comments about the attitude of our faculty regarding this action of the Department of Mental Health. I believe this decision will have a profound effect on our faculty, at least some of the staff of the Michigan Institute for Mental Health, and ultimately the programs there. It clearly has had a profound effect on me.

In my personal view, this is the third major unilateral decision on the part of the Department of Mental Health during the first year of a major contract between the Department and Michigan State University's Department of Psychiatry. The contract was intended, I thought, to operationalize a "collaboration" with mutually beneficial long range goals. Unilateral decisions scarcely characterize a collaborative relationship nor do they foster trust.

...These matters will require considerable future discussion and in my view the future at this moment is uncertain.

Despite continued protestations by Enzer and MSU faculty, the renewed contract gave complete administrative and ultimate clinical control, including power to appoint the Director of Clinical Affairs, to the Department of Mental Health.

The schism was wider than most system participants were willing to acknowledge. While none of the inter-play occurred publicly, there was a continual tug and pull between the two lead agencies. Generally DMH won the battles because, while MSU had prestige, DMH had the money.

One final example, although occurring at the end of MIMH's existence, shows this division most clearly. Gordon Gritter, M.D. (1981b), MIMH Director of Clinical Affairs, brought together an ad-hoc committee of agency staff to assist the tri-county community mental health board in developing alternatives to agency in-patient services. Through a January 23, 1981 letter to Enzer, Gritter laid out some criteria for a proposed program at St. Lawrence:

Let us begin, then, by deciding that the involvement of the Department of Psychiatry in the proposed unit at St. Lawrence Hospital be determined by teaching and research considerations, not by community service needs. As a first step, let's unabashedly name it the "MSU Unit". Having done so, we can state its characteristics.

...It is expected that some members of the staff of the MSU Unit will be employed and paid by the University and some by the Hospital. This is a highly undesirable and potentially troublesome arrangement, but seems fiscally unavoidable. It is an arrangement that makes it urgently necessary that lines of authority and responsibility be clearly defined.

The proposal continues in considerable detail, revealing issues of concern and sources of irritation

regarding the existent MIMH/MSU relationship.

Ongoing discussions between the two agencies provide evidence of a power struggle that lasted throughout MIMH's four year history. One MIMH staff member characterized the underlying problem as "one of control, who had the ultimate responsibility. Conceptually I'm sure everyone agreed it was supposed to be shared, but realistically it was completely different. The big issue seemed to be who had the final word on administrative decisions."

Several observers considered Charles Pearson the weakest link in the programmatic chain: "We saw him as somebody biding his time with a couple of years to go before retirement and not wanting to rock the boat or really do anything."

When MSU administrators were asked to identify when they saw the program begin to fall apart, one said:

I think when Chuck Pearson was selected to administer the program. He had an almost invisible style. ...What happened was that there was a weak administration and what was needed to get that program through was a strong, well-thought of, outspoken leadership. That's how other new programs survive. But, Chuck wasn't much of an advocate. Then you had a rather strong University component with all the direction coming from outside the facility, and problems naturally erupted.

#### MIMH - The Last Years

Symptoms of these conflicts were to emerge at

unexpected times. The Step Level program and subsequent media attention serves as one example. Residents progressed through MIMH in steps. Level I was designated for observation. Patients were generally escorted to activities and evaluated continually. Those who were aggressive or self-destructive might be placed on a "15-minute checks" schedule.

At level II and above, clients were allowed access to the dining room which included a snack bar, pool tables and other recreational equipment. Patients could also take classes and participate in work therapy programs where they were paid for performing housekeeping duties.

At step III they were allowed to go on field trips in nearby communities with staff supervision. At level IV the client was allowed access to the grounds and unsupervised community trips. At each level patients could receive visitors, go home with family and participate in unit activities.

No cards or passes were issued and administrative staff, unfamiliar with client levels, would either refer to the patient chart or check with direct-care staff before allowing patients to accompany them from one area to another. Direct-care staff were assigned as "primary therapists" for specific individuals and were responsible for knowing where their patients were at all times.



In February, 1980 the decision was made to implement an open door policy. In the past, all outside and many of the inside facility doors were locked. Staff were responsible for providing client admission to activities.

The new policy meant few changes except that all inside doors as well as external doors in one unit would only be locked at night. It was a change supported by administrative staff as well as the Joint Commission on Accreditation. Therapeutically the intention was to encourage patient responsibility toward his/her own recovery. In an internal memorandum, Gritter (February 12, 1980) noted that few psychiatric facilities in the country remained on a completely locked status.

#### Community Influentials

Concerned over complaints from neighbors, the Windsor Township Board asked MIMH to submit monthly progress reports "to substantiate claims that most patients were capable of handling the responsibility of unrestricted movement" (Schultz, 1980a). Following a public meeting, the Board also recommended that residents submit written documentation of "incidents". This followed Maybelle Alderman's recount of being forced to flee her home about six months earlier when a patient kicked her door open, ransacked her house, then slashed

his wrists, and stabbed himself repeatedly.

It was mentioned by MIMH staff, including the Clinical and Nursing Directors, that 1,234 patients had gone through the facility without incident and that previously all doors were locked but patients were allowed to walk on the grounds unsupervised.

Another staff member pointed out that the change was in response to Chapter 7 of Michigan's Mental Health code which requires patients to be placed in the least restrictive environment. "In actuality," the MIMH Administrative Assistant stated, "we have been in violation of the law for the last three years" (Schultz, 1980a).

Probate Court Judge Don Owens and County Prosecutor Peter Houk said they were informed of the change by letter and were very upset by the policy, but at a loss to stop it (Grose, 1980). "Although," said Owen, "no one sent to New Riverside has been charged with a crime, many of them are desperately ill and dangerous."

On February 27, the Windsor Township Board appointed a special committee to evaluate the policy and "incidents reported by dozens of residents" ("Jarvis Walkaways,..." 1980). Upset by the number of complaints, the board named township Supervisor Arthur St. Clair, clerk Dorothy Hull, trustee Jim Davis and township resident Michael Mitchell to look into complaints

that the new "'open door' policy of the facility allows patients to leave the grounds and wander through the neighborhoods" ("Jarvis Walkaways,..." 1980).

It was noted that the state had given assurances to the board about the "type of patient, treatment and security" to be provided prior to issuance of the special use permit. If there were changes, then the township would have to review its own policy toward the facility, according to township attorney Richard J. Robinson.

#### MIMH Staff

MIMH direct-care employees added to this ongoing controversy in April by attending a Windsor Township Board meeting to express their own concerns about patient, community and staff safety. The aides informed the board that they feared impending layoffs would lead to increased violence at the facility (Schultz, 1980b). Walt Whalen, Chief Union Steward of Local 3071 of the American Federation of State, County and Municipal Employees (AFSCME), mentioned that his nose had been "cracked" four times since last September and stated, "We are very much in jeopardy out there." David Henigan, Local President who had his arm in a sling, allegedly as a result of trying to subdue a patient, said that union members at MIMH planned a petition drive

demanding that "actions be taken to instill safety and security" (Schultz, 1980b).

### Community Attentives

Shortly thereafter, Mitchell presented to the board a petition signed by 50 area residents, requesting that MIMH be fenced and equipped with a push-button gate through which patients could be monitored.

Because of the level of community concern, MIMH's Office of Evaluation and Research studied the effects of the "open door" policy by analyzing data on unusual incidents and seclusions. Prior to the February 4 date when the new policy would go into effect, the unit asked all staff members and patients to answer a questionnaire. On one hand, results showed that patients were unconcerned about opening the doors. Staff members, on the other hand, thought unlocking the doors was a good idea as it would increase the quality of care, but were concerned about the burden it would cause them.

An examination of unusual incidents and seclusions before and after the unlocking shows that immediately after opening the doors, a marked increase in unusual incidents and seclusions occurred. This increase, however, lasted only three weeks, and thereafter the rate of unusual incidents and seclusions was the same as before opening the hospital. (See Figure 11.)

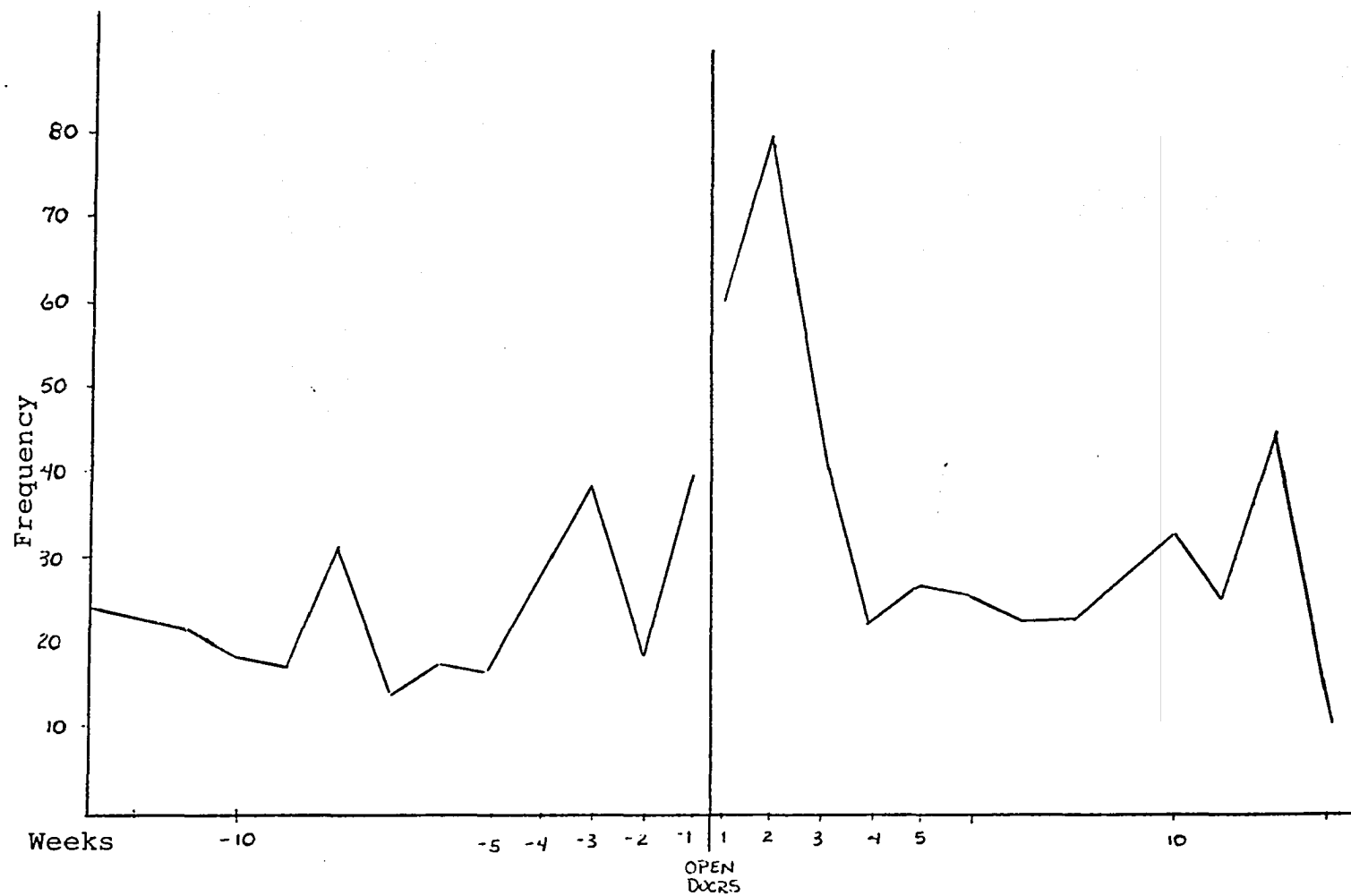


Figure 11. Frequency of unusual incidents and seclusions before and after implementation of an open door policy at Michigan Institute for Mental Health.

Although seemingly separate issues, staff concern about unlocking doors related directly to staffing changes created by budget reductions. As discussed in Chapter IV, 1979 and 1980 were critical budget years. Agency staffing had been reduced to 90% of SNAP (Staffing Needs Assessment Plan, a DMH measure of minimal staffing requirements), and further cuts appeared inevitable. Michigan Institute's annual budget had already been cut from \$4.2 million to \$3.7 million for FY 1980-81.

#### Community Mental Health

At the same time, MIMH was placing considerable pressure on Community Mental Health services to find placements for patients who were no longer considered in need of acute care. Any increase in length of patient stay at the Michigan Institute could be directly attributable to CMH's inability to find appropriate placements. In fact, by definition, clients on the placement unit were ready to be discharged under Community Mental Health supervision as soon as suitable living situations were found for them.

Community social workers were asked to continue their case work with admitted patients, in essence serving as an adjunct to the MIMH treatment program. MIMH appeared to be asking for more and more services at

a time when fewer dollars were available and suitable placements at a premium.

#### MIMH Direct Care Staff

Further budget reductions were threatened by new legislative initiatives, including the Tisch amendment which would mandate drastic reductions in state spending. MIMH Acting Director Cretta Johnson made it clear that, "If Tisch passes, we don't have the chance of a snowball in hell" (Schultz, 1980c).

Newly unionized direct-care staff were vocal about what they perceived as unsafe working conditions at MIMH. Management could not hire. Not only was there a state-wide freeze on filling positions, but Michigan Institute had always been considered poshly staffed by Departmental officials. Vacancies were not being filled. Employees who were injured or sick could not be replaced. By October 1 resident care staffing levels dropped to 35 from an original level of 54. Personnel felt they could not meet rigid accreditation standards and still provide adequate treatment for patients. In light of the stakes, employees decided to take a stand.

Victoria Martin, AFSCME Board member and direct-care aide, met with Lansing State Journal reporter Teri Schultz and told her that MIMH employees were "literally afraid for their lives" (Schultz, 1980c). "I don't want

to lose my job," she said, "but at the present staffing levels it is too dangerous. I would rather see it close."

Direct-care aides and local 3017 of the AFSCME filed suit against MIMH in district court on June 30, 1980. The action, also supported by parents of patients in the facility, charged that staff reductions mandated by DMH budget cuts had resulted in patient and staff injuries and potential hazards to everyone. The group unsuccessfully sought an injunction to prevent further layoffs.

Two months later many of the same concerns resurfaced in the newspaper. "It's an emergency situation out there," stated Victoria Martin, President of the AFSCME local (Bronson, 1980a). The August 14, 1980 Charlotte Republican Tribune article by Peter Bronson went on to say:

Along with Clinical Director Gordon Gritter, Johnson said she is concerned with patient and staff safety, but added that recent fears on the part of patients' families, staff and patients are exaggerated. She blamed the lawsuit on an attitude problem among the staff. "We are grossly overstaffed in nursing," she said.

But Martin, at home recovering from a back injury she said she got trying to restrain an unruly patient, claimed otherwise. (p. 1)

#### Politicians and Bureaucrats

As a result of the publicity, Senator Richard J.



Allen, Jr. (R-Ithaca) asked DMH Director Frank Ochberg, M.D. to look personally into reports of increasing patient and personnel injuries caused by fiscal shortages. In his letter to Ochberg, Allen said he was registering his concerns over recent news reports indicating that the institute was staffed at "dangerously low levels".

Ochberg continued to reduce mental health direct-care staff, rather than Central Office (administrative) positions, in answer to budget cuts. Facilities for the adult mentally ill received a disproportionate share of layoffs (Ochberg, 1981a).

The possibility of closing MIMH was raised during a pre-election debate between Democrat Bill Davis and Republican Ernest Nash as they contested a Michigan House of Representatives 56th District seat. Both men contended that closure was a rumor and that they would be opposed to any such a move. Nash added he doubted a closing would come about and that the plan came from state executives, not the legislature (Albright, 1980).

#### MSU Faculty

Despite acknowledged problems, there remained considerable MSU faculty support for the MIMH training program. A joint memo (November 25, 1980) from W. Donald Weston, M.D., Dean of the MSU College of Human

Medicine and Myron S. Mage, D.O. Dean of the College of Osteopathic Medicine to Ochberg noted that:

We see the partnership between Michigan State University and the Department of Mental Health not only as a national model, but also as a major contribution to the field of psychiatry for the State of Michigan, and mutually beneficial to both the Department of Mental Health and Michigan State. We have been very pleased with the developments in the psychiatric residency program, and had high hopes that the significant progress which has been made could be stabilized to assure an exciting and viable future.

Copies were sent to Senators DeSana and Sederburg; Representatives Dillingham, Hollister and Stabenow and other DMH and University people.

MSU faculty felt that some of the problems encountered were historically based. One key figure saw a concern on the part of the Department of Management and Budget that control over MIMH would be lost and it "would become another University of Michigan hospital". The implication was that astute lobbying would allow direct institutional allocation of monies, rather than having funds filter through the Department of Mental Health budget.

Perhaps for that reason, consensus was that Gerald Miller, DMB Director, was no longer supportive of the agency. An MSU clinician commented:

People said that to me too. And, you know, I was saying to some of those people downtown, "Why don't you give us a chance to talk to him?" Let's go talk to him and let him see us, and maybe he'll find out we're not such awful folks. ...I mean, if

he feels that way, let's answer his questions. I could never get that to happen. I never had the opportunity to talk to him about MIMH.

...People around would say, the legislature feels that the University of Michigan has ripped off the Department of Mental Health and they don't like the Department dealing with universities. ...I'd say, "Let's go talk to them and tell them, explain what we're trying to do together. I could never get anyone to agree to do it. ...With Frank I came to understand. He didn't want to go see those guys because he recognized they didn't like him very much."

### Key Decision Makers

Southeastern Regional Coordinator Joe Farrell, in a September 16, 1980 letter, assured Westendorp that the "Department of Mental Health is in the process of identifying reductions which it must take in response to the Governor's request for agencies to identify savings for FY 1980-81." He went on to add that there is "considerable support for the high quality of clinical activity at the facility." Clearly the letter was an attempt to reassure Westendorp and the Deans about cutback rumors.

MIMH Director Cretta Johnson, in a September 1, 1980 program evaluation for Farrell, was optimistic about the continued need for state hospital and MIMH treatment programs. In updating the Institute's original five-year plan she reflected on the state's changing service requirements:

What we have seen is a concentration of resources among the three primary actors (Community Mental

Health, State Hospital, Michigan State University) coming to bear on the acute short-term care population, and a reluctance to acknowledge the reality that our state hospital population has become mostly chronic over the last three years. The experience relating to acute beds and chronic beds, as the calculation shows, is just the reverse of the information presented in the 1977 plan.

Hence the program emphasis in 1980 is forced to shift to the treatment and care of the chronically mentally ill, those persons whose length of stay averages longer than 90 days.

With that she outlined a comprehensive plan for provision of the necessary services, including continued expansion of MIMH programs into the Jarvis Acres complex. As local communities began to handle more and more of the acute mental health care needs, she saw a new role emerging for State hospitals -- habilitation of the "institutionalized" client.

This proposal was at odds with what MSU faculty envisioned as MIMH's purpose and their own continued role in provision of clinical services.

The Legislature appropriated \$3.9 million for MIMH FY 1980-81 operating expenses. Then, in an unusual move, lawmakers unable to agree on a total state budget for the fiscal year, voted to give Milliken unprecedented spending powers. They then recessed until after the November 4 election.

Shortly thereafter, on October 8, Milliken made a rare televised budget address (his fifth in 12 years in office). In it he outlined Michigan's "depression-

level" financial problems and "hoped" he could convince voters to reject the Tisch proposal in next month's election (Longstaff, 1980). For the first time since 1940, the Governor said, state government would live within a smaller budget "this fiscal year than it did in the previous fiscal year" (Longstaff, 1980).

During the speech Milliken ordered the Department of Mental Health to take an \$18 million budget cut in an overall state-wide reduction totalling \$116 million. In addition, Milliken announced that MIMH would be closed by July 1 as a cost-saving measure.

The Charlotte Republican Tribune described the announcement:

A televised budget address by Governor William Milliken included some bad news for patients and staff at Michigan Institute for Mental Health, Dimondale. In his live speech, the governor explained the state's worsening financial crisis and the effect of rising unemployment on state programs. About midway through his talk, Milliken also announced his decision to cut costs by closing MIMH. And although such a move has been discussed during recent months, his announcement came as a surprise to MIMH staff members, patients and their families. ("Governor Milliken Orders,..." 1980)

"The major reason is the lousy situation of the state's economy," Doug Johnson of the Department of Management and Budget said in explanation of Governor Milliken's decision. "It's one of the smaller facilities in the state and because it is, closing it will affect fewer people than closing larger homes in

Ypsilanti or Traverse City" (Bronson, 1980b).

Doug Johnson added:

The MIMH hospital is also more research oriented, opened in cooperation with Michigan State University to study a progressive "open door" policy, and research facilities are more expendable than traditional mental health facilities. The same open door policy drew criticism from neighbors who often complained of walkaways and from staff members who said patient freedom posed a risk to both staff and patients. But Johnson said controversy had little to do with the governor's decision to close MIMH. (Bronson, 1980b)

Governor Milliken made his speech on October 8, 1980. On October 10, DMB Budget Director Gerald Miller sent a letter to Ochberg ordering him to make plans to close the facility as soon as possible.

Ochberg (personal communication, January 17, 1985) would describe the incident by saying, "we lost a Washington Monument Play". He added:

Every time the Feds find their budget cut too close, they threaten to close the Washington Monument. We had to take a \$20 million cut. DMH Budget Director Bob Gleeson presented me with a list of options. You realize that I don't go hunting around for the budget savings or issues. That is the way it traditionally happens. Those were the options so we attempted some creative thinking. ...We made a special pitch to the Governor and the legislature to save the whole budget. They said yea, yea, yea and didn't do it.

MSU faculty reaction to Ochberg's story was forthright. According to one clinician: "That's exactly my understanding. And that's what he said to me, that they won't agree to this. Well, baloney." He went on to say:

When Ochberg presented his reduction plan to the Governor, or to Gerry Miller, he listed MIMH as one of the facilities that might be closed to save money. The very fact that, although it was the last one on the list, the very fact that he listed it made it begin to be pretty clear what was going to happen. ...Then when the Governor made his budget announcement, that's when we all heard it.

The Project Director of Governor Milliken's Human Services Cabinet mentioned that "Frank (Ochberg) just didn't have the real managerial or the legislative experience. He just didn't have the kind of support within the Department. ...You've got to know which monument to offer up."

The Michigan legislature appeared largely unaware or uninvolved in the decision to close the Institute. Money was allocated to continue funding the agency almost simultaneously with cutbacks that resulted in its closing. Many legislators, including Representative Debbie Stabenow (personal communication, February 20, 1985) Chair of the Mental Health committee, were generally unfamiliar with the program, other than a vague understanding that it was more expensive than the average.

An MSU faculty member stated that "there was this sense of wanting to either protect the communications with the legislature or keep them in the dark. I couldn't tell which it was." The Chairman of the Department of Psychiatry at the time, agreed with that

assessment. He added:

I never met with a member of either the House or the Senate about this facility. Nor am I aware of anybody else from here (MSU) really doing that, the Deans or anybody. We were never given that kind of opportunity. I always had the feeling that if the legislature could see a well-intentioned, at least well-intentioned, cooperative effort between the State University and the Department of Mental Health, that they would have been interested, and at least attitudinally supportive of it."

#### MIMH Clinical Staff

Professional staff quickly rallied in an attempt to save the program: "When we found out what was happening we had originally considered a lot of strategies, including going to the newspapers. But we felt that, given the upcoming (Appropriations) hearings, the legislature would be the greatest help and most influential."

One MSU psychiatrist commented:

I kind of had the sense that we could sit down with some of these guys and talk with them and have them understand what was going on. That if indeed there was this incredible legislative pressure to open and then to close, that we might work it out with them, some kind of compromise.

Department of Mental Health regional staff also remained supportive. The Coordinator's feeling was that "the decision was not motivated by objectivity, because the performance of the place was not bad at all." Budget data could be interpreted several ways. "When you look at comparative analysis data, it had short lengths of stay which was good. The cost per day was



higher, but if you looked at the cost per spell of illness, it was less."

The general consensus of a number of Michigan Institute professional staff was that "the legislature was operating on a misconception." As a result:

One evening we called on every member of the Mental Health Appropriations subcommittee. We wanted to present them with the actual budget figures. We actually called various legislators off the floor of the House, called them out of session, and talked to them one by one. The Appropriations Committee was going to be meeting the next morning to discuss whether or not to give money for MIMH operation and they were operating off of some false assumptions.

...At 10:30 that night we all got calls to be in the (DMH) Chief Deputy Director's office the first thing the next morning. He informed us that it would not be in our best interest to make the presentation we had planned. When push came to shove we were DMH employees. We were employees of the Department and the Director had made decisions and he was speaking on our behalf. It was clear to us that we were to abort this plan of ours.

As a result, no further legislative action occurred. The decision to close had been made, the next step was implementation.

#### MIMH - The Last Days

In light of the closure order MIMH Clinical Director Gritter frankly evaluated MIMH's strengths and weaknesses in a letter to Enzer (January 5, 1981). Among the many strengths, he argued, were that "recruitment, training and experience have combined to produce a

team of professional, paraprofessional, administrative and clerical staff which have built an effective organization operating at a high quality level, as attested by a series of successful accreditation and licensure surveys." He also mentioned a successful treatment program meeting the needs of area residents, training programs, cost efficiency and continued excellent working relationships with a variety of community service providers.

Among the weaknesses, Gritter focused on the MSU/DMH interaction:

Throughout its existence MIMH has been buffeted by unresolved conflict and ambiguity about definition of its primary role and task. DMH clearly defined it as a Regional Psychiatric Hospital to provide the full range of acute and chronic care and treatment. ...MSU, however, continued to regard it as primarily intended for diagnosis and treatment of acute psychiatric illness and for training and research.

...It has been highly characteristic of MIMH that there has been no clear line of authority and responsibility. While administratively a facility of DMH, its clinical functioning was to have been very much influenced by MSU. In actual experience, this has meant a series of covert skirmishes, and occasionally open clashes, between an administrative staff with clear responsibility and allegiance to DMH, and a clinical staff with mixed employment arrangements, a predominant allegiance to MSU, and a highly mistrustful attitude toward DMH and all its works. Thus neither partner could really be in charge, many policies, decisions, and directions rested upon an uneasy consensus, and each party was in recurrent danger of acting unilaterally in ways that proved to be at least ineffective or at worst destructive. (Gritter, 1981a)

### Community Mental Health

As the facility began to phase down, an effort was made to transfer the MSU contract for provision of clinical services to tri-county community mental health (CMH). St. Lawrence would assume some of the inpatient services (30 acute beds). As a private facility, however, it would only be able to accept voluntary clients from Clinton, Eaton and Ingham counties.

CMH proposed to contract with St. Lawrence Hospital for inpatient psychiatric care. St. Lawrence, in turn, would subcontract for clinical services with the MSU Department of Psychiatry. Costs would include \$650,000 for Clinton-Eaton-Ingham Community Mental Health at St. Lawrence, \$130,250 for Central Admitting and \$150,000 for the MSU Residency program.

The Department of Mental Health appropriation bill to close MIMH recognized that no clear community alternative existed for either chronic or involuntary patients. Accordingly, it included in the boilerplate Section 73 that: "Funds appropriated in Section 1 for the Michigan Institute for Mental Health are for a phase-out of that facility by April 1, 1981. Community alternatives shall be developed for clients in their area of residence" (State of Michigan Public Act 361, 1980, p. 1384).

In a February 24, 1981 letter to DMH Director Stehman, Farrell estimated a surplus of \$562,700 from the MIMH closing appropriation of \$3,386,700. Expenditures were projected at \$2,824,000, including an estimated \$250,000 for remodeling at least one ward at Ypsilanti. Farrell requested legislative and executive support for the additional \$367,550 needed to implement the C-E-I/St. Lawrence plan.

On March 6, Farrell sent a follow-up letter to Stehman clarifying the Department's unwillingness to provide any additional funds and outlining alternatives, including directing all new MIMH inpatient admissions to Ypsilanti Regional Psychiatric Hospital.

Closing MIMH was much like the earlier closing of Riverside Center, Ionia. Patients in need of long-term care were transferred to Ypsilanti, which continues to admit involuntary patients from the tri-county area. Other clients were discharged to home communities. CMH and St. Lawrence provide 30 private beds for short-term, acute care.

#### Organized Advocacy Groups

Michigan Institute for Mental Health staff chose the media as one way of voicing their concerns. There appeared to be a generalized belief in the value of taking issues to an attentive public and to the legis-

lature. As mentioned in Chapter II, decision makers are increasingly aware of the importance of constituency involvement in public programs. Interviews of Michigan leaders showed a growing appreciation for the strength of organized mental health advocacy. It is worthwhile to take a brief look at the role of such groups in the larger system as discussed by relevant actors.

William Cote (personal communication, January 31, 1985), a former Capitol Bureau Newspaper Reporter observed that:

Certainly the legislature, and to a somewhat lesser degree the Governor's office, are very sensitive to those things. They get calls and telegrams and letters from just a comparative handful of people, a hundred people or something, and they may see that as an enormous flood of feeling on one issue.

Most actors involved in the mental health field are aware that one of the handicaps faced by programs for the mentally ill is a lack of cohesive advocacy. There remains a sense of stigma attached to mentally ill clients and their relatives. Unlike parents of mentally retarded children, there is little sympathy or understanding for those related to the seriously disturbed. In fact, historically, the blame for psychotic behavior has often been placed squarely on the family. While developmentally disabled persons are less able to advocate for themselves, they are also represented by a more credible group, their parents.

Representative Debbie Stabenow (personal communication, February 20, 1985) said:

There are two kinds of consumer groups, I think. One relates to the DD (developmentally disabled) and that has been predominantly parents, although more direct consumers are becoming involved, but predominantly parents. That movement has been in place much longer (than organized groups for the mentally ill), and is much more sophisticated. In fact, that's why we have many more services for DD than we do for MI (mentally ill), because of the advocacy. They are very organized, very sophisticated.

The President of OASIS, a self-help group, seconds that opinion:

The MI population compared to the DD is disadvantaged because the DD groups, such as Associations for Retarded Citizens, seem to talk with a more unified voice. Oh yes, we all recognize that they (ARCs) are doing a heck of a lot better job at it than we.

There appears to be general consensus. Michigan decision makers and system observers acknowledge that the mentally ill population has received little advocacy support in the past and changes are occurring slowly with limited impact.

One Legislative Analyst summarized the relationship well:

In general our psychiatric hospitals don't have a very good constituency. They're not the ones who are well known to the legislators and are real active. We do have, and this is quite new, just in the last few years, a growing network of ex-patients who are organized after a fashion. But that has become so difficult to deal with up here (the Capitol) because some of them come and are very extreme in their testimony. ...Many people who have been mentally ill, and who have recovered and

maintain themselves sufficiently well to really be integrated back into society, they aren't going to get up and talk about it. It's the stigma. ...No, I think what concerns me most is not the way they talk, or anything of that order, it's the fact that they don't have their act together.

Representative Stabenow (personal communication, February 20, 1985) agrees with that assessment:

The radical folks are hard to deal with, the folks who want to get into the whole question of the myth of mental illness and there should be no civil commitment procedure, and so on. There's no way the majority of people buy that. ...The legislators, most of them know relatively little about mental illness, even people on the Mental Health Committee, and when that's their first contact with somebody who's an advocate, it just doesn't help.

Although one member of a client advocacy group tends to concur, she adds:

Really we aren't always sure that what we're doing is doing any good, partly because we don't know what would happen if we weren't involved. But, we have a vested interest too. And, if we aren't there to be seen, the counterforces could really sweep us away.

Use of the media, as will be discussed in Chapter VI, is rarely the strategy of choice for such groups. Most often, attempts to sway opinion occur through personal contact. The leader of a self-help coalition for the mentally ill said, "We are trying to make our viewpoints known to the main decision makers. I'm on the Governor's Council on Mental Health and its Recipient Rights Committee and the Advisory Council of Institutions. I'm just trying to awaken people to what's going on in the system."

Approaches seem orthodox and generally involve a comparative handful of vocal advocates. When asked how issues come to legislative attention, Betty Davey (personal communication, January 28, 1985), a Legislative Analyst, said "telephone calls". "Sometimes it's something that shows up in the newspaper and I think that's how any legislator gets involved in local decision making or what happens at the local level, through constituents who call or write."

Representative Claude Trim (personal communication, January 23, 1985) seconded that opinion. He prefers as much personal contact as possible. He attempts to reach every group that has a potential interest in issues through news letters, as well as face-to-face meetings. "And of course," he continues, "in case there's someone out there you forgot or may have overlooked, you try to do it through the media. Just every way you can think of."

Stabenow (personal communication, February 20, 1985), in addition to directly contacting constituency groups, sponsors topic-oriented community meetings. She also holds informal discussion groups in outlying areas: "I'll announce that I'll be there at 8:00 in the morning when all the people come in for coffee or something and just sit and talk. I get a good reaction."

Representative Ernest Nash (personal communication,



February 25, 1985) adds:

We receive a lot of calls here because I think the most it would cost anyone probably is 20 cents in my district. ...It's an advantage in that whenever something is on their minds they call me. On the other hand, I do spend a lot of time answering inquiries.

Constituents are considered. They have weight with bureaucrats and politicians. One Fiscal Analyst mentioned that DMH Director Pat Babcock:

unlike the previous directors, is paying a lot more attention to what is occurring outside the Department, more of a team player. But he, as an administrator, is also more concerned about what is occurring within the Department. He will often go mix with people, visit institutions on the night shift. Then he will come back to the legislature and tell the story of his Department.

Despite this evidence of attention, there is little direct evidence of interest group impact on the Michigan legislature. We remain unable to evaluate the strength of decision-maker attention to specific groups, although there is a suspicion that less weight is given to opinions of advocates for the mentally ill than for the developmentally disabled.

Boulter's (1983) policy ladder and matrix offer a visual accounting of these pressures. The implication is that decision makers are aware of, and react to, public opinion. Some observers consider this reaction a natural outgrowth of operating within the political sphere. However, it remains difficult to separate simple attentiveness from spurs to action.

It is assumed, but never stated, that those at the top of the policy ladder are far more powerful than those at the bottom. While patient groups may attain considerable visibility, Michigan Department of Management and Budget, Department of Mental Health, and institution bureaucrats are more politically powerful and, therefore, hold more sway in the decision-making process.

Several persons interviewed discussed an incident which serves as one example of a major policy change which appeared to result directly from constituent involvement. Beth Leeson (personal communication, February 4, 1985), Director of the Mental Health Association in Michigan, described the incident:

Back in the very early '80s, when we were going through Executive Order cut after Executive Order cut, literally almost on a monthly basis, there was a decision that some of the institutions would have to be closed. And it was decided that Clinton Valley Center would be targeted for closure. ...So there was a decision made to close it. And it was a serious decision. It wasn't a, "We might have to do this," sort of decision. It was a, "Let's get things rolling decision." And it was based essentially on money.

The people of the Pontiac area and others joined and coalesced into a giant group and that included residents of the institution, parents, the police departments, the school systems, religious groups, people in the community, just about everyone you could imagine joined together. They held a huge public hearing down on the grounds of Clinton Valley Center for the legislators.

And then, shortly thereafter, they got on buses, organized really a wonderful effort, one of

the best we've seen at the State Capitol. ...They all came to Lansing, about 660 strong, and crowded into the House chambers and one after another spoke all afternoon. Finally, at the very end of the day -- and it really was such broad-based support for Clinton Valley Center -- at the end of the day Pat Babcock had his opportunity to speak and he said, "I'd like to make an announcement. I've just been meeting with the Governor," who at that time was Milliken, and said "We've found an extra," I think it was six million that was needed to keep it open, "and you can go home satisfied that you've done your job well because Clinton Valley Center will remain open."

The decision to retain Clinton Valley appeared to result from a perception of strong support as publicly voiced by interested actors.

With that kind of evidence of efficacy, groups will continue to join forces in organized efforts to sway decision makers. Cigler and Loomis (1983) tell us that the effectiveness of protest is related to three areas: the quality of publicity received, the congruence of interest group goals with the values of decision makers, and coordination of the protest with the needs for ongoing maintenance of the group (p. 350).

Boulter (1983) argues that predicting decision outcomes in the public sector is less dependent upon the organization of the effort than the development of widespread coalitions; less dependent upon total numbers than the unified voice of those who speak out publicly.

### Summary

Interviews, correspondence and other public documents provide insight into two facilities developed with the highest expectations. Optimism about innovative treatment programs and intensive care quickly gave way to the realities of budget issues. Power struggles within and throughout the agencies ultimately weakened their structures.

Lafayette Clinic resided within a benign and even supportive community. It was surrounded by other service agencies with professional expertise. By the time budget reductions became a serious concern, the program was an integral component of local services. Staff worked hard at proving agency indispensability. Grant programs were chosen that were of interest to attentives and could show measurable returns.

Dual ownership by the Department of Mental Health and Wayne State University did not appear to be a liability for Lafayette Clinic. Although primarily funded by DMH, agency perception of purpose was strongly tied to University programs. Disagreements over goals were softened by the protective relationship of medical and academic communities. Clinical privileges were granted for a number of other Detroit-area hospitals, as well as the University. A faculty position at Lafayette

was prestigious.

Lafayette Clinic leadership was entrepreneurial. Administrators were able to provide services to a ghetto area without losing sight of the institutional goal -- research.

Michigan Institute for Mental Health, on the other hand, seemed unable to retain necessary support at the highest bureaucratic levels. There is evidence, particularly in relationships with the legislature, that administrators actually suppressed potential support for MIMH within both the Executive and Legislative branches. While there may have been widespread belief in program effectiveness and value, this message was never clearly received by decision makers.

The result was an increasing focus on organizational and fiscal issues, rather than programmatic concerns. This ultimately proved disastrous as factions pulled against each other. Potential allies, particularly in the community, were alienated by conflicting messages. Patients were presented as dangerous. Direct-care staff considered themselves under siege and administrators felt increasingly constrained. Community Mental Health and other local service agencies found their case loads increased, rather than eased, by this DMH program. MSU and DMH were struggling with their own definitions of how to handle the power inherent in this

potentially valuable, but also volatile resource.

MIMH leadership was weak, partly because of an inability to clarify the chain of command. Both the Director and Clinical Director were former Department of Mental Health Central Office employees preparing for retirement. As a result, most operational direction came from DMH.

University faculty were unable to establish the co-equal administrative relationship they considered important to program viability. Clinicians assigned to the facility received little peer support and even found their academic status lowered by such "field" work. The Institute was never able to develop a research component.

Chapter VII will use Boulter's (1983) decision ladder to demonstrate graphically the different levels of support for these two programs and the resulting impact on agency survival.

## CHAPTER VI

### NEWSPAPER CONTENT ANALYSIS

Boulter (1983) only peripherally discusses media involvement in the policy making process. However, in Chapter II it was proposed that the media, particularly newspapers, can play an important role in directing public attention. As a result, they also direct decision maker attention. Newspaper editorials, selective choices of headlines, and coverage of some issues while ignoring others may even directly sway opinion or force action on issues.

It was suggested that program success or failure is dependent on decision-maker's perceptions of the sum of constituency support. Part of this perception of public concern is obtained from the media, particularly newspapers. It was further proposed that those organizations that receive strong public constituency and media support are more likely to survive than those which receive less support. More specifically, the decision to maintain or close an institution for the mentally ill (particularly in a time of crisis) will be influenced by newspaper coverage.

These issues will be explored through a newspaper content analysis and discussion of decision maker

strategies regarding the press. Chapter VII will pull together information from the case histories and group advocacy strategies, the content analysis and decision maker perceptions, in a comparative analysis.

Boulter (1983) determined decision-maker opinions by coding public statements as either positive, negative or neutral toward a given policy. For groups, such as organized advocates or a legislative body, he aggregated opinions to develop a single score. There is no mention of how ratings were obtained or scores quantified. For the purposes of this study three methods were employed: interviews, surveys of public documents, and a content analysis of newspaper articles. This chapter will examine more closely the newspaper medium's involvement in public decisions.

All mental health articles during an eleven year period were read and logged for the three local newspapers considered most likely to provide press coverage of Lafayette Clinic and Michigan Institute for Mental Health. (See Appendix A.) For the years 1973 through 1983 a total of 887 Detroit Free Press, Detroit News and Lansing State Journal newspaper articles on mental health issues were reviewed. Of this number, a total of 7 percent mentioned either facility. Thirty-four named Lafayette Clinic and 28 named MIMH. One mentioned both.



Initially, it had been assumed that most mental health articles would focus on a currently breaking story. The story would appear once or twice, then fade as media (and public) interest turned to other areas. This did not seem to be the case for the newspapers studied. Rather, substantive issues such as community placement, deinstitutionalization and budgetary cutbacks received ongoing media attention.

A year-by-year discussion of coverage for these three newspapers will provide a more comprehensive understanding of trends occurring in the mental health field while laying the groundwork for additional information obtained through interviews and public documents.

### 1973 Through 1983

In 1973 one story to gain considerable media attention was the emotion-arousing issue of psychosurgery. As mentioned in Chapter V, this controversy touched upon Lafayette Clinic. Eleven articles named the facility, almost a third of the total coverage for Lafayette Clinic during the eleven year period. Headlines such as "Psychosurgery Called Partial Euthanasia" and "Can You Cut Out Hate With a Knife: The Story of a Tortured Mind by John Doe" (Doe, 1973) served to generate public interest.

What brought the problem to media attention was the contention by Doe's attorney that the law by which he had been confined was unconstitutional. As a result, the court determined that Doe had been illegally confined and ordered him immediately released.

Every potential fear issue was aroused. Uncontrollably insane persons, raping, killing and then being discharged because of legal technicalities; surgery on involuntary patients; and lobotomies on non-consenting individuals.

In some sense this foreshadowed concerns in later years about the helplessness of institutionalized patients, juxtaposed with the helplessness and anger of citizens forced to deal with a seemingly inflexible and unconcerned bureaucracy.

One other article only peripherally mentioned the Lafayette Clinic that year. A new law changed most state facility names; Lafayette Clinic's name remained the same.

A year later (1974) Lafayette was involved in another emotional issue similar to that of 1973. Out of a total of 33 articles, five mentioned the Clinic, three in the State Journal and two in the Detroit News. This time the headline read, "Lawyers Fight Experiment on Girl, 7, in Test Case" (1974). Children committed to

institutions were being used as experimental subjects without their knowledge or consent.

On further consideration, the stories revealed that parents had given permission for the procedures. The implication was that parents who would institutionalize their children could not be good parents, and institutions felt no compunction about experimenting on the innocent. In actuality, blood samples routinely gathered during physical examinations upon admission were used to test for high levels of zinc. If levels were low, children were given supplements.

Again, the issue was not so much the experiment as a point of law. Can parents, admitting a person involuntarily, give consent for experimental procedures? Once more, all the trigger words were there. But added to these emotional words were the legal concerns raised in courts about a parent's right to commit involuntarily a child without a court hearing. Basic parental responsibilities were in question.

These relatively short-term problems were soon superseded in 1974 and 1975 by the new Mental Health Code. A sample of 1974 headlines tells the story: "Judges Upset Mental Commitment Law," "Ruling Broadens Mental Patient Rights," "Revised Mental Code Urged," "Mental Care Programs Face New Strain," "Mental Health

Code Passed," "Where Will Adult Retarded Go?," and "Judge Won't Send Mentally Ill to Jail."

There were 34 mental health articles in 1973 and 33 in 1974. In 1975 that number jumped to 51. The biggest concern related to individuals admitted to facilities years ago. Originally found insane after heinous crimes, they were no longer considered mentally ill. Under the new law they had to be discharged. Headlines included "State to Release 3,000 Mentally Ill" and "'Dangerous Man' Free; Mental Code Gets Blame". The Detroit Free Press published a series of stories after locating seven "mental escapees", most of whom had committed either rape or murder. State of Michigan officials were accused of being lax in attempts to apprehend such dangerous criminals. The Department responded by either returning the AWOL former patients to their facilities or removing them from escape status. One individual had died two years earlier. Clearly the Department was on the defensive.

Thirty-two out of 51 articles in 1975 dealt directly with Mental Health Code changes and their effect on involuntarily confined patients. 1974 and 1975 were both marked by resignations under fire of top-level mental health officials, including DMH Director E. Gordon Yudashkin, M.D.

In 1976 the number of articles about mental health programs rose to 80. The year was one of increasing attention to the broader mental health issues that would continue to surface during the next few years. In the spotlight were fiscal problems (7 articles), institutional care concerns (13 stories), and system-wide deinstitutionalization (12 articles).

Ten stories, all but one in the Lansing State Journal, discussed establishment of the MIMH facility at Jarvis Acres. Although others covered the same meetings, the specific agency or site were not mentioned as in "Mental Board Again Rejects Mental Care Facility". The first article to mention the facility by name reports on proposed sites. The next six discuss the controversy surrounding establishment of a mental health agency in a suburban setting. Local meetings and neighborhood opposition were covered in detail. The remaining three stories, one in the Detroit News, reported on the Windsor Township Board and Planning Commission approval for DMH to lease the site.

During that same year, the single State Journal feature on Lafayette Clinic would seem to presage new attention for an important problem. The headline was "'Cure' for Schizophrenics Now in Hands of FDA" (McCarthy, 1976). Neither Detroit paper mentioned the breakthrough, and there was no further coverage.

As discussed in Chapter V, Lafayette Clinic had been receiving funding for accelerated schizophrenia research since 1974. The appearance of this story in the Lansing State Journal two years later may be reflective of the Journal's ready access to the Capitol Bureau and the fact that Mental Health appropriation hearings for the new fiscal year were underway.

There were eight "upbeat" feature articles in 1976, many during December, all regarding the mentally retarded such as "Self-Respect is Part of Their Job's Pay" and "Retarded Find Warmth, Hope at New Center".

In 1977 the total number of mental health stories dropped back down to 61. Unlike years before or after, there appeared to be little concentration on broader problem areas. Articles seemed more supportive of patient rights and the system, e.g., "Handicapped Are Fitting In To Society", "A Proud Young Man Demonstrates 'New Era' In Chance For The Retarded" and "Healing An Ailing System" (1977).

The latter article mentions MIMH. While the focus remained on problems within the Mental Health Department, there was some discussion of inroads and planned improvements. MIMH was considered part of the coming new era.

A series of Detroit-area newspaper articles served as an impetus for the Michigan Legislature, in House Concurrent Resolution 144 of 1977, to call for the resignation of the Coldwater State Home and Training School Superintendent, whose "policies have left a cloud of public distrust over the operation of the State-run mental health institution." The resolution goes on to cite the "low morale of the institution's employees, along with the recent personnel disturbances which were widely reported in the media. ...If immediate attention is not given to this critical matter, the public's confidence in State-run institutions will be irreparably harmed." As a result of legislative and media pressure, the Superintendent resigned the following week.

During the next year, news coverage of the mentally ill and retarded changed irrevocably. In November, 1977 Oakdale Center for the Developmentally Disabled, Lapeer came under investigation regarding allegations of patient abuse. Several staff were fired. On February 19, 1978 the Detroit Free Press began a series of front-page exposes on Plymouth Center with "Children Tortured; State Center Covers Up".

Again, people's worst fears were realized. Helpless children were being physically, sexually and

emotionally abused by workers in a large impersonal system. Abuse investigations spread to other facilities and programs. Heads of facilities quit. The Acting Director of the Department of Mental Health resigned.

The mental health news in 1978, as seen in 187 articles, talked of little else. Added to these horror stories was increasing controversy about community homes for the retarded and mentally ill and the beginning of the deinstitutionalization push as depicted in "Lawsuit Protests Adult Care Home" and "2 Suburbs Seek to Bar Homes for Retarded Adults". Of the 42 articles not specifically focused on allegations of abuse, 20 were about group homes in the Detroit area.

On the one hand, institutions were pictured as horrifying warehouses where innocent children cried out unheard, "Children Held Our Hands, Wouldn't Let Go". On the other, placement of handicapped adults in community settings was vigorously opposed, "Lawsuit Protests Adult Care Home". Seldom were attacks on individual homes linked with the broader problems of lack of coordination and inadequate preplanning within the Department of Mental Health.

House Mental Health Committee minutes of May 18, 1978 find representative Thomas Brown chiding fellow members by saying, "We are keeping people locked up that



shouldn't be and we are responding to what the press says rather than what the professionals in the institutions have to say."

One of the few upbeat notes during the year was coverage of the Macomb-Oakland Regional Center, a new facility for the mentally retarded. Agency administrators appeared to make a concerted effort to talk about their community programs through such articles as "'Rest Break' for Parents of Retarded" and "Plan Helps Find 'Special Sitter'".

Of the 187 mental health articles during 1978, four named either Lafayette Clinic or MIMH, two for each facility. For MIMH, mention was part of the tag for articles such as "Reports of Patient Abuse Not Limited to Plymouth" and "Most State Homes Have Abuse Cases". MIMH was listed among agencies with no reported incidents of abuse. Lafayette was not mentioned at all.

However, during the year Lafayette did receive renewed accreditation, "8 Mental Hospitals Win Recertification" and a staff member was quoted in an article regarding the search for a new DMH Director, "Panels Try to Fill Mental Health Job". It is interesting to note that MIMH's accreditations were never covered, nor was the name change from New Riverside Treatment Center to Michigan Institute for Mental Health ever mentioned.

The media remained focused on abuses at mental facilities during the following year in articles such as "Crime, Morale Crises Plague State Hospital", "Plymouth Center is 'Disastrous' Court is Told" and "How Captivity Since Birth Left Jack, 54, a Mental Cripple". Again, the majority of articles concerned Detroit area facilities. The Detroit News also did a series on Ypsilanti Regional Center's filthy kitchen.

Attention remained on deinstitutionalization as well. Community homes were under siege as in "Bullets 'Welcome' Home for Retarded" and "Fire Destroys Troy Home for Retarded". During the year, a new DMH Director and Lafayette Clinic Director were hired, with minimal press attention.

In 1979, out of a total of 85 articles, 43 concerned institutional deficiencies and 9, community homes. Three mentioned Lafayette Clinic. Two were regarding the problems of appointing an Australian Clinical Chief and the third about state facilities that contracted linen services to non-local providers ("Dirty Linen Hits the Road").

The one article about MIMH had an unusual focus given the tenor of the times, "Patients Protected from Abuse; Who Protects Attendants?". The State Journal

article by Yolanda Alvarado (1979) begins, "Administrators at the Dimondale state hospital for the mentally ill have gone overboard in their zeal to protect patients from abuse, a group of nursing attendants say."

The story quotes direct-care workers who contended that serious incidents occurred because of "asinine" state mental health code rules and hospital policies, the most critical of which was forbidding the use of "seclusion" as a disciplinary tool. According to the reporter, Director Cretta Johnson "appeared both surprised and disturbed at finding out that some attendants were so dissatisfied that they would contact the press."

Such a public argument between care providers served to fuel the dissonance surrounding deinstitutionalization that was already causing considerable discomfort for readers in the community. The dangers of the mentally ill were reinforced at the same time as the potential for abuse of powers within institutions. If trained attendants were afraid, then certainly citizens had every right to be.

In 1980, the issues began to change. Eighty-nine articles focused on mental health. The potentially volatile story of involuntary sterilization faded quickly with such articles as "Michigan Had 3,000 Sterilized in 1929-50", "Sterilization Victim, 63, Still

Asks 'Why'". Interest remained fixed, however, on the continued problems of community placement. Five articles looked at sterilization of the institutionalized mentally retarded and 19 at problems in deinstitutionalization planning, including several cases of arson, as seen in "FBI to Investigate Fire at Home For Retarded".

Nine articles were written about renewed allegations of abuse at mental health institutions. Added to these ongoing controversies was a relatively new concern, the budget. Seventeen stories focused on spending cuts and pending layoffs of direct care staff in institutions. Such articles only contributed to the uneasiness citizens were feeling, "Hospitals Notify Staffs of Cutbacks", "Budget Cuts Imperil Mental Health Units" and "Milliken Seeks Another Big Slash in Spending".

Although never publicly stated, the implication appeared to be that if institutions had enough money, there would be plenty of staff, abuses would not occur and there would be no need to place people in the community. Yet, such thinking was clearly at odds with the deinstitutionalization push. Why put money in institutions if patients were going to be placed in the community? It seemed to be an almost irreconcilable

dichotomy. Only rarely were philosophical issues raised such as what was best for the mentally disabled or how better services could be provided.

The article "Mental Health Cuts Will Hurt" offers one of the first discussions of potential budget reductions that could force closing MIMH. Two other stories, "Mental Health Director Protests Cuts in Budget" and "Injuries Up At Mental Institutions" both briefly add MIMH to a list of Michigan's few accredited facilities.

MIMH staff reacted to the threat of fiscal cutbacks through such articles as "Care Aides 'Afraid for Their Lives'" and "Mental Facility Aides Say Layoffs A Danger". These appeals to decision makers through community attentives appeared to be aimed at generating fear -- fear of reducing staff to the point that patients would become unmanageable.

Of the remaining nine articles mentioning MIMH during 1980, six relate directly to the open door policy or neighbor concerns about patient "runaways". Some examples are "Riverside's 'Open Door' Policy Arouses Concern", "Fencing of Mental Unit Asked" and "Jarvis Walkaways Upset Windsor Board".

Lafayette Clinic celebrated its 25th anniversary that same year. The anniversary received brief notice

in a Detroit News story about a research breakthrough. Dr. Tibor Farkas, Psychiatrist at the New York University School of Medicine, addressed a psychiatric conference held at Lafayette Clinic and described his new brain scan machine as "one of the most ambitious and complex research projects ever attempted in psychiatry" ("Scanner Provides Peek Inside Brain").

A second 1980 Detroit Free Press article is entitled "Lafayette Clinic Seeks Old Luster". By Colin Covert (1980), it begins:

Just over a year ago when Dr. Samuel Gershon became director of Detroit's Lafayette Clinic, he was like a man buying a used car. He expected to find some problems but didn't realize their full extent until he took over.

A half page picture shows George Smoot, lab technician, performing a brain implant on a mouse. The article is positive, focusing on clinical research, with no discussion of patient care.

Of the 111 mental health stories in 1981, most can be divided into two categories: budget and deinstitutionalization/placement programs. Forty focused on the problems of deinstitutionalization; eighteen on budget. Community dissonance was prompted by such back-to-back stories as "State Agrees to Costly Lease of Foster Home" and "Budget Slashes Worsen Woes of Psychiatric Care".

Eleven articles were specifically about Dr. Frank Ochberg, DMH Director, who resigned following an audit of Departmental practices. Headlines read, "Ochberg Out, Group Homes Stay" and "New Chief Backs Group Home Policy".

Another potentially serious and damaging issue was raised by the Detroit News which carried a series of seven articles beginning with "120 Died in State Hospitals in '80". However, no other newspaper provided coverage. Given the outrage of the 1970's over allegations of abuse, it is surprising that allegations of murder received less attention. While it is not possible to judge the validity of such accusations based solely on Detroit News articles, it appears that community interest was turned elsewhere.

Michigan Institute was mentioned in two 1981 reports about a televised budget address by Governor William Milliken, who discussed the impact of proposed cuts. This was the first notice that MIMH would be closed, "Economic Woes Force Hospital Closing". Lafayette Clinic was also considered for closure later that year if cutbacks continued, "Mental Health Sends Budget Warning".

Michigan Institute for Mental Health closed in 1981 without further newspaper mention. This lack of media

attention appears counterintuitive given evidence of ongoing community concerns about the facility, coupled with earlier publicity about staff working under siege. MIMH workers had seemed willing to take their story to the newspapers. If nothing else, publicity about closing the facility would have been a useful tool for local legislators wanting to gain constituency support.

In 1982 the focus on mental health began to wane, approaching 1975 levels. There were 65 articles, with almost half (32) spotlighting worsening fiscal woes and the impact on deinstitutionalization. Headlines in 1982 tell of the continuing tug and pull created by these two issues in the community: "Michigan Mental Care 'On Ledge', Chief Says", "Breaking Point: A Bare Minimum Isn't Enough For Mental Care", and "Community Placement Plan Saving Mental Health Funds".

During the year there was renewed interest in the Mental Health Code with six articles, including "Should the Insanity Plea as a Defense Be Abolished?" and "Michigan's Insanity Verdict Under Fire". With jail overcrowding, the chances a mentally ill criminal would be released early were greatly increased.

Two 1982 articles mention Lafayette Clinic peripherally, with short quotations from staff members. Another, in the August 29 issue of the Detroit Free



Press, features Dr. Barbara Geller, Child Psychiatrist, who studied depression in children caused by chemical imbalances. The story is positive and one of several reflecting more generously on the mentally ill and developmentally disabled.

Of the remaining 14 articles, only one is placed within an institutional context, "Ex-Mental Patients Aid Others". The rest are more typical of such features, "Retarded Child May Aid A Marriage, Study Finds", "God's Children: 'Love Is the Message We Want to Teach Them'", and "Self Esteem Grows Along With Flowers and Vegetables".

The range and type of stories during 1982 are more reflective of those first evidenced in the early 1970's. In fact, this pattern had originally been anticipated. It was expected that the focus would be on a few stories of newsworthiness, carried while interest lasted, then dropped in favor of the latest news. However, throughout the analysis, we have seen persistent media attention on specific issues of community concern. In 1982 the spotlight remained on budget and placement.

These same concerns carried into 1983. Out of 91 articles, 13 discussed the DMH budget and disability benefits for patients; 15 were about deinstitutionalization problems or group homes; and 13 related to a

death at Northville. The death was allegedly caused by a drug overdose which prompted further investigation of the facility. Lafayette staff were mentioned twice in quotation attributions.

### Perceptions of the Medium

In total, over an eleven year period, the Michigan Institute for Mental Health was mentioned in newspaper articles 28 times and Lafayette Clinic 34 times. Two factors appear to be responsible for this limited press attention: deliberate risk avoidance on the part of the agencies, and an ongoing news focus on the volatile issues of the day, many of which were occurring in a few Detroit locations.

During interviews most mental health advocates mentioned that unless stories were sensational, they tended to be of little interest to editors and reporters. One Director of a client advocacy group said, "We try to talk to the press, whoever we can. But we can't get much attention." The Lansing-area leader of a relatives group he founded 25 years ago commented that "It is hard to get quiet, good stories in the media." Another self-help group program coordinator added "I find it bothersome and irritating at times for them (the press) to come and interview us, and they want gory stories."

These opinions were supported by the content analysis. Generally mental health topics were highly volatile, and stories were filled with emotion-arousing words. Of the 694 articles for which page numbers were obtained, almost half (336) were on A1, A2, A3 (inside front page) or B1 (front page of the second section), an unexpectedly high figure.

Overall, during the eleven-year period studied, the feature-type "soft-sell" articles were few and far between. When they did occur, they were more frequently about the mentally retarded. Of the 80 stories classifiable by the trade as "upbeat", 60 highlighted the retarded and 20 the mentally ill. Examples are such features as "Last Chance Family - Love for Disabled" and "Wonder Woman: She Works Magic With Retarded."

Lack of media interest may also have been caused by larger issues sweeping attention away from the two facilities. Initially it had been assumed that most articles would focus on a currently breaking story. The story would appear once or twice, then fade as media (and public) interest turned to other areas. For the newspapers studied, at least in the mental health system, this did not seem to be the case. In 1978, for instance, there were 187 mental health articles, 11 in the Lansing State Journal, 112 in the Detroit News and

64 in the Detroit Free Press. One-hundred-and-forty-five focused on allegations of abuse in institutions for the retarded, primarily at Plymouth Center for Human Development. This story was initially investigated by the Detroit Free Press. Of the remaining 42 articles that year, 20 dealt with community concerns about foster care homes which were first established in the Detroit area.

State Journal interest in the larger mental health issues may have been less than for the two Detroit papers because the major problems, including allegations of abuse, deinstitutionalization, and foster care home placements, either originated in the Detroit area or had their greatest impact there.

Edwin Diamond and Claire M. Tallarico (1985) in exploring media reactions to a highly publicized New York City crime help to explain these findings:

Researchers refer to the media's presumed agenda-setting power -- the idea that the press tells people what to think about, if not what to think. We found that notion in this case dead wrong. Most of the media went along with an intense, emotional public opinion. (p. 7)

#### Decision-makers and the Media

We see considerable evidence of crisis within the mental health system, crises that threatened the stability of programs and forced large-scale changes.

We also see evidence that politicians and bureaucrats are aware of the media. Joe Snyder, a Michigan Legislator for 16 years, said about the Department of Mental Health:

We just had to go out after them more than once and publicize the problems that no one else would notice if we hadn't. ...Then it was a question of using the resultant publicity to force the Department into making the changes that were needed. I used strong press releases to get my point across. ...The media was very supportive in those days, particularly the Detroit Free Press. They delighted in our shenanigans. (personal communication, February 4, 1985)

A former Governor's Office Project Director stated that the Governor also used the press: "Sure. That's what it's there for. That's what part of the job of being a politician is all about. Get your story out."

From the news writer's perspective, an MSU Journalism Instructor and Booth Newspaper Reporter for 15 years agreed that legislators read newspapers to help them respond to community concerns. Officials "certainly read our stories ... because they would often call us and discuss them, talk about them, disagree with what somebody else had said or agree." He added, "They may be relying too much on what a comparative handful of people are saying. But what if they're the only people who speak up? Fairly small groups have a lot of influence because of that."

A Legislative Research Analyst agreed, "I do think more legislators react to the press than they like to admit. But many of them don't have the opportunity to really try to shape it (press coverage)." A former Legislative Liaison for the Governor's Office responded even more succinctly when asked if legislative inquiries were triggered by the press, "Sure. Absolutely. No question of the power of the press. The press is very influential."

In almost every case, positive interaction with the media is considered to be a result of personal contacts, dependent upon an individual relationship with a local newspaper writer or editor interested in mental health issues. The Director of the Office of Community Residential Services stated:

I think after a while you sort of establish good relationships with two or three press people and they need information and you need information so you get sort of a detente with them. But, the relationship is good enough that you can trust them and if you have to go off the record they will.

However, Department of Mental Health Director C. Patrick Babcock (personal communication, March 25, 1985) considers the media from a somewhat different perspective. News stories serve as signposts: "I think once you stop reading criticisms in the press or stop getting shot at in a positive way in the legislature, getting tough questions or getting into trouble, you're getting

complacent. And that is how (the problems at) Plymouth developed."

### Summary and Discussion

During the 11 years under study, the Michigan Institute was only mentioned in relation to its opening or closing, with little in between except peripheral inclusion in larger stories.

A Lansing State Journal staff writer for the past 15 years described her involvement:

Regarding MIMH there were some big meetings at Dimondale, but mostly the papers didn't pay any attention. And these were people who were trying to make a difference, but they weren't much heard. ...At that time the Lansing State Journal was getting away more from that meeting type of coverage. We were becoming more dependent on the wires and stories of broader interest. As a consequence, some of the local stuff got lost. And, when nobody paid attention, the issues sort of just disappeared.

Lafayette's reaccreditation was mentioned briefly, and Michigan Institute's not at all. Both facilities had a low public profile and, given the heat of the media's spotlight, perhaps chose such a strategy deliberately.

Lafayette Clinic was involved in two early conflicts in 1973 and 1974. For the most part, agency mention was peripheral to larger legal and research questions. Indeed, several articles about psychosurgery

did not name Lafayette Clinic as an involved party. While articles were filled with connotative, emotional words that would surely impact negatively on the reading public, that negativism was not tied as directly as it could have been to the Clinic.

Most stories focused on larger mental health issues and not the institution. Interviews with Michigan decision makers and leaders demonstrate, however, that there is a belief that the media had some influence during the years studied. When asked how the legislature became involved in investigating an institution scandal, the Director of the DMH Office of Legislative Liaison said, "Well they read the papers, got upset. Something had to be done."

Pressure exerted on legislators and the Department of Mental Health forced re-evaluation of the Mental Health Code, resignations of Directors of the Department and several facilities, and continued attention to the problems of deinstitutionalization and development of group and foster homes.

One of Governor Milliken's former staff members criticized a DMH Director by saying:

I think he was sharp and very dedicated but didn't realize, or wasn't quite as sensitive as perhaps any of his staff people would be, to the impact of that kind of media and the fact that he did need it. Image is part of getting your mission accomplished.



For the most part, mental health stories during these years were damaging to Department of Mental Health programs and, as a result, harmful to public understanding of problems of the developmentally disabled and mentally ill.

When newspaper features emphasized the positive, they were often about the mentally retarded. However, the few "upbeat" articles about availability of community services or overcoming handicaps were clearly overshadowed by such exposes as the six page magazine insert by "John Doe", a rapist and murderer scheduled to be released under new mental health laws.

Harvey Brazier (1982), Professor of Economics at the University of Michigan, noted in the massive 1982 study he edited on Michigan's political economy that:

The Department of Mental Health seems to have been the target of more than an average amount of unfavorable publicity. Charges of nepotism, lawsuits directed at state institutions, neighborhood confrontations over residential facilities, and charges of fraud and corruption in the leasing of residential facilities have been common during the early 1980's. Many of these problems may be inherent in a mental health care delivery system, but not all of them are. (p. 291)

Mental health issues do not tend to be value-neutral when presented in the press. This may be a result of the nature of the media itself. The media are dependent upon sensitive issues, controversial concerns and those problems that strike at the heart of the

community's fears. One newspaper reporter calls it the "Woodward and Bernstein syndrome":

Many of the papers ... are doing what they consider, not advocacy, but interpretive reporting and analytical reporting, where they are trying to come to some conclusions as to whether the Department or a particular facility, or whatever, is living up to its aims at least.

Politicians tended to see the press as generally negative toward state institutions and Department of Mental Health care of the mentally retarded and ill. Deinstitutionalization was criticized because of lack of forethought and preplanning. During the Plymouth scandal, DMH was even criticized for failure to ask for sufficient funds to properly maintain facilities.

### Conclusion

This study concerns two facilities: Michigan Institute for Mental Health and Lafayette Clinic. It was suggested that newspapers direct decision-maker attention and that program success or failure is dependent on perceptions of support, as filtered through the media. It was also proposed that the decision to maintain or close an agency for the mentally ill will be influenced by newspaper coverage.

It is not possible to affirm these propositions based on the content analysis. Nor can they be rejected. There is insufficient evidence of media

support, or lack of it, for either of the two institutions under study.

The media's impact on the larger system is visible. Changes occurred in the Mental Health Code and within the Department of Mental Health. Increased scrutiny continues to be focused on the care and treatment of the mentally handicapped and the state system in which they reside.

We do not know how many of these changes can be attributed to newspaper influence. But, thanks to the interviews, we do know that there is a generalized perception by decision makers that they are influenced. There is widespread belief in the importance of information provided through newspapers and the strength of public concern as represented in the media. Although there are differing opinions about how direct the connection is between information and action, there is increasing awareness of press involvement in the decision-making process.

Over a century ago John C. Calhoun (1929, p. 537) said that public opinion "instead of being the united opinion of the whole community is usually nothing more than the voice of the strongest interest or combination of interests; and not infrequently a small but energetic and active portion of the people."

The newspaper serves as a tool for this small but energetic group of people. There are growing numbers of attentives that can become a powerful force in the decision process. A massive rally of support, like that which occurred at Clinton Valley Center, becomes possible only by reaching all of those who may have a stake in the outcome. The newspaper is one medium for providing information on a single issue to a disparate group of individuals.

This brief survey does suggest one important caveat, however. It appears that the media tends to focus on the negative. Those agencies which intend to survive, at least in Michigan's current mental health system, are best served by avoiding public attention regarding such volatile issues as the mentally ill.

Articles mentioning Lafayette Clinic or Michigan Institute for Mental Health were overwhelmingly negative. Although Lafayette Clinic had a number of community service programs, they were never covered; neither were community meetings, open houses and other local services provided by the Michigan Institute. Lafayette leadership began to deliberately avoid media attention following several public controversies in the early 1970's. At Michigan Institute, staff took their

concerns to the press, to the ultimate detriment of the program.

This lack of positive media attention for Michigan Institute may have been instrumental in limiting advocacy and legislative involvement in the agency. There was little understanding of, and interest in, facility services. Coverage of broader mental health issues contributed to this problem. Legislators were not engaged by MIMH program success. Rather, they were captured by the disasters that were occurring at other institutions. This opened the door for greater bureaucratic control of MIMH operations and ultimately made it easier, as interviews in Chapter V show, to close the facility.

The following chapter will summarize information in examining the final proposition: Organizations which receive strong public constituency support are more likely to survive than those which receive less support.

## CHAPTER VII

### A COMPARATIVE ANALYSIS

Considerable background information has been provided. Both the crisis period and actor perceptions of that time were outlined in an effort to clarify system dynamics. Boulter's (1983) decision ladder was then used as an overlay to examine the stakes and stands of specific groups involved in decision making at both Lafayette Clinic and the Michigan Institute for Mental Health.

For our purposes it was important to provide this research foundation in order to demonstrate that the data was firmly grounded in historical reality. In addition, for those unfamiliar with the Michigan mental health system, it offers a basic framework.

The role of the media in policy development was also explored. While media involvement in outcomes at the two agencies appeared to be minimal, the findings cause attention to turn to another potential source of support and political power -- organized advocacy groups. We have looked at strategies used by these groups and how they perceive the media. This chapter will take the information gathered and summarize it in the form of plus and minus ratings of actor or group

support toward the two agencies both before and after the crisis period.

The fiscal crisis, exacerbated by placement concerns, became a state-wide institutional issue in 1979 and 1980. Therefore, the first few years of Michigan Institute for Mental Health operation, 1977 through 1979, will be compared to its last years before closure, 1980 and 1981. Lafayette Clinic will be examined during this same period.

Boulter's (1983) decision ladder will then be used to translate information into a rating table of positions toward each agency. The resulting matrices will graphically display public opinion and clarify decision outcomes by encapsulating the data.

This chapter, in conjunction with the case studies, will serve as a basis for assessing the applicability of Boulter's (1983) policy ladder, as well as its utility in other public decision making situations. After having applied the framework it becomes possible to step back and examine it in Chapter VIII.

#### A Summary of Positions

Boulter's (1983) framework is relatively simple. He rated actor positions toward a decision (reducing the speed limit to 55 miles per hour in several countries) based on public statements and the crisis period (a

sharp reduction in petroleum imports), using a tally sheet.

Opinions for groups, such as the Michigan legislature, are aggregated in Boulter's (1983) framework to create a single overall rating. The assumption is that the majority opinion is the one that will hold sway during a policy debate. In the legislature, for instance, outcomes are agreed upon by votes and evidenced by budget allocations.

Both Lafayette Clinic and Michigan Institute for Mental Health programs were examined in depth to obtain an enhanced understanding of the process under study. With that background, it is possible to offer a comparison using a modified form of Boulter's (1983) policy ladder and matrix. Ratings of actor support before and after the crisis period will be discussed briefly. Ratings will then be combined in tabular form to offer an enhanced understanding of stands and how they impacted on the two facilities under study.

#### Lafayette Clinic

One example of a policy ladder for Lafayette Clinic may be found in Figure 12. It shows that the decision was to retain the facility, even though the budget had been severely cut. That decision was made by Michigan politicians and bureaucrats, as influenced by a variety



LEVEL I      The decision was to retain the facility  
                 although the budget was severely cut

made by

LEVEL II            Frank Ochberg, DMH Director  
                     William Milliken, Governor  
                     Gerald Miller, DMB Director  
                     Michigan Legislature

influenced by

LEVEL III                      Clinic Administration  
                                        Wayne Faculty  
                                        Regional Director

LEVEL IV                  Civil Service Staff  
Community Mental Health Staff  
Wayne Staff              Unions

**LEVEL V**                      shaped by

Organizational Leadership  
Civil Service/Wayne Operational Relationship  
Staff Concern About Treatment and Research  
Facility Age and Reputation  
Facility Location

The crisis was extensive budgetary cutbacks throughout the state.

Figure 12. Lafayette Clinic decision-making ladder.

of people, issues and circumstances. Based on information provided in Chapters IV and V, it is possible to rate key actor support toward Lafayette Clinic as positive (+), negative (-) or seriously divided (split opinion) before and after the crisis period, as documented by public statements.

### Bureaucrats

#### Before and After the Crisis Period (+)

In its developmental stages, Lafayette Clinic received a great deal of support from bureaucrats, including the Governor and the Director of the Department of Mental Health. Initially there was considerable optimism that Lafayette Clinic would find a solution to the devastating problem of schizophrenia. By 1977, when that hope had begun to fade, Clinic program's were so much a part of the system that any attempt to eliminate beds or services would have been subject to severe public criticism.

The Wayne County population was in need of mental health resources. Most patients were served by state-funded programs in institutions which were part of the largest placement effort in the state. Despite receiving a majority of mental health dollars, Wayne County continued to operate under the biggest deficits of any

county mental health program in the nation.

Elimination of any Detroit and Wayne County mental health program at this time, as allegations of abuse elsewhere were occurring and deinstitutionalization efforts were receiving increasing scrutiny, would have been ill-advised politically and programmatically. Not only was attention clearly turned elsewhere, but, at least initially, Lafayette's reputation was such that elimination of the program would also have eliminated one of the few bright spots in Detroit-area mental health services. While support for the agency may have deteriorated because of reduced levels of funding, there was still a need to retain what was perceived as a quality program in Wayne County.

The Lafayette Clinic Director, Jacques Gottlieb, M.D., was a strong agency advocate who strove to insure that many key decision makers developed a personal interest in Lafayette Clinic. When he left, this support began to fade. Differences in perception of value began to occur among bureaucrats when services appeared to deteriorate and the facility strayed from its original mandate.

DMH Director Smith (+)

Don Smith, M.D., was an advocate. He, however, found himself under considerable personal pressure when

allegations of abuse surfaced in the Detroit area. He remained concerned about Lafayette Clinic, and was a personal friend of Gottlieb's, but found himself unable to continue sheltering the program because of his need to protect himself.

DMH Director Ochberg (split opinion)

Frank Ochberg's support is not as easy to define. Ochberg (personal communication, January 17, 1985) did not consider the legislature as a whole to be an ally because of what he called "the anti-Mental Health Department sentiment" of rather powerful Detroit area legislators, "There was no legislative attention to what we were doing in a positive way." This ongoing battle between Ochberg and the legislature may have served to temper Ochberg's interactions with the facility.

The crisis period affected the institution by reducing funds. Ochberg had neither the strength nor inclination to redirect those allocation shifts.

Michigan Department of Mental Health Officials

Before the Crisis Period (+)

Lafayette Clinic is a designated training center for most of the mental health disciplines. About 60 percent of all State of Michigan psychiatric residents

study at the facility.

The Clinic was conceived, at least by staff, as a prestigious research program that would also provide adjunctive services to a most difficult area and population.

After Crisis (split opinion)

Budget cuts made it necessary for personnel to change their focus. The Department of Mental Health began to emphasize fast, efficient treatment. Operational, rather than educational, services were funded. Research became of tertiary interest, which meant that staff were forced to depend on grants in order to continue their studies.

DMH bureaucrats remained concerned about the facility's ability to treat patients rather than just study them, and evidenced some dissatisfaction over staff unwillingness to drop grant projects and concentrate on care of the chronically mentally ill. There were also splits in opinion regarding the value of sustaining research during a time of fiscal restraint.

However, Lafayette Clinic proved adept at changing to meet new contingencies. Research focused on current issues of the day, and bed utilization was modified to meet DMH requirements while still attempting to maintain core research components.

## Wayne State University

### Before Crisis (+)

From the beginning Wayne State University officials and faculty were supportive of Lafayette Clinic. The new center promised additional funds, prestige, applied training programs and the ability to recruit top quality researchers. University land, space and staff were offered to assure that the Clinic became an integral part of ongoing academic efforts. Ties were further strengthened by Mental Health Code clarification and legitimation of the University/Clinic relationship.

There were few administrative problems associated with this joint effort, perhaps because Clinic personnel identified more closely with the University than with the Department of Mental Health. The University affiliation and joint faculty appointments provided a measure of prestige for Civil Service clinical staff.

### After Crisis (+)

Discussions have occurred periodically about transferring the Lafayette clinical program directly to the University, along with state funding. Such a move would fully integrate the two services, which have been sharing resources since Lafayette's inception.

Department of Management and Budget StaffBefore Crisis (split opinion)

DMB personnel, as a group, have always expressed mixed feelings about the Lafayette Clinic program. As fiscal analysts, they have a concern about spending money where little immediate return is forthcoming. If funds are to be provided for mental health services, they should produce quantifiable results in the form of patients treated, or costs reduced. Research is seldom that clearcut.

After Crisis (split opinion)

While Department of Management and Budget staff essentially follow the mandates of the Executive Office and the legislature, their analyses of the Lafayette Clinic budget showed a general lack of support for any programs other than treatment and training. As legislators became increasingly aware of these issues in the late 1970's, despite some evidence of Lafayette Clinic's research efficacy, budget analyses became even more direct in their focus on operational planning and patient care. In general, legislators followed DMB budgetary guidelines in the appropriation process. The results were annual reductions in state allocations to the Clinic.

Michigan LegislatureBefore Crisis (+)

The legislature was extremely supportive of the facility in its early years. This is partly because of Gottlieb's talents as a salesman, and partly a result of Detroit-area legislators who were powerful figures on both the Mental Health and Appropriations committees. Lafayette Clinic and other state mental health programs in the Detroit area, were among the county's major employers, serving a large number of constituents.

There had been a real hope that Clinic staff could solve the problems of schizophrenia. This expectation was used to gain support and funds from the Department of Mental Health, the Governor's Office, and the legislature.

After Crisis (split opinion)

As Detroit-area legislators began to change and less attention was paid to the needs of Lafayette Clinic, funds began to drop. The lack of results in schizophrenia studies, despite allocation of millions of dollars, raised serious questions about the viability of Lafayette's research program. Although funding support remains, continued staff insistence on research despite ongoing budgetary deficits has caused the legislature to



take a closer look at the program and the resources it offers.

### Community

#### Before Crisis (+)

The establishment of Lafayette Clinic within an inner city service community served a protective function. Neighbors were generally supportive of the agency which meshed well with a developing "continuum of care" concept.

In 1973 and 1974 the Clinic survived several bouts of public concern regarding the type and kinds of research being conducted, as noted in Chapter V. However, such difficulties were cushioned by location within a tightly knit academic and medical community. In fact, many Clinic programs, such as continuing medical education and training, were specifically aimed at this "elite" population.

#### After Crisis (+)

Deinstitutionalization, however, created considerable stress for local community mental health boards. Lafayette Clinic staff would admit clients who fit research criteria or offered compelling teaching opportunities. Then, after a period of care, these

non-residents were released to an already overburdened and understaffed county. Discharged patients were becoming increasingly expensive for local service providers.

To its credit, Lafayette did offer several unique programs for the community, including a methadone clinic and counselling center.

### Clinic Administration

#### Before Crisis (+)

Gottlieb was a strong Director who remained at the helm for 20 years. He provided program continuity and a strong personal relationship with major decision makers at all levels of government. He nursed the facility from its beginnings and so embedded it within the system that questions about funding and program direction only developed after his retirement.

Lafayette Clinic weathered many of the same staff difficulties that MIMH experienced in integrating clinicians with direct-care personnel and academicians with state workers. During this period, one of the most difficult considerations in such a relationship was clarified by the legislature and accepted by both the Department of Mental Health and Wayne State University, the clinical chain of command.

### After Crisis (+)

After Gottlieb's retirement the facility drifted for almost six years. Funds were lost, and questions arose about agency direction. While there is no doubt that Clinic administration remained strongly supportive of the agency, this lack of leadership during the interim may have been one of the critical factors in declining legislative and Executive Office support.

### Media

As mentioned in Chapter VI, there was little media interest or involvement in the facility. Gottlieb deliberately kept the agency out of the public eye during the early years when programs were most vulnerable. Only rarely was publicity positive. In 1973 and 1974 attention focused briefly on psychosurgery and experimentation on involuntarily committed people. Even the announcement of a cure for schizophrenia received only minimal press attention.

### Interest Groups and Attentives

#### Before Crisis (+)

Interest group perceptions of the facility varied greatly. Initially there was support of the Clinic and belief in its ability to fill service gaps. However, a

growing sense of alienation by the population in need and rising numbers of former patients still requiring assistance caused opinions to shift.

After Crisis (split opinion)

The lack of media attention may have limited public understanding of facility programs, resulting in differing interest group perceptions of the Clinic's utility, responsiveness and effectiveness. Concerns were raised about Lafayette's role as a "guinea pig place" and research experimentation on involuntarily committed patients.

The concept of research on patients carries with it serious connotations for former clients. A general sense of wariness was evident among members of patient advocate groups interviewed. This same sense of wariness about Lafayette Clinic programs carried over to patients and their families. However, those former clients who were interviewed were generally positive in comments about their treatment.

While some studies (Kish and Lowinger, 1971) suggest that Lafayette was not serving the population in need, that group is not usually considered part of the decision-making process and, therefore, caused little negative impact.

## Michigan Institute for Mental Health

The MIMH decision ladder is shown in Figure 13. There are some differences in rank order between this conceptualization and Figure 12 for Lafayette Clinic, based on perceived differences in power structures for the two agencies. Let us briefly review the key groups and actors involved with the Institute, their stakes and public stands.

### Bureaucrats

#### Before Crisis (+)

DMH Director Don Smith originally proposed the development of the Michigan Institute. It met a well-defined need. There was interest in transferring the Ionia State Hospital building to the Department of Corrections in response to prison overcrowding and reduced state revenues. The transfer would save money and would allow for the creation of a modern mental health alternative, an inpatient psychiatric treatment center in an urban area.

DMB Director Gerald Miller was supportive and, in fact, drafted the transfer bill for the legislature.

#### After Crisis (serious split)

The ongoing struggle to delineate the agency chain

LEVEL I      The decision was to close the facility

made by

LEVEL II      Frank Ochberg, DMH Director  
 William Milliken, Governor  
 Gerald Miller, DMB Director  
 Michigan Legislature

influenced by

LEVEL III      MIMH Civil Service Staff  
 Community Mental Health Staff  
 Michigan State University Staff  
 Unions            Neighbors

LEVEL IV      MSU Faculty  
 MIMH Administration  
 Regional Director

LEVEL V      shaped by

Organizational Leadership  
 Civil Service/MSU Operational Schism  
 Staff Concern About Treatment  
 Relatively New Origins of Facility

The crisis included extensive budgetary cutbacks  
 throughout the state.

Figure 13. Michigan Institute for Mental Health  
 decision-making ladder.

of command, authority and responsibility caused key decision makers to reconsider their initial support for the program. MSU faculty were angry and resentful about renewed contract negotiations. Budget analysts showed that MIMH institutional costs per day were double those at Ypsilanti Regional Center. At the same time, it appeared that staff were only serving 74 residents. While there was little question of program quality, there were ongoing concerns about "quantity" -- serving as many clients as quickly as possible. At the same time, direct-care workers were in the process of suing the Department to force the hiring of additional staff. So, when Ochberg offered the facility to the Department of Management and Budget Director Miller, he, in turn, saw little reason not to recommend closure to the Governor.

### Legislature

#### Before Crisis (+)

The Michigan legislature passed the bill to establish MIMH quickly and unanimously. Senator Joe Snyder and Representative Dave Hollister, head of the Senate Appropriations and House Mental Health Committees respectively, were both advocates of the new program. Representative Ernest Nash, an MIMH neighbor, had intro-

duced the bill as one way of publicly demonstrating his stand.

#### After Crisis (split opinion)

MIMH faculty and staff believed that the legislature could have been supportive, given enough information. Budget appropriations for facility operation were always approved quickly, without controversy. In fact, the legislature had already approved MIMH's 1981 budget allocation.

Institute costs were not as high as projected, and care was generally better than clients could receive elsewhere in the system. Yet, there was general legislative ignorance of MIMH programs even though the Chair of the House Mental Health Committee served the Lansing district.

Legislators were more aware of, and concerned about, community reactions. Local residents were generally unhappy about the facility. There were few, equally vocal, advocates.

#### Department of Mental Health Officials

##### Before Crisis (split opinion)

DMH officials were split in their opinions on the Institute. There was a sincere interest in the prospect



of providing treatment in a small, local hospital. Smith proposed the concept of a jointly operated State University program that would encourage top-quality faculty to engage in mental health research and training.

Yet, Vern Stehman, the DMH Director following Smith, seemed to be one of the Michigan Institute's strongest detractors, according to one observer.

#### After Crisis (split)

While the next Director, Frank Ochberg appeared initially supportive, he offered to close the agency when cuts were asked of the Department. Although many feel that he just got "aced out of the action" (P. Babcock, personal communication, March 25, 1985), and he himself considered it a "Washington Monument play" that backfired (F. Ochberg, personal communication, January 17, 1985), others saw the action as a priori evidence of lack of support.

#### DMH Regional Director

##### Before and After Crisis (+)

The Southwest Regional Director was involved in the early decision making and considered himself a strong agency advocate throughout its history.

University Officials -- MSU FacultyBefore Crisis (+)

University faculty in the Department of Psychiatry were initially enthusiastic about the research opportunities offered. The Chairman of the Department of Psychiatry at the time Michigan Institute opened, mentioned that the idea of a jointly funded program was in large measure what encouraged him to move to Michigan from New York. A former DMH Director came from Illinois to serve as Institute Clinical Director.

After Crisis (split opinion)

There continued to be ongoing struggles, however, regarding staffing, funding and, most important, clinical supervision. DMH Directors Stehman and Ochberg made it clear that the facility would remain a state program under Department of Mental Health direction. The MSU/DMH contract was renegotiated during its first year to stipulate that the Clinical Director would report to the DMH Administrator, not the University. MSU personnel found research becoming a lower DMH priority. Budget reductions added to the existing pressures to keep beds fully utilized, further limiting research and educational opportunities.

Department of Management and Budget StaffBefore Crisis (split opinion)

DMB staff had more mixed feelings about the agency. Originally MIMH appeared to DMB to be a viable cost-savings measure. The Department of Corrections would obtain a new prison at minimal expense, while DMH would be able to operate a new local program without first investing in capital outlay. Concerns began to build about a limited bed capacity and high patient costs per day.

After Crisis (split)

Fiscal constraints became a serious concern at the same time as expenses were rising and direct-care workers were complaining about inadequate staffing. During pre-election debate over the Tisch amendment, designed to further reduce state revenues, MIMH administrative staff began tentative negotiations to purchase the Jarvis Acres building. DMB staff were feeling ongoing pressures to close facilities and move patients into the community as part of a budgetary reduction that was closely tied to deinstitutionalization and federally funded foster homes. The Institute's apparent unwillingness to participate in budget and staffing reductions was a source of concern to DMB staff.

## Community

### Before and After Crisis (-)

Community neighbors as a group were never supportive of the concept of a mental health agency on the Jarvis Acres site. Officials did approve the Special Use Permit, but Windsor Township Board meetings showed a great deal of negative community reaction and, at least initially, a split among board members. However, the Use Permit and zoning approval were garnered without much difficulty. Jarvis Acres residents filed a petition expressing their concerns. While many of those concerns were laid to rest, controversy over a new "open door" policy late in agency history served to once again arouse neighbor and Jarvis Acres citizen anxieties.

## Michigan Institute Staff

### Before Crisis (+)

MIMH staff were initially enthusiastic about the program. It is generally agreed that they remained supportive of top-quality care for patients.

### After Crisis (split opinion)

With budgetary cutbacks the unions raised the issues of reduced staffing creating dangerous work

conditions, staff injuries caused by aggressive clients, patient walk-aways, the open door policy which made control of patients even more difficult, and other potentially volatile problems. While few staff wanted to lose their jobs, there was a definite schism between ward personnel and management concerning these care issues.

The same types of mixed feelings came from the MIMH faculty. They were MSU staff, interested in research programs but bound to provide patient care at the agency. There was concern about the neglect of the research component, exacerbated by a lack of clarity in roles.

Most clinicians were civil servants with faculty appointments, recruited by the University, yet bound by Department of Mental Health rules and regulations. Sometimes considered "second class" academicians at the University because of their patient care role, Unit Directors were under pressure to work toward MSU Department of Psychiatry goals while circumscribed by the need to provide ongoing treatment.

Other University officials began to feel those same frustrations. There was a deep philosophical difference between the type of program that DMH required and that envisioned by MSU officials. MSU Department of Psychiatry staff found themselves investing more and more time

and money in an agency that was serving their needs less and less, while the Department of Mental Health made it clear in contract negotiations who was paying for, and therefore running, the program.

Unlike Lafayette, MIMH had not embedded itself within the system. Therefore, it was more difficult to insist on a research program where no firm foundation had yet been laid.

### Media

The newspapers did not appear to be a key actor in the decision-making process, except as a conduit of information. However, while MIMH tended to keep a fairly low profile throughout its history, the open door policy and staff concerns were of media interest. This interest ultimately impacted through the reactions of neighbors and other interest groups toward agency policies.

### Interest Groups

#### Before Crisis (+)

Community Mental Health administration appeared supportive throughout the facility's operation. The Clinton-Eaton-Ingham CMH worked with the Department of Mental Health in developing an agency that would serve

local needs, lobbied for its placement in the tri-county area, and provided Social work and other adjunctive staff.

The community mental health staff was initially supportive of a local service alternative. They were willing to refer people to the agency and operated the Central Admitting Point.

#### After Crisis (split opinion)

As budget cutbacks occurred, CMH direct-care personnel were asked to provide more services without a concomitant increase in funding or personnel.

All MIMH outpatient programs became the responsibility of community mental health social workers. Even some inpatient services, such as assisting clients to apply for Medicare or Medicaid payments, were considered the responsibility of CMH case workers. These rising expectations drew heavily on community resources during a time of scarcity. In 1980 the tri-county board instituted a case manager system which increased demands on professional time.

#### Courts and Police

##### Before and After Crisis (+)

Courts and police remained supportive of the agency

as an acceptable community alternative to large state hospitals. Although there were frustrations when MIMH refused to admit some patients, the facility offered a local alternative for service providers forced to deal with the mentally ill.

### Attentives

#### Before and After Crisis (no concerted opinion)

Few of the attentive groups surveyed in this study considered themselves either for or against the facility. During the time it existed, MIMH was acknowledged as a useful service for seriously disturbed individuals. According to one advocate group leader, "It was an alternative, and the more alternatives the better for someone in trouble."

But most special interest groups focused on self-help programs and local assistance to avoid hospitalization. The Psychiatric Alternative Alliance was adamantly opposed to the concept of involuntary commitment. Members consider state institutions the outgrowth of a Big Brother mentality that is, by its very nature, objectionable. Therefore, philosophically the group remains strongly opposed to any form of inpatient service.



## Patients and Families

### Before and After Crisis (+)

Patients and their families liked the facility. Although initially neutral about the program because of its recent origins, families found MIMH to be an excellent alternative to long travel hours and lower levels of care at older mental health institutions. There was genuine appreciation of agency services for acutely mentally ill persons.

While this group had a vested interest in facility programs, it was also the least powerful within the system. This was also true, although to a lesser degree, of other organized patient advocate groups.

### A Comparison

By placing these ratings in a table, it is possible to examine system-wide support for the two facilities. Table 5 graphically shows actor positions toward Lafayette Clinic before and after the crisis period. In the years before budget cutbacks, 20 actors or groups were strongly supportive of the Lafayette Clinic program. Five were seriously split in their opinions and, six issued no public opinion. Only one group, the Psychiatric Alternative Alliance, was adamantly opposed to the modus operandi of the facility.

Table 5

## Actor positions toward Lafayette before and after crisis

	Before Crisis			After Crisis		
	Majority Against	Serious Split	Majority For	Majority Against	Serious Split	Majority For
Bureaucrats			+			+
Smith			+			+
Ochberg		*			*	
Milliken			+			+
Miller		*			*	
DMH officials			+		*	
Regional Dir.			+			+
University			+			+
Officials						
Wayne Faculty			+			+
DMB staff		*			*	
Legislature			+		*	
Community			+			+
Officials			+			+
Neighbors			+			+
Clinic Administration			+			+
Civil Service Staff			+			+
Clinic Faculty			+			+
Media		x			x	
Interest Groups			+		*	
CMH Admin.			+		*	
CMH staff			+		*	
Courts/Police		x			x	
Attentives		*			*	
MH Assoc.			+			+
JIMHO		*			*	
Psych. Alt.	-			-		
Recovery		x			x	
Relatives		x			x	
Citizens for		x			x	
Action						
OASIS		x			x	
Patients			+			+
Families			+			+
+ - Majority For - - Majority Against * - Serious Split in Opinion x - No Public Opinion						

After the fiscal crisis, although support had eroded, it was still evident. Fifteen groups or individual actors continued to be supportive. Ten had divided opinions, and six expressed no public opinion. The Psychiatric Alternative Alliance remained in firm opposition to the Lafayette Clinic.

The matrix for Michigan Institute for Mental Health, as seen in Table 6 shows widespread public support for the agency between the years 1977 and 1979, and a general lack of support in 1980 and 1981. Initially, 17 key actors and groups were strongly supportive of the Michigan Institute, and four were opposed to the program. Three groups had serious splits in opinion, and nine had no public opinion. By 1980, 6 groups or individuals were against facility continuation; 13 actors or groups showed serious splits in opinion; 6 remained strongly supportive; and 8 had no opinion.

#### Summary

As Tables 5 and 6 have shown, there appeared to be strong initial support for both Lafayette Clinic and Michigan Institute, which deteriorated over time. If we consider that decision makers are faced with a sum of public opinion that weighs on the final decision, then the outcome for Michigan Institute becomes clear.

Bureaucrats and legislators found little support

Table 6

## Actor positions toward MIMH before and after crisis

	Before Crisis			After Crisis		
	Majority Against	Serious Split	Majority For	Majority Against	Serious Split	Majority For
Bureaucrats			+		*	
Smith			+		x	
Ochberg			+		*	
Milliken			+	-		
Miller			+	-		
Legislature			+		*	
DMH Officials		*			*	
Regional Dir.			+			+
University			+		*	
Officials						
MSU Faculty			+		x	
DMB Staff		*			*	
Community	-			-		
Officials		*		-		
Neighbors	-			-		
Jarvis	-				*	
MIMH Staff			+		*	
Civil Service			+		*	
MIMH Faculty			+		*	
Media		x			x	
Interest Groups			+		*	
CMH Admin.			+			+
CMH staff			+		*	
Courts/Police			+			+
Attentives		x			*	
MH Assoc.			+			+
JIMHO		x			x	
Psych. Alt.	-			-		
Recovery		x			x	
Relatives		x			x	
Citizens for		x			x	
Action						
OASIS		x			x	
Patients		x				+
Families		x				+
+ - Majority For - - Majority Against * - Serious Split in Opinion x - No Public Opinion						

for MIMH during a fiscal crisis, even from the Department Director who offered the program as a budgetary sacrifice. Existing support appeared to be eroding rapidly. With that deterioration came an unwillingness to continue to place money in a program that, during a time of cutback management, seemed to be more expensive than other available services within the system.

Over the years there has been some tendency toward similar opinion shifts for Lafayette Clinic. But, agency leaders have been able to entrench programs within the system so that budget reductions, while having some effect, were not fatal.

Perhaps it could be argued that if fiscal crises had occurred during Lafayette's first years of operation, it too might have closed. However, Lafayette administrators managed to clarify legislatively the agency mandate while retaining DMH, academic, and community backing. The ability to garner grants, change programs to serve community needs and maintain appropriations levels are all evidence of ongoing support. With this foundation, and continued awareness of environmental issues that impinged on the agency, Lafayette Clinic has managed to survive, although with a somewhat tarnished reputation.

It was stated initially that policy output is a factor of actor positions during and after the decision

period, as defined by conflict and crises. We have explored Boulter's (1983) decision ladder, using the Michigan Institute for Mental Health and Lafayette Clinic as case studies, and then rated actor positions.

By assessing the positions of key groups toward programs, decision outcomes become more predictable. The following chapter will discuss some of the implications of this finding and the study more generally.

## CHAPTER VIII

### SUMMARY AND CONCLUSIONS

This study began with a single question: How were decisions made that affected the success and survival of two mental health institutions? In 1977 the Michigan Institute for Mental Health (MIMH), a public psychiatric hospital, opened. It was intended to serve the needs of acutely mentally ill persons in a seven county area. Michigan State University was under contract to provide the clinical, teaching and research component. This cooperative concept in treatment was heralded as launching a new era in small, community-based, short-term care programs. Four years later a decision was made to close Michigan Institute.

Lafayette Clinic is another small, intensive treatment center established in the Detroit area. Similar to MIMH in a number of ways, it also has a strong University affiliation. Despite some serious setbacks in achieving its mandate as intended by the legislature, and decreases in funding, the decision of key actors within the system has always been to continue this program.

Public decision making is complex at best. To answer why decision makers closed one facility and

maintained the other presumes considerable background information. At a minimum, an understanding of the environment, history, political actors and the decision-making process is required. Narrowing the focus to a manageable research problem necessitates placing the study within a framework.

Boulter (1983) offers one conceptualization of the policy-making process. He tells us that decisions are made by politicians and bureaucrats who are influenced by interest groups and the media, attentives and the general public. In addition, policy is ultimately shaped by the environment, culture, tradition and institutions which impinge on decision makers. Research began with a brief review of this framework as well as relevant literature within that structure.

A series of propositions are presented in Chapter II. Chapter III explains the research methods and procedures which include a historical review, administrative case studies, a newspaper content analysis, interviews, and document analysis.

The next step was to complete the decision ladder for the problem under study. A comprehensive presentation of data in Chapter IV outlines the key components of Boulter's (1983) framework while addressing such questions as: Who were the decision



makers? What were the critical environmental factors? What was the crisis and what were reactions to it?

These types of questions had to be answered at each level of Boulter's (1983) policy ladder in order to provide an understanding of the ultimate decision, closing or retaining a mental health facility. Without that background, it is difficult to envision the complexities and decision impact of a variety of actors and events.

The shaping influences -- the environment, culture, history, and tradition -- are presented in Chapter IV. Assessment of the forces impinging on institutions establishes the foundation for Chapter V, an in-depth look at the two facilities. A clearer understanding of the dynamics of agency operation, the political environment in which programs were embedded, and key actors, is developed through comparative administrative case studies.

Within this context, Boulter's (1983) policy ladder also considers media and interest group involvement. Chapter VI, a newspaper content analysis, and Chapter VII a comparative analysis explore these additional facets of the decision-making process. Chapter VII compares the support of key actors toward Michigan Institute and Lafayette Clinic both before and after the crisis period.

Research began with a basic question: Why did one facility survive while another did not? Although intriguing, by itself such a case study offers little more than historical perspective on events occurring in the Michigan mental health system. In order to establish the depth of understanding required, research questions were developed at a second level. Although framed in light of the two facilities under study, they reflect broader concerns. The following propositions based on Boulter's (1983) policy ladder provide additional research focus:

1. Those organizations that receive strong public constituency and media support are more likely to survive than those which receive less support.
2. Program success or failure is dependent on the decision-maker's perception of the sum of constituency support, as filtered through the media.
3. The media serves both as a carrier of opinion and as an influential actor in its own right. The media impacts on mental health decisions.
4. Thus, the decision to maintain or close an institution for the mentally ill (particularly in a time of crisis) will be influenced by newspaper coverage.

These propositions were analyzed using Boulter's (1983) framework. Chapter VII summarizes opinion data

using a tally sheet of constituency and media support for the two facilities.

Finally, at a third level, the study was designed to test the applicability of Boulter's (1983) framework to public policy issues. By structuring research within this framework, it becomes possible to examine its strengths and weaknesses.

#### Results: Case Studies

Chapter IV presents an overview of the political environment in which both Lafayette Clinic and the Michigan Institute existed. The crisis was fiscal, as the State of Michigan continued to experience a recessionary downturn. At the same time, the Michigan legislature mandated community mental health boards. Throughout the state these boards began to request greater involvement in Michigan mental health decision making and the right to have mental health dollars follow the client into the community. Each of these problems created stress for institutions, which were forced to treat more patients in a shorter length of time with less money. Traditionally, they were also responsible for adequate community placements, which exacerbated funding shortages.

The Michigan deinstitutionalization program was part of this crisis period, particularly in the Detroit and Wayne County area where the majority of mental health clients were placed in adult foster homes. Ongoing allegations of abuse, "ghettoization" of former patients, and regular changes in Department of Mental Health (DMH) Directors only served to highlight system weaknesses.

The Michigan Institute for Mental Health was born into this environment. Chapter V discusses its history. While there was initial community resistance to the facility's location, there was general constituent and interest group support for the new concept in health care to which MIMH subscribed. The decision to open the facility was made by Department of Mental Health Director Don Smith, with the concurrence of Governor William Milliken and Department of Management and Budget (DMB) Director Gerald Miller. Michigan State University faculty were also involved in laying the groundwork for an operational teaching and training facility.

Support for the agency, however, eroded quickly and perhaps irreversibly. Ongoing staffing problems caused by a lack of clarity in the clinical chain of command; DMH insistence on placing a higher priority on care of the chronically mentally ill than research; and staff

anger and fears about underfunding caused decision makers to question the facility's value. MIMH began to be perceived as more of a problem than a solution to care needs.

Even though treatment quality was consistently high, decision makers found themselves dealing regularly with operational issues. Factions developed as attention centered on the power struggles among key groups. Support began to deteriorate within the Department, DMB, the University, and ultimately among facility employees. Despite the best hopes of administrators, the agency was not able to sustain the support foundation upon which it had been built. The decision was to close the facility.

Lafayette Clinic had strong leadership from the beginning, which garnered equally strong legislative and gubernatorial support. The political strength of its management team enabled the Clinic to survive serious concerns about the research mandate, as well as regular budget cuts. When the crisis period occurred, Lafayette Clinic was well entrenched in a medical community. It expanded its services to other professionals, in addition to clients.

Re-examination of the ongoing utility of the program occurred with gradual loss of legislative interest, changing Department of Mental Health

priorities, concern about the human subjects of research on mental illness, and differing conceptions of the value of institutions. Survival became contingent upon a strong sense of internal cohesion, a supportive University affiliation, willingness to change to meet community needs and success in focusing on the "hot topics of the day".

Comparative case studies in Chapter V provide extensive description and analysis of institution dynamics. Chapter VII then compresses and re-organizes this information in accord with Boulter's (1983) framework. Each of the factors is briefly examined; then decision maker opinions are listed in tabular form. Tables 5 and 6 graphically show an erosion of support for the two facilities as publicly expressed by key actors. Seventeen key actors and groups were supportive of Michigan Institute when it was established. By the time it closed, only six remained on record as advocates.

For Lafayette Clinic, in the years before budget cutbacks, 20 actors or groups were strongly supportive. Fifteen maintained their support. Although neither agency added advocates, Lafayette had more positive constituent involvement from the beginning and retained more of it over time.

Through this process, the answer to the first question -- how are decisions regarding public policy issues made? -- becomes clearer for this problem. We can identify decision makers, the linkages they established and the steps they followed. The case studies reveal changing perceptions of facility value and the gradual loss of support for an agency that was never fully part of the community. The attempt to maintain MIMH, given internal and external pressures to the contrary, became too great to sustain.

In this instance, the decision to close or retain a facility appeared to be politically, rather than programmatically, motivated. MIMH could demonstrate program success, including quality care and minimal recidivism; yet saw a steady erosion of political support. Lafayette Clinic, on the other hand, had a history of political success including funding for a drug clinic and special legislative attention. Yet, there was ongoing programmatic erosion, especially regarding support for schizophrenia research.

### Propositions

Based on this study it is possible to accept the proposition that program success or failure is dependent on decision maker perception of the sum of support. The organization that received the strongest public constit-

uency and media support survived. As MIMH began to lose constituents, it also began to lose its footing.

Few decision makers are willing to stick with a solution that is unpopular or that appears to generate more problems than payoffs. In both the rational and political actor models, policy is based on a perception of value. MIMH's value was fading. Lafayette was able to maintain its sense of purpose along with support for its programs, although in a modified form.

The proposition that the media impacts on mental health decisions by serving both as a carrier of opinion and as an influential actor in its own right, was not sustained. There appeared to be little media involvement, as evidenced through newspaper articles, in the decision to maintain or close institutions for the mentally ill. In fact, based on an eleven year analysis of mental health newspaper articles in Chapter VI, there was only minimal coverage of institutional programs and negligible involvement in the two facilities studied. Out of a total of 887 articles in the Detroit Free Press, Detroit News and Lansing State Journal, 34 mentioned Lafayette Clinic and 28 named MIMH. For Lafayette Clinic, most articles centered on a controversial psychosurgery case and an experimental program for children. For MIMH, there was some discussion regarding the facility's establishment and, late in the



agency's history, articles about the open door policy and patient walk-aways.

Mental health news in general tended to focus on long-standing issues of state-wide import. Only rarely were articles positive. Some of the issues over the years included deinstitutionalization and placement programs; the mental health code, admission and discharge criteria; institutional abuses; and budgetary concerns. This policy-oriented rather than institution-specific focus may be a factor of the human resource area studied.

Two factors appear to be involved in the lack of media attention for MIMH and Lafayette. Lafayette Clinic Director Jacques Gottlieb chose a deliberate strategy of risk aversion. He preferred to avoid the press. At the same time, there was a continual news focus on the volatile issues of the day. Only rarely did this media attention involve the two facilities under study.

There were few attempts on the part of agency decision makers to use the press to sway opinions. Research shows that several astute legislators and mental health directors utilized newspapers in the early years to generate changes. However, subsequently there were few examples of efforts by advocates to "manage the media", although in several instances MIMH direct-care staff

went to local newspapers to generate support for their position.

The newspaper content analysis in Chapter VI and a discussion of advocacy strategies in Chapter V, suggest that newspapers are considered an important source of information. During personal interviews, politicians and bureaucrats mentioned that they pay attention to what appears in the newspaper. At the same time they acknowledged that most advocacy occurs through face-to-face contacts.

The idea that the media serves as a conduit of information is much more accurate in this instance than the concept of media involvement in shaping and focusing attitudes. We see that decision makers do weigh opinion, partly based on what they read in the paper. However, reporters only rarely covered the issues involved in operation of either Lafayette or MIMH. So, while the media may be instrumental in directing attention or advocating in some policy areas, there was little evidence of it in this study.

Results of this content analysis, however, can not be extended too far beyond the bounds of this research. Although discussion has centered on the media, only a limited number of newspapers, regarding a potentially volatile topic, were examined.

## The Framework

Boulter (1983) provided a framework through which to organize the volume of material presented. In his 1983 study, Boulter used the policy ladder to explain United States retention of the 55 mile-per-hour speed limit after the crisis (gas shortages) had passed. He tallied the opinions of politicians, bureaucrats, interest groups, attentives and the general public in several countries toward this issue. Essentially a balance sheet totaling political influences was developed. The resulting check sheet clearly showed ongoing support for the lowered speed limit in the United States.

Following the same guidelines, tally sheets were developed in Chapter VII that show ongoing support for one agency and a lack of support for another. Along the way, though, a number of methodological questions arose.

In each application of the policy ladder, outcomes were already known. How can we be sure that we are not involved in a circular argument? MIMH was closed because it lacked support. MIMH lacked support because it closed. Given a foregone conclusion, ratings become relatively easy.

One answer to that concern is Boulter's (1983) insistence on using only publicly stated opinions. An

attempt has been made to substantiate carefully the positions of relevant actors through interviews, public documents and a newspaper content analysis.

That, however, raises the second question. How do we know who to include and who to exclude from such a study? Boulter (1983) implies that the opinion of anyone who is interested, even peripherally, should be considered.

Narrowing the focus becomes somewhat easier, thanks to the public nature of the debate. Those who feel strongly about an issue, and consider themselves involved, will be discussed by the media or other political actors. Legislative debates, public meetings, correspondence and newspaper articles, are all means of assessing the relevant decision groups.

The third question then becomes: How much value should be placed on each opinion? Boulter (1983) gives exactly the same value to every public opinion in the decision-making arena. The crackpot from Citizens for a Better World is given the same plus or minus rating as the ministers of OPEC.

This lack of discrimination is problematic. Realistically, we understand that a decision maker's confidante will hold more sway over the policy outcome than a hastily organized interest group containing only a few members.

An effort was made to consider these issues in the development of the rating table for the two facilities. Those individuals or groups who would be expected to exert the greatest power in the decision-making process were placed at the top of the chart. Governor William Milliken, Department of Mental Health heads Don Smith and Frank Ochberg, Department of Budget and Management Director Gerald Miller are, by virtue of their formal roles, policy leaders. However, this placement of key figures is subjective and dependent on a thorough understanding of the policy under study. Only after developing a history of the era did it become truly evident that Gerald Miller was a key figure for mental health decisions.

Boulter (1983) does not provide for differentiation between actors based on power or position. But it remains necessary to struggle with the concern that seldom are positions always clear-cut, seldom are weights and strengths of opinions directly comparable.

Nor does Boulter (1983) offer much insight into his methodology. While it seems simple enough to provide + and - ratings, we are given little understanding of how these scores are to be developed. Nor can we be sure that we are aggregating opinion in the same way as the decision maker.

This is not considered a problem by Boulter (1983).

If as many opinions as possible are included in a crude count on the rating sheet, the decision outcome should be predictive.

This study ameliorates some of these concerns by careful documentation, beginning with case studies. Then, in presenting the matrices in Chapter VII, each step is discussed. As a result, there is some understanding of why it was stated, for instance, that Detroit-area legislative support for Lafayette Clinic began to fade.

Opinions were determined through a combination of interviews, public documents and a newspaper content analysis. Each person contacted was asked to name others in the mental health field who might be knowledgeable about the issues. This "snowball" effect lead to involved persons who might not otherwise have been considered.

There are acknowledged limitations to the use of interviews as a research technique. Some information is not freely available to "outsiders". Cognitive dissonance around crisis events may cause opinion shifts over time. Awareness of these issues helped to inhibit their potential impact. Cross-verification of material, through a variety of individuals and sources, served to verify and strengthen data accuracy.

A newspaper content analysis is presented in

Chapter VI to better quantify answers regarding media involvement in public policy. Although intuitively we may think that the press is a powerful factor in the daily decision making of politicians, that fact was not reflected in mental health decisions. Most people admitted to an awareness of media issues; yet only rarely were the facilities under study mentioned in the newspaper. Nor were the linkages between media attention and resulting public policy ever established.

Boulter (1983) did not quantify his policy ladder in this way. As a result, it has been argued that Boulter (1983) offers merely a framework, not a model with predictive ability. There is some evidence of a predictive function in this study. However, that potential remains to be explored. By carefully quantifying specific aspects of the framework, we can see it move toward the heuristic capabilities of a true model.

The first step is awareness of the need to systematically incorporate strength of opinion, power and potential for involvement of pressure groups, as well as formal and informal positions of key actors and their linkages, into the decision ladder. Standardization of procedures, including development of ratings and levels of support, is also necessary.

Other forms of stakeholder mapping are designed to identify groups (both within and outside the agency)

that have the potential for affecting organizational objectives. Some ask the decision maker to identify positions, power and potentials of involved individuals. Comparative research, using several similar frameworks, would highlight both the positive and negative aspects of utilizing Boulter's (1983) policy ladder. Different approaches to analyzing a single problem can offer increased understanding of the decision process. If outcomes are consistent, then the value of this method of ordering the events surrounding crisis is enhanced.

The question remains: Is this particular framework a useful tool for the public administrator? It presents many of the same difficulties as other tools of its type. To use it properly requires either in-depth knowledge or research. The ability to condense background information into a rating sheet requires a thorough understanding of relevant actors and their stands. While most of us can perform such a tallying function regarding any issue of importance to us, Boulter (1983) requires an awareness of the arena's environment and the overall political situation as well.

One of the greatest strengths of Boulter's (1983) framework is inclusion of a wider study universe. In addition to considering the environment, culture, history, tradition and other situational variables within the decision-making process, Boulter (1983) adds a



variety of interested groups and attentives. He also acknowledges that these people and groups will change, depending on the policy under study.

The increasingly pluralistic nature of modern society helps to explain the growing complexity of the decision-making process and the mounting pressures placed on public leaders. Crises add to those pressures. While Boulter's (1983) framework may appear simplistic, it does incorporate a systems perspective that is often neglected in other forms of stakeholder analyses.

At a minimum, most astute politicians have some understanding of stakeholders and the dynamics in which they are involved. It is useful to explore what is "intuitively understood" by laying it out in its starkest form in a check sheet of those for and against the policy. Such thinking focuses attention on generally neglected aspects of the decision-making process while forcing the administrator to quantify his or her own stand toward the policy.

#### Recommendations and Future Research

Problems encountered in developing the substantive portions of this study were often tied directly to Boulter's (1983) lack of methodological guidelines. There is little quantification of a process that could

be intricate and meaningful if applied with sophistication by a decision maker. Without such support, each step is subject to criticism regarding the inherent subjectivity of the information provided.

Considerable groundwork has been laid. Within the mental health framework already provided, it would be possible to test its heuristic ability by developing rating matrices for current mental health problems. One starting place would be to examine the potential transfer of Lafayette Clinic to Wayne State University. Will a tally of support predict whether that move will occur?

Chapter V mentioned briefly that if the crisis period had been extended, and/or Lafayette Clinic's leadership less astute in attending to institutional needs after a lapse of six years, the facility might also have been closed. In hindsight, perhaps the two programs -- MIMH and Lafayette Clinic -- were too similar. It is possible that none of the more innovative, research-oriented programs would have survived if the crisis period had continued.

A future study comparing a small, matrix-type mental health program with a large, more traditional institution, might be fruitful. Perhaps a critical factor left unexplored is size. The number of patients and staff that would have to be displaced if a facility

were to close, may be a predictor of survival. If budget allocations are indeed an incremental process, then a small institution becomes a more tempting target for elimination than larger programs. It does appear that in a budget crisis, research and high quality treatment become lower priorities for DMH decision makers.

Another factor worth exploring is leadership. It has been mentioned that Gottlieb was an "entrepreneurial" leader, taking advantage of circumstances that benefited the institution, even during crises. Perhaps one additional aspect that should be considered is the "institutionalization" of Gottlieb's position within the system. Formal appointments to powerful positions within the University and within the Department of Mental Health lent credibility and strength to his interactions with important agency constituents. This unique relationship undoubtedly impacted on facility survival.

It would also be useful to look beyond the issue of survival in the mental health field. This study reveals the inherent political nature of decision making surrounding public institutions serving the mentally ill. Perhaps the policy ladder is most applicable to the political sphere. However, that is not expected to be the case. The strength of the framework would be enhanced by consideration of a different type of policy

problem in a different decision-making arena.

Boulter (1983) might argue that the elaborate procedures followed in this study to identify leaders and determine public opinion are unnecessary. The policy ladder is designed as a working tool that rests upon a firm foundation of knowledge: knowledge by the decision maker of his or her constituents, of the problem, its background and the system in which it is embedded. As a result, an analysis can be performed without the depth of research provided here.

That argument runs counter to much of the previous discussion about the weaknesses of Boulter's (1983) policy ladder. Nevertheless, it is an idea that should be explored, if for no other reason than to reveal the need for further quantification of the framework.

In line with this thinking, one way to simplify the process and deal with the predictive potential of the decision ladder is to consider briefly a number of current issues. Then, based on statements in such public forums as the Kiplinger Letter, Gongwer and the press, establish tally sheets of support. Boulter (1983) would tend to argue that they will reveal much the same type of decision outcome as any more elaborate research. However, accurate, consistent results would be unexpected and would negate the major strengths of Boulter's (1983) decision ladder: its ability to incor-

porate a mass of data and a variety of theories.

There remains considerable room for future research. The most critical areas of interest lie in additional quantification of the methodology and a focus on the heuristic abilities of the framework. Without these steps, it is questionable whether different researchers studying the same issues would be consistent in their ratings and evaluation of outcomes. Even an elaborate gathering of background information will not assure uniformity. Systematic application of the framework, development of objective ratings and cutoff values for support outcomes, standard measures of power and strength of support would more readily assure the framework's utility as well as its use by administrators on the front line.

### Conclusions

What has been gained by this study of decision making in the mental health field? While we did not expect environmental, contextual and historical perspectives to differ much around a given agency, there was evidence of differing levels of constituency support. During its four years in operation, support for MIMH slowly eroded among almost all attentive groups. Support for Lafayette Clinic programs also dropped, but then seemed to stabilize at the lower level.

Sometimes high levels of public attention can be good, particularly when resources are scarce and programs can vividly demonstrate utility, efficiency and effectiveness. But, it has been argued that the differences between an agency that remained open and managed to entrench programs during a time of cutback management and one that was closed is not a result of inherent differences but, rather, one of changing perceptions of utility and value as manifested by support groups. The decision to close or retain a facility appeared to be politically, rather than programmatically, motivated. Through the use of a framework and several alternative methods of gathering and verifying data, an understanding and appreciation of this process occurred.

Although these particular findings may have only limited generalizability, the policy ladder itself offers considerable potential for further development. It allows us to explore thoroughly a public sector decision in a systematic fashion, highlighting the complexity of the process. While lacking the elegance of a full-fledged model, it permits incorporation of several intermediate level theories that now predominate in political science and thus, represents a useful step forward.

## APPENDIX A

### NEWSPAPER CLIPPINGS

Paper	Date	Article
State Journal	1/15/73	Mental Health Care Pact Signed by State, Gratiot
Detroit News	1/28/73	Mental Institutions' Names are Revamped*
Free Press	2/01/73	Transfer Program Cheats Mental Patients
Detroit News	2/04/73	How We Can Reclaim
State Journal	2/09/73	'Respite Care' Home Ok'd
Detroit News	2/20/73	Audit Reveals Theft of Mental Patients' Funds
Free Press	2/24/73	Senate Probes 'Brain Control' (A1)*
Free Press	2/26/73	Crisis Center Has Crisis — A Pay Feud (A3)
State Journal	3/04/73	Ionia Hospital Changes Explained by Director
Free Press	3/13/73	Brain Experiment Already Dead? Judges Hear Case*
State Journal	3/13/73	Brain Surgery Case Opens*
Free Press	3/14/73	Cut Sought in Clinic's Budget*
Free Press	3/16/73	3 Judges to Rule on Brain Test*
State Journal	3/20/73	Mental Health Board Urged to Pay
State Journal	3/23/73	Tri-County Mental Health Seeks \$5.4 Million Budget
Free Press	3/28/73	Psychosurgery Goes on Trial With Ionia's John Doe*
Detroit News	4/06/73	Mental Patient John Doe Ordered Freed*
Detroit News	4/06/73	Psychosurgery Called Partial Euthanasia*
Detroit News	4/08/73	'John Doe' Threatened With Murder Trial (A3)
Detroit News	4/20/73	Murder Charge Asked Against John Doe
State Journal	4/23/73	Care Centers Fight Zoning Crackdown
Detroit News	5/01/73	Mental Health Reform Underway
Detroit News	6/01/73	Brain Research of Future at Stake in John Doe Case (A16)*
Detroit News	6/03/73	Can You Cut Out Hate With a Knife: The Story of A Tortured Mind by John Doe*
Free Press	8/14/73	State to Ease Secrecy Rule on Residential Care Centers (A2)
State Journal	8/20/73	Nursing Homes Cater to Retarded
Free Press	10/14/73	Mental Health Chief Chafes Under Fire (A3)
Free Press	11/04/73	How Much Freedom for Mentally Ill?
Detroit News	11/08/73	Arts Conservatory for Retarded Sought in Oakland (B2)
Free Press	12/06/73	Health Records Denied Despite Court Order
Detroit News	12/10/73	Detroiters to Control Mental Health Unit
Free Press	12/11/73	City Fights Concentration of Homes for Mental Patients
Free Press	12/18/73	Ex-Mental Patient May Face Trial*
State Journal	12/26/73	Johnny Sees Himself Anew (B1)

\* This article mentions Lafayette Clinic

# This article mentions Michigan Institute for Mental Health

Free Press	1/12/74	Citizen's Group Wins Records
State Journal	2/07/74	Dr. Yudashkin Will Depart Mental Health Job on June 1
Free Press	2/08/74	State's Director of Mental Health Quits Under Fire
Detroit News	2/10/74	Lawyers Fight Experiment on Girl, 7, in Test Case (B13)*
Detroit News	2/20/74	Accord Reached on Mental Patient Experiments*
State Journal	2/20/74	'Help' is Answered (B3)
State Journal	2/24/74	Yudashkin Farewell 'Biting Fun'
State Journal	3/07/74	Group for Retarded Seeks New Image
State Journal	3/07/74	Youth Home Hits Snags
Free Press	3/14/74	Mental Program Criticized
Free Press	3/22/74	State to Examine Psychosurgery (A3)
Detroit News	4/21/74	Sterilization of Patients Under State Inquiry
State Journal	4/30/74	Mental Health Cuts Affect 11 Programs
Free Press	6/04/74	Judges Upset Mental Commitment Law (A3)
Free Press	6/05/74	Ruling Broadens Mental Patient Rights (A3)
State Journal	6/09/74	Revised Mental Code Urged
Free Press	6/18/74	Mental Care Programs Face New Strain (A3)
State Journal	7/14/74	Mental Health Code Passed
Free Press	7/24/74	Youth Clinic Denied License, Accreditation
State Journal	9/01/74	State Mental Research Controls Reviewed*
State Journal	9/12/74	Controversial Youth Clinic May Remain Open
Detroit News	9/13/74	State Relicenses Clinic Named in Probe
Free Press	9/13/74	Civil Insanity Test a Must in Criminal Cases
State Journal	9/13/74	Controversial Center's License Renewed
Free Press	9/22/74	Mentally Ill Trapped in Health Care Maze
State Journal	10/01/74	State Mental Research Controls Reviewed*
State Journal	10/10/74	Mental Health Officials Await Decision (B8)*
State Journal	10/11/74	Where Will Adult Retarded Go?
State Journal	11/01/74	U.S. Suit Claims Retarded Slighted
Free Press	11/02/74	Doctor Out of Jail, Quits Job
Free Press	11/17/74	Psychiatric Unit Swamped by Lay-off Related Crime (A3)
Free Press	12/19/74	Law Idles Mental Patients Craving Work (A3)
Free Press	12/24/74	Judge Won't Send Mentally Ill to Jail (A3)



State Journal	1/05/75	Mentally Ill Blocked (B1)
State Journal	1/05/75	Freeing Criminally Insane Stirs Livingston Debate
Free Press	1/10/75	1954 Slaying Trial Ordered*
State Journal	1/12/75	Prosecutor Seeks Changes in State Mental Laws
Detroit News	1/14/75	New State Mental Code Stirs Fears (A1)
Free Press	1/16/75	The Issue: What's Insanity? (A1)
State Journal	1/20/75	Wide Range of Health Services Offered (B8)
Free Press	2/08/75	Mental Health Code Blasted at Hearing
State Journal	2/09/75	Some Mentally Ill Confined to Jail
State Journal	2/11/75	Mental Health Code Blasted
State Journal	2/16/75	Mental Health Studied (B16)
Free Press	2/18/75	State to Release 3,000 Mentally Ill (A3)
State Journal	2/18/75	State's Plan to Release Mentally Ill Rapped (B5)
Detroit News	2/20/75	'Warehousing' of Mentally Ill is Protested
State Journal	2/20/75	State Can't 'Free' 3,000
State Journal	2/23/75	Insanity Plea Tougher Under New House Bill
Detroit News	3/05/75	Commitment on Insanity Plea Fought
Detroit News	3/05/75	Mental Health Chief Outlines Patient Policy
Detroit News	3/16/75	Mental Facility Tour Jolts State Officials
Free Press	3/24/75	New Mental Health Code has Court System in a Turmoil (A1)
Free Press	3/26/75	Striking Out a Future for Disturbed
Free Press	4/15/75	Judges to Rule on Mental Health Guardianships (B3)
Free Press	4/24/75	Mental Care Bills Praised, Opposed (A1)
Detroit News	4/26/75	Legislators Will Seek to Close Loopholes in Mental Health Law
Detroit News	5/09/75	Bargain Days Cost State Researcher His Job (A3)
State Journal	6/12/75	License Loss Requires Hearing (B12)
Free Press	6/15/75	Freedom Didn't Help Ex-Patient
State Journal	6/16/75	'Dangerous Man' Free; Mental Code Gets Blame
State Journal	6/19/75	New Restraints on Mentally Ill Advance in Senate
Detroit News	6/20/75	Alien Psychiatrists a Mental Care Problem (A3)
State Journal	6/22/75	State 'Fighting Walking Time Bombs' (A1)
Free Press	6/29/75	Patient Dies in Bath; Probe Set
Free Press	7/06/75	Reporters Locate 7 Mental Escapees (A1)
Free Press	7/09/75	Officials Tighten Up On Mental Escapees
Free Press	7/10/75	3 Fleeing Mental Patients Caught (A3)
Free Press	7/13/75	Suit Demands Mental Care
Free Press	7/14/75	The Escapes by Patients -- Whose Fault
Detroit News	7/26/75	Tougher Law on Insanity is Approved
State Journal	8/01/75	Mental Health Leaders Resign
Free Press	8/03/75	Life With Our Unhappy Wanderers (C1)
Free Press	8/03/75	Just Don't Have Enough Money, Agencies Say (C1)
Free Press	8/08/75	Police Arrest 2nd Escapee (A3)
State Journal	8/30/75	State Hospital Director Fired
Detroit News	9/11/75	Office to Guard State Patient's Rights
State Journal	10/16/75	Mental Director Named
Free Press	10/27/75	Mental Health Nominee is Backed -- But Not By All
Free Press	11/02/75	Slayer Sparks Mental Code Tug-Of-War (A3)
State Journal	11/26/75	Confirmation Now Likely (B4)
Detroit News	12/09/75	Freedom Sought for 'Dangerous' Mental Patient

Free Press	12/15/75	Parents Battle Son's Lawsuit (B3)
Detroit News	12/20/75	Patient is Ruled Threat to Society

Detroit News	1/15/76	A New Hope for St. Mary's?
Free Press	1/16/76	2d Mental Hospital is in Jeopardy (A3)
Free Press	1/19/76	Southfield Clinic's Psychotherapy Called Destructive (A1)
Detroit News	1/25/76	Retarded Students Give Lesson in Love (D11)
Detroit News	1/26/76	Steps Taken to Stop State Hospital Cuts (B2)
Free Press	1/27/76	Mental Patients Writ in Hallways (A3)
Detroit News	1/28/76	Chaos? Suit Charges Hospital Beatings, Escapes (A1)
Detroit News	2/02/76	Judge Refuses to Halt Clinton Valley Center Layoffs (B2)
Free Press	2/02/76	Mental Health in Fiscal Straitjacket (A3)
Detroit News	2/07/76	Judge Takes Court to Mental Patients (A1)
Free Press	2/07/76	Legislators Find Filth at Hospital (A3)
Detroit News	2/12/76	Hospital Concerns Officials (D1)
Detroit News	2/13/76	Ed: A Boon to Public, Patients (B6)
Detroit News	2/13/76	Mentally Ill Need Homes (D1)
State Journal	3/06/76	Other Sites Proposed for Riverside Transfers (A3) #
Detroit News	3/07/76	Ed: The Chaucey West Case: A Tragic Failure to Communicate (E8)
State Journal	3/09/76	More Area Men Accept Mental Counseling (B5)
Detroit News	3/12/76	Dr. Robey Drops Suit in Swap for Back Pay (A5)
Detroit News	3/12/76	Retarded to Vie in Ice Olympics (B3)
Free Press	3/16/76	Challenge to State's Mental Act Broadened
Detroit News	3/18/76	Excess Use of Behavior Drugs on Mental Patients Charged (A3)
Detroit News	3/19/76	Mentally Ill Victimized, Report Says (D12)
State Journal	3/22/76	'Cure' for Schizophrenics Now in Hands of FDA*
State Journal	3/28/76	Bills Push Neighborhood Care Facilities
Detroit News	4/08/76	Macomb-Oakland Agency Developing New Programs (B3)
Free Press	4/11/76	13 Given Mind-Altering Operations (A1)
State Journal	4/13/76	'Someone to Listen' Need of Disturbed Youth (D1)
State Journal	4/13/76	Teen Problem Solving Under Test in Schools (D1)
State Journal	4/14/76	Mental Patients to Jarvis Acres? #
Detroit News	4/15/76	Senate Votes \$48.3 Million (F11)
Detroit News	4/29/76	Mental Health Code Change Urged (A16)
Detroit News	4/29/76	Pontiac Mental Facility May Lose Accreditation (A10)
Free Press	4/29/76	Pontiac Mental Hospital to Lose its Accreditation (A3)
Detroit News	5/02/76	Mental Code Reconsidered After Assault (A8)
Detroit News	5/02/76	Ed: Mental Health Code Change Urged (G8)
Detroit News	5/04/76	Foster Home Scandal Stirs Probe (A15)
Detroit News	5/04/76	Ed: Protecting Patient and Community (B6)
Free Press	5/04/76	Cutbacks in Mental Care Seen (A3)
State Journal	5/04/76	Mental Patients Might Share Jarvis Acres #
State Journal	5/05/76	Federal Funding to Help State Expand Mental Health Care (B16)
Free Press	5/08/76	Mental Health Switch Rapped (B8)
State Journal	5/16/76	Eaton Fighting Mental Health Center #
Detroit News	5/24/76	Piston Scores From Heart (C1)
Detroit News	5/26/76	Abuse Claims Probed (A1)
Detroit News	6/03/76	Milliken Plans to Inspect Mental Institutions (B2)

Detroit News	6/04/76	Parents of Retarded Offered Hope (B1)
State Journal	6/09/76	Jarvis Acres Controversy Splits Board #
Detroit News	6/17/76	State to Appeal Hospital Cases (D13)
Free Press	6/24/76	Prison Care of Psychotics 'Lousy', Doctor Testifies (A3)
State Journal	6/24/76	State Use of Jarvis Acres #
Detroit News	7/01/76	Wyandotte Plant Has Pride (B3)
Free Press	7/07/76	Mental Aftercare In a Shambles, Legislators Say
Detroit News	7/08/76	State's Mental Aftercare Program Called a Disgrace (B6)
State Journal	7/09/76	Board Delays Use Decision #
Free Press	7/10/76	Study Paints Sad Picture of Mental Care in State
Detroit News	7/17/76	State is Urged to Probe Mental Health Funding (A6)
State Journal	7/17/76	Mental Patient Returning to State Beats Youth, Shoots Cop on Jetliner (A1)
Detroit News	7/19/76	Hospital Studied For Mental Facility (B1)
Free Press	7/23/76	Inmate Can Sue On Brain Operation
Detroit News	7/29/76	Hospitals Edgy on Accreditation Ruling
State Journal	8/04/76	Planning Board Again Rejects Mental Care Facility
State Journal	8/05/76	Planners OK Use of Jarvis #
Detroit News	8/07/76	Ex-Mental Health Chief Denies Kickbacks (B6)
State Journal	8/11/76	Jarvis Acres Switch OK'd #
Detroit News	8/12/76	Center for Mentally Ill OK'd #
State Journal	8/15/76	Neighborhoods Block Adult Care Homes
Detroit News	8/29/76	Too Many Mentally Ill Live Alone (MAG6)
Detroit News	9/21/76	Village Sued in Home's Use by Retarded (B1)
Free Press	9/22/76	Judge Voids Guilty-But-Ill Verdict (A3)
Detroit News	10/07/76	Mental Health Aid at Stake (C10)
Detroit News	10/18/76	Bloomfield Care Home May be Shut (A1)
Detroit News	10/20/76	Warren Mongoloid's Adoption is Cleared (A1)
Detroit News	10/31/76	Hepatitis Isolates 250 at Hospital (A1)
Detroit News	11/06/76	State Mental Facility's Accreditation Restored (A12)
Detroit News	11/10/76	Northville Hospital Hepatitis Outbreak Seems Over (A26)
Detroit News	11/11/76	Brain Surgery Suit Filed Against Providence (B2)
Free Press	11/24/76	Suit Challenges Quicky Hearings for Retarded
Detroit News	12/12/76	Self-Respect is Part of Their Job's Pay (D22)
Detroit News	12/15/76	Hope Healed a 'Handicap' and Give Patient the Best of Christmas Gifts (F3)
Detroit News	12/28/76	Retarded Find Warmth, Hope at New Center (B2)

Detroit News	1/06/77	Converted Ionia Center Ready for First Inmates (B1)
Detroit News	1/22/77	Blues Rules Ask Community Involvement (A7)
Detroit News	1/31/77	Old Redford Home Allows Retarded to Live on Own (B1)
Free Press	2/13/77	Controversial Psychologist Ousted by State Association (A3)
Free Press	2/19/77	State Sued on Mental Care Right (A3)
Detroit News	3/02/77	Horticultural Therapy Helps Mentally Ill (BD4)
Detroit News	3/08/77	Demotion Plan at Plymouth Facility Fought (BW1)
Detroit News	3/08/77	Mother's Plight Prompts Move For Respite Center (BE1)
Detroit News	3/09/77	State Home Chief's Ouster Sought (BE3)
Free Press	3/10/77	Add 270 to Staff, Plymouth Told (A1)
Free Press	3/19/77	Mental Health Spot Hard to Fill - Milliken (A3)
Detroit News	3/22/77	Inner City's Mentally Ill to Get New Facility (BD1)
Detroit News	4/09/77	Northville Hospital Regains Mental Unit Accreditation (A8)
Free Press	4/10/77	Sentenced as Mentally Ill -- But Vet Can't Get Treatment (A1)
Detroit News	4/12/77	Foster Grandparents Buoy Handicapped (BE2)
State Journal	4/17/77	Jean: Phone Link to Sanity (C1)
State Journal	4/17/77	Rocky Economy Boosts Mental Health Load (B16)
State Journal	5/06/77	Shiawasee Students Abused?
Detroit News	5/26/77	Mentally Handicapped Are Fitting In To Society (GD6)
Detroit News	6/02/77	Respite Care: A Real Break for Parents of Special Children (CD5)
Detroit News	6/06/77	State Is Urged to Study Chemistry of Insanity (B2)
Detroit News	6/16/77	300 Rally in Michigan House to Urge More Mental-Health Funds (A20)
Detroit News	6/17/77	A Proud Young Man Demonstrates 'New Era' in Chance for Retarded (BN1)
Free Press	6/17/77	Persons, Not Patients, At Macomb-Oakland Center (A3)
State Journal	6/23/77	Caring Atmosphere Stressed
Detroit News	6/24/77	Foster Home Giving Retarded Woman Zest (BE1)
Detroit News	7/20/77	Faster Transfer of Mentally Ill Prisoners Ruled Out (BD6)
Detroit News	7/30/77	Ypsi State Hospital Denied Accreditation (A17)
Detroit News	8/04/77	Retiree Gives and Gets Love With Retarded Kids (BN2)
Detroit News	8/09/77	Gov. Milliken Signs Increased Budget for State Mental Health (BN2)
Detroit News	8/10/77	'Family' Zoning Ruling is Upheld (BD2)
Free Press	8/28/77	Patients Stood in for Spies in Tests
State Journal	8/30/77	'Primal' is a Screaming Success in Ann Arbor
Detroit News	9/02/77	Court Plan for Retarded Stirs Debate (B1)
Detroit News	9/23/77	Regional Center Seeks Those Who Will Open Homes to Retarded (BN2)
Detroit News	9/24/77	U.S. to Aid 3 State Mental Facilities (E7)
Detroit News	11/01/77	School Aide Reveals Abuse of Retarded Children at State Center (BN2)
State Journal	11/04/77	Survey Eyes Mental State
Detroit News	11/06/77	Pickets Hit Suspensions At Lapeer Mental Hospital (B2)
Free Press	11/06/77	Lapeer Abuses Probed (A1)

Detroit News	11/08/77	OK for Force is Asked in Handling Mental Cases (B3)
Detroit News	11/11/77	Suspensions Jar Mental Facility (A3)
Detroit News	11/13/77	2 Supervisors Disciplined at Mental Facility; Abuse of Patients is Suspected (B6)
Detroit News	11/15/77	3 Lapeer Center Aides Fired; 11 Cleared by Abuse Report (D8)
Detroit News	11/16/77	Home for Handicapped Opens Doors to Talent (DD8)
Detroit News	11/16/77	Illinois Man Named Chief of Mental Health Center (A17)
Detroit News	11/18/77	Retarded Oakland Youngsters Find Hockey Excitement in Floor League (BN1)
Detroit News	11/19/77	Investigators Confirm 2 Cases of Abuse at Center for Retarded (A17)
Free Press	11/22/77	Therapists Revolt on State Quiz (A3)
State Journal	11/23/77	Center Sues State Over Questionnaire
Free Press	11/24/77	Checklist on Mental Patients Halted (A3)
Detroit News	11/25/77	Judge Halts State Use of Forms on Retarded's Sex, Toilet Habits (BD1)
Free Press	12/04/77	In and Out of Mental Hospitals (A1)
Free Press	12/05/77	Who Gets Mental Care and Why (A1)*
Free Press	12/06/77	Sanity Cases Leave Scars (A1)
Free Press	12/07/77	Little Crimes Can Be a Cry for Help (A1)
Free Press	12/08/77	Its 'Northville Shuffle' for Mentally Ill (A1)
Free Press	12/09/77	Inside a Good Foster Home (A1)
Free Press	12/09/77	Trying to Find Sanity on the Streets (A1)
Free Press	12/10/77	Healing An Ailing System #
State Journal	12/21/77	Meridian Has Surprise: 'Oasis' Opponents Don't Show Up

Detroit News	1/12/78	New Homes for Retarded Win Praise but 'Monumental' Problems Remain (B1)
Free Press	1/15/78	Mental Hospital Seen From Inside (A3)
Detroit News	2/04/78	Mental Health Staffing Assailed
Free Press	2/19/78	Children Tortured; State Center Covers Up (A1)
Detroit News	2/20/78	Plymouth Home Inquiry Slated (B1)
Detroit News	2/20/78	Court Aid Urged for Retarded (B1)
Free Press	2/20/78	Retarded 'Trained' With Abuse (A1)
Free Press	2/21/78	Parents Feel Helpless Against Abuse
Free Press	2/22/78	Abuse is Obvious - Reasons Aren't (A1)
Detroit News	2/23/78	Mental Facility Chief Ousted (A1)
Free Press	2/23/78	Abuse Probers Find System of Coverup (A3)
Free Press	2/23/78	Plymouth Center Director is Out
Free Press	2/23/78	Stalling in Lansing Let Abuse Go On
Detroit News	2/24/78	Top Health Aide Out in Center Scandal (B1)
Free Press	2/24/78	Center Criticized to No Avail (A1)
Free Press	2/24/78	Wayne Board Asks Probe Into Abuse
Detroit News	2/25/78	Mental Hospitals Get Flak at Public Hearing (A3)
Detroit News	2/25/78	Panel Will Watch Care of Patients (A1)
Free Press	2/25/78	Area Mental Aide Out (A4)
Free Press	2/25/78	Milliken: Halt Any Abuses of Retarded (A1)
Free Press	2/25/78	Plymouth's Boss: From Kindly Dad to a General (A3)
State Journal	2/25/78	Milliken Outlines Mental Health Reforms
Detroit News	2/26/78	9 Fired in 1977 For Abusing Retarded (B10)
Detroit News	2/26/78	Lawmaker: Misers Gyp Retarded (B1)
Free Press	2/26/78	Center Fires Worker: He Cared Too Much (A1)
Detroit News	2/27/78	Attendants Tell of Abuse By Retarded (B1)
Detroit News	2/28/78	Attendants Rally to Deny Abuse (B1)
Detroit News	2/28/78	Reports of Patient Abuse Not Limited to Plymouth #
Free Press	2/28/78	Retarded Receive Poor Medical Care (A3)
State Journal	2/28/78	Britten Avenue Residents Rush to Protest Foster Home (B1)
Detroit News	3/01/78	Attendant Stands Mute on Assault Charge (B6)
Detroit News	3/01/78	Most State Homes Have Abuse Cases (B1) #
Detroit News	3/01/78	Panel Gets Stalled on Hospital Inquiry (B1)
Detroit News	3/02/78	Critics Call Mental Chief Unqualified (B1)
Detroit News	3/02/78	Mental Facility Case Will Go to Grand Jury (A3)
Detroit News	3/03/78	Grand Jury Seen as Crucial to Plymouth Center Inquiry (B3)
Detroit News	3/04/78	State to Add Staff at Unit for Retarded (A1)
Free Press	3/05/78	Dr. Smith Was Told of Abuse in 1976
Free Press	3/06/78	Health Chief Denies Inaction on Abuse (A1)
Detroit News	3/07/78	Ed: Doing Something About Plymouth (A14)
Detroit News	3/07/78	How Mental Health Chief 'Resigned' (A1)
Free Press	3/07/78	Mental Health Chief Quits (A1)
Free Press	3/08/78	Milliken Expands Abuse Inquiry (A3)
Detroit News	3/09/78	Special Jury Probe on Retarded Barred (B1)
Detroit News	3/10/78	Mental Health Inquiry Gets 4 New Members (B1)
Detroit News	3/11/78	Acting Mental Health Chief Vows Reforms (A3)
Free Press	3/11/78	Mental Health Gets Old Pro as New Boss (A3)

Detroit News	3/12/78	Plymouth: How Years of Complaints Grew Into Political Response (A1)
Detroit News	3/14/78	Ex-Plymouth Center Bosses Still Get Pay (A1)
Detroit News	3/15/78	Care Center Suspends 7 for Abuses (A1)
Free Press	3/15/78	7 Suspended at Plymouth Center (A3)
Free Press	3/15/78	Senate Panel OKs Funding of Advocates for Retarded Patients (C13)
State Journal	3/15/78	More Investigation at Plymouth Center; 7 Suspended (B8)
Detroit News	3/16/78	Visits to Home Contrast Starkly (B1)
Free Press	3/16/78	Patient Abuse Probes Starting (A3)
Detroit News	3/17/78	Senate Passes Patient Abuse Plan (B2)
Detroit News	3/18/78	New Plan to Protect Workers From Hostile Mental Patients (A14)
Detroit News	3/18/78	State Hospital Chief Back on Job (A14)
Free Press	3/19/78	Mental Health Spot Hard to Fill - Milliken (A3)
Free Press	3/24/78	Panel Named to Watch, Report on Plymouth (A4)
Detroit News	3/28/78	Warnings Preceded Care Crisis (A1)
Free Press	3/29/78	9 at Mental Hospitals Charged with Illegal Medical Practice (A3)
Free Press	3/29/78	Plymouth Probers Want Ex-Directors (A3)
Free Press	3/30/78	Hospital Adds Unit for Mentally Ill Kids (A3)
Free Press	4/01/78	Ex-Mental Health Chief Blames Press
Free Press	4/01/78	Mental Health Workers Get to Vote on a Union
Detroit News	4/02/78	Plymouth Staff Cuts Feared Harming Care (D3)
Detroit News	4/03/78	'Rest Break' For Parents of Retarded (B2)
Detroit News	4/06/78	Coldwater Hospital Gets New Chief (C6)
Free Press	4/06/78	Parents of Retarded Kept Off Panel (A17)
Detroit News	4/07/78	Mental Patient Abuse Bill Wins House Approval (B6)
Detroit News	4/11/78	Tough Boss Matches Job: Woman Trying to Clear Plymouth Center Mess (A1)
Detroit News	4/12/78	3 Doctors Quit Jobs at Plymouth Center (B4)
Detroit News	4/13/78	Steps Set to Prevent Abuse of Retarded (A1)
Detroit News	4/18/78	Plymouth Ex-Chief Lashes 'Untrue' Stories (B3)
Free Press	4/18/78	Probe of Abuse Should be Wider, Womack Asserts (A3)
Free Press	4/19/78	Task Force to Widen Abuse Probe (A3)
Free Press	4/21/78	Plymouth Panel Told of Abuse, Lies (A3)
Detroit News	4/25/78	Attendant Faces Trial for Abusing Patient (B2)
Free Press	4/25/78	Staff Shortage, Uproar Seen at Plymouth (A1)
Free Press	4/25/78	Suggestions for Plymouth Kept A Secret (A3)
State Journal	4/25/78	State Unit Hit Again (B6)
State Journal	4/26/78	Lawsuit Protests Adult Care Home (B1)
Detroit News	4/29/78	Plymouth Center Worker Faces Sentence in Beating (A9)
Free Press	4/29/78	2 More of Center's Employees are Fired (A3)
Free Press	4/29/78	Plymouth Employee Found Guilty in Patient Abuse Trial (A3)
Free Press	4/30/78	State Finds Abuse at Plymouth (A1)
Detroit News	5/01/78	Center Prober Seeks Cure for Patient 'Abuse, Neglect' (BD4)
Free Press	5/02/78	Womack is told: Quit or Be Fired
Detroit News	5/04/78	After 10 Years, He Wins Bias Fight (E7)



Detroit News	5/04/78	Attendant Convicted of Abuse (E7)
Detroit News	5/05/78	Panel Denies Patient Abuse Hushed (BD2)
Free Press	5/05/78	No Cover-up at Plymouth - Task Force (A1)
Free Press	5/05/78	Womack Calls Plymouth Abuse Report Biased and Inaccurate (A8)
Detroit News	5/06/78	Home Operator Says Abuse Charges Are Ex-Workers Lies (A8)
Detroit News	5/06/78	Plymouth Center Director Takes HEW Job (A8)
Detroit News	5/14/78	Abuses Spur Mental Health Moves (BD8)
Detroit News	5/17/78	Hospital Bills Seek to Clear Abuse Rules (BD3)
Detroit News	5/18/78	2 Suburbs Seek to Bar Homes for Retarded Adults (BE4)
Detroit News	5/24/78	Psychologist Claims Victory in Hospital Dismissal Suit (BW3)
Free Press	5/24/78	Plymouth Still Gets Bad Marks (A3)
Free Press	5/27/78	35 More Suspended at Plymouth (A3)
Detroit News	5/28/78	Plymouth Center Suspends 35 More (B1)
Detroit News	5/30/78	Mental Unit's New Director Maps Reform (B1)
State Journal	5/30/78	Mental Health 'Breaks Ice'
Detroit News	6/03/78	Panel's Goal: New Mental Health Chief (A8)
Detroit News	6/04/78	Judges, Psychiatrists Rack Brains Over Rights of Mentally Ill (C17)
Detroit News	6/06/78	Keeping Up: The Gist of the News (A2)
Free Press	6/06/78	Lapeer Center Rates Poorly But Better Than Plymouth (A3)
Free Press	6/06/78	Southfield Objects to Men Trying to be Good Neighbors (A1)
Detroit News	6/07/78	Study Criticizes Mental Facility (BD2)
Detroit News	6/07/78	Woman Gets Probation in Beating (B1)
Free Press	6/09/78	Association Stalls Bid to Exclude Retarded (A3)
Detroit News	6/12/78	Neighborhood Welcomes Retarded 'Family'
Detroit News	6/14/78	Report to Milliken Assails 'Armed Truce' at Lapeer (BE3)
Free Press	6/15/78	A New Home for Retarded Men
Free Press	6/16/78	More Cash for Mental Health (3)
Free Press	6/16/78	Swat on the Rear Seals Plea in Plymouth Abuse Case (3)
State Journal	6/16/78	Foster Care Homes Replacing Mental Hospitals
State Journal	6/16/78	Mental Health Fee Increase to be Aired
Detroit News	6/19/78	Suit Attacks Isolation of Retarded (B1)
Detroit News	6/21/78	Judge Rules Out Survey of Patients
Free Press	6/21/78	Court Ruling Ends State's Snooping on the Retarded (A3)
State Journal	6/21/78	They'd Do Dishes, Floors for Jobs (C3)
Detroit News	6/22/78	Michigan Closes Suburban Home for Retarded Men (BN7)
Free Press	6/22/78	Transfer of Five From Home OK'd Pending Sex Probe (A20)
Free Press	6/23/78	Care for Retarded Inadequate State Director Admits (A13)
Detroit News	6/25/78	State Severs Ties at Home for Retarded (B8)
Detroit News	6/26/78	Mental Aid Plan Gains Support of Psychiatrist (BD1)
Detroit News	6/26/78	State Plans to Hire 130 at Plymouth (BD2)

Detroit News	6/27/78	Home for Retarded Faces State Charges (BN2)
Detroit News	6/29/78	Mental Health Funds Get OK (A12)
Detroit News	7/02/78	Home for Retarded Men Denies Neglect Charge (BW8)
Detroit News	7/05/78	25 Suspended at Plymouth Sue to Get Jobs Back (B3)
Detroit News	7/05/78	Taylor to Get First Homes for Retarded (B1)
Detroit News	7/12/78	Retarded Home Sues Agency (BE4)
State Journal	7/13/78	Progress Slow at Plymouth: Rosen (B9)
Detroit News	7/18/78	Judge Delays Mental Ruling (BN2)
Detroit News	7/19/78	Senator Claims Milliken Ignored His Call For Patient Abuse Probe (BW8)
Free Press	7/20/78	24 More Are Fired at Plymouth (A3)
Detroit News	7/21/78	Extensive Patient Abuse Found in State Facilities (B1)
Free Press	7/21/78	Plymouth Better, But Far to Go (A1)
Detroit News	7/25/78	Ed: Same Mental Health Story: Patient Abuse and Neglect (A20)
Detroit News	7/25/78	Retarded in St. Clair to Get Aid (BE3)
Detroit News	7/26/78	Dorm Chief Got Ax at Plymouth (B1)
Detroit News	8/05/78	State Boosts Mental Health Funds (A19)
Detroit News	8/08/78	Revised Mental Code Open for Review (BN2)
Free Press	8/15/78	Poor Care Blamed for Plymouth Deaths (A1)
State Journal	8/15/78	Plymouth Health Care 'Poor' (B6)
Detroit News	8/22/78	Plan Helps Find 'Special Sitter' (BE2)
Detroit News	8/28/78	8 Mental Hospitals Win Recertification (BW4)*
Detroit News	9/14/78	Panel Hears of Abuse in Care Homes (B8)
Detroit News	9/21/78	State to Hire 55 Workers for Mental Aid Facilities (BW20)
Detroit News	9/24/78	Hospital Escape Try Fails (A1)
Detroit News	9/24/78	Mental Care Angers Fitzgerald (C23)
Detroit News	9/25/78	State Tried to Put Lid on Plymouth (B1)
Detroit News	9/26/78	12 Guards Bolster Staff at Ypsilanti Mental Hospital (B1)
Detroit News	9/28/78	Big Mental Institutions Criticized (BD2)
Detroit News	10/04/78	Holly-Area Developers Sue to Bar Disabled Adults From Subdivision (BD3)
Free Press	10/04/78	Builder's Suit Stalls Home for Retarded
Detroit News	10/06/78	Retarded-Home Approval Awaits Ruling by Court (BN2)
Detroit News	10/09/78	22 Get Jobs Back at Plymouth (B6)
Detroit News	10/10/78	Plymouth Rehiring Face a Test (A1)
Detroit News	10/11/78	Union Offers Defense for Health Aides (B1)
Detroit News	10/14/78	Workers Ask State to Begin Pact Talks (A2)
Detroit News	10/21/78	Ed: Mental Illness (A18)
Detroit News	10/23/78	Group Homes for Retarded Rouse Fears (B1)
Detroit News	10/25/78	Plymouth Panel Reports 'Modest' Gains at Center (B1)
Free Press	11/03/78	TV Debate Revives Questions About Plymouth Center Death (A3)
Detroit News	11/17/78	House Passes Rules for Mental Patients (BD4)
Detroit News	12/01/78	Child Home Aide Gets Suspension (BD2)
Detroit News	12/03/78	Panels Try To Fill Mental Health Jobs (B8)*
Detroit News	12/05/78	The 'Hot Line' to Help (D4)
Detroit News	12/06/78	Ed: Plymouth Center Gains (A22)

Detroit News	12/09/78	Court Orders 2 Men to Testify on Abuse (A9)
Free Press	12/10/78	'Children Held Our Hands, Wouldn't Let Go' (C1)
Free Press	12/10/78	Plymouth Center: In 10 Months, Drastic Changes (C1)
Detroit News	12/12/78	Mental Health Budget Won't Be Cut - Milliken (B9)
Free Press	12/14/78	State to Review Patient Abuse Report (A1)
Free Press	12/15/78	Report Blasts Mental Institutions (A1)
Detroit News	12/19/78	Ex-Con Bids for Nursing Care License (B1)
Detroit News	12/22/78	Task Force Takes Aim at Hospital 'Fat' (B1)
Detroit News	12/24/78	Kelley Upsets Child Admission Rule (BW6)
Free Press	12/25/78	Ousted Plymouth Director Fights for Job, Reputation (A3)
Detroit News	12/28/78	Court Drops Immunity for General Hospitals (BN3)
Detroit News	12/31/78	Even Exorcism Fails to Cure Him
Free Press	no date	Emptying the Warehouse...

Detroit News	1/10/79	State Panel to Revise Mental Health Set-Up (BN2)
Free Press	1/12/79	Long Waits Chronic In Mental Unit (A3)
Detroit News	1/23/79	Panel Cites Neglect in Mental Care (B1)
Detroit News	1/24/79	Home's Use by Retarded Approved (B1)
Detroit News	2/02/79	Turnover Hurts Plymouth Home (B1)
Detroit News	2/03/79	Ed: Mental Illness (A18)
Free Press	2/03/79	Court Hears of New Abuses At Plymouth (A1)
Detroit News	2/06/79	Plymouth Center Deadline (B1)
State Journal	2/06/79	Plymouth Center Gets Ultimatum (B9)
Free Press	2/17/79	Patient Rights Cases Pile Up (A3)
Detroit News	2/22/79	Plymouth to Hire 300 Attendants (B1)
Free Press	2/25/79	How Captivity Since Birth Left Jack, 54, a Mental Cripple (A1)
Free Press	2/28/79	Money Bind May Disrupt Cases of Mentally Ill
State Journal	3/12/79	Aid Here Inadequate for Mentally Ill Youth (B1)
Detroit News	3/23/79	Judges Assail Mental Health 'Waste' (A3)
Detroit News	3/24/79	Ypsi Hospital Kitchen Filthy, Workers Say (A1)
Detroit News	3/25/79	Hospital Tour Backs Employees (B1)
Detroit News	3/25/79	Jackie's Victory - He's Own Man
Detroit News	3/25/79	Now, a 'Last Emancipation' (A3)
Detroit News	3/26/79	(Full page set of 3 stories) A Home From Both Sides of the Street: 'It's Not as Bad as I Thought' - A Neighbor; 'On Your Own, a Little Scared,' Says Resident; The Battle: Clamor Subsides (C1)
Detroit News	3/26/79	State Plans Food Check at Hospital (B1)
Detroit News	3/27/79	Mental Hospital Scrubs for Visit (B1)
Detroit News	3/28/79	(Full page set of 3 stories) Retarded Work Here: Why Not?; State Pays Big Money to Train Retarded; Job Brings Dennis Out of His Shell (G1)
State Journal	3/29/79	State Mental Care Report Sympathetic (B1)
State Journal	3/29/79	Mental Center Still Troubled (B2)
Detroit News	3/30/79	Hospital Suspends Dietician After Tour (B1)
Detroit News	4/04/79	Chief Quits At Mental Hospital (B1)
Detroit News	4/05/79	Mental Unit Improving, Judge Says (B1)
Detroit News	4/15/79	Fired Center Chief Ordered Reinstated (B2)
Detroit News	4/15/79	Mental Center Proposal Dies (B2)
Detroit News	4/16/79	Bretton Square: Hope for Retarded
Detroit News	4/17/79	Lawmaker Urges Fight on Womack (B4)
Detroit News	4/24/79	State Fights the Rehiring of Womack (BD4)
Detroit News	4/27/79	Poetry: Therapy With a Pen (D1)
Detroit News	4/29/79	Mental Facility Will Keep New Boss Busy (B1)
Detroit News	5/01/79	When Someone Cares (D10)
Detroit News	5/06/79	Bullets 'Welcome' Home For Retarded (B2)
Detroit News	5/06/79	State Starts Kitchen Repair in Hospital (B9)
Detroit News	5/08/79	200 in Troy Discuss Gun Attack on Disputed Home for Retarded (B1)
Detroit News	5/08/79	Alpena Home Gives Retarded New Hope (B1)
Detroit News	5/09/79	Felony Asked in Mental Aid Abuse Case (BD2)
Detroit News	5/16/79	Task Force Blames Mental Facility Staff for Patient's Death (A1)
Detroit News	5/17/79	Study Told of Trouble in Hospitals (B1)

Detroit News	5/19/79	Jobs Went to First - But Not Best (A8)
Detroit News	5/22/79	Ed: Clinton Valley Center (A20)
Detroit News	5/25/79	Mental Health Chief (B1)
Detroit News	5/27/79	Opportunities Knock at 'Clubhouse' for Ex-Patients (CE8)
State Journal	5/27/79	Patients Protected from Abuse; Who Protects Attendants #
Detroit News	5/29/79	New Official Can Handle Crisis (B4)
State Journal	5/29/79	Patients First with Mental Health Nominee (B1)
Detroit News	6/10/79	Dirty Linen Hits The Road (A1)*
Detroit News	6/21/79	High Court Curbs Rights of Juveniles (A1)
Detroit News	6/22/79	More State Hospital Workers? Maybe (B1)
Detroit News	6/24/79	Decision on State Hiring Delayed (B4)
Detroit News	6/24/79	Ed: Parental Rights (A20)
Detroit News	6/28/79	Suit Calls Commitment Plan Illegal (B1)
Free Press	7/02/79	Many Fired Plymouth Aides Rehired (A1)
Free Press	7/12/79	Plymouth Attendant Accused (A3)
Free Press	7/17/79	Battered Parents: Victims of Our Times (C1)
Detroit News	7/20/79	Crime, Morale Crises Plague State Hospital (A1)
Detroit News	7/21/79	Clinton Valley Problems Await New Health Chief (A8)
Detroit News	8/07/79	Milliken Vetoes 3 Projects (BD2)
Detroit News	8/21/79	Complaints Skyrocket at Mental Units (B1)
State Journal	8/29/79	Mental Patients May be Moved Into Apartments
Detroit News	8/31/79	Drug Laxity Loses Rating for Center (B1)
Detroit News	8/31/79	Plymouth Center Closing Ordered (A1)
Detroit News	9/02/79	Court Plan For Retarded Stirrs Debate (B1)
Detroit News	9/19/79	Hospital Rapped on Drugs (B5)
Detroit News	9/21/79	U.S. Judge Names 2 to Phase Out Center (C2)
Free Press	9/21/79	Plymouth Center is 'Disastrous' Court is Told
Detroit News	10/10/79	Fired Official Gets New Job (BDE6)
State Journal	10/10/79	Industrial Mental Health Aid Readied
Detroit News	10/21/79	Sexual Abuse Inquiry Moves Slowly (B2)
Detroit News	10/23/79	End Patient-Rights Office, Senator Asks (B1)
Detroit News	10/26/79	Abuse Case Goes to Prosecutor (BN2)
Detroit News	10/26/79	Fire Destroys Troy Home For Retarded (B1)
Detroit News	10/31/79	Ed: Terrorism in Troy (A12)
Detroit News	11/06/79	State Gets Mental Health Aid (BN2)
State Journal	11/16/79	State Opens Probe of Treatment at Adolescent Home
Detroit News	11/30/79	Metropolitan Psychiatric Unit to Close
Free Press	12/01/79	Psychiatric Hospital Is Unsafe and Will Close
Free Press	12/18/79	Lafayette Clinic Chief Blocked (B8)*
Detroit News	12/19/79	State Can Use Donations for Gifts to Patients (B14)
State Journal	12/20/79	Chosen for Clinic, Australian Waits for House Action (B12)*
Detroit News	12/28/79	Patient Abuse Complaints Rise (B1)

Detroit News	1/16/80	State Post Challenges Psychiatrist (BD2)
Detroit News	1/21/80	Neighbors Oppose Home for Retarded (BN8)
State Journal	2/04/80	Fencing of Mental Unit Asked #
Detroit News	2/05/80	Panel Proposes Shift in Patient Abuse Cases (B1)
State Journal	2/12/80	Riverside's 'Open Door' Policy Arouses Concern #
State Journal	2/14/80	Windsor Has Eye on Riverside #
Detroit News	2/19/80	'Mickey Finn' Death of Boy Sparks Inquiry of Wayne Center for Retarded (B1)
Detroit News	2/20/80	Frustrated Kids Learn to Cast Off Hang-ups (G1)
State Journal	2/20/80	Michiganians Weigh 'Brother's Keeper' Role
Detroit News	2/22/80	Nothing But Winners: Winter Special Olympics (A1)
Detroit News	2/23/80	State Limited in Takeover in County - Kelley (A10)
Detroit News	2/26/80	State Acts in County Crisis (BDE2)
Detroit News	2/27/80	State Seeks to Take Over County Unit (BDE2)
Detroit News	2/27/80	Teen Center Faces Loss of State License (B1)
State Journal	2/28/80	Jarvis Walkaways Upset Windsor Board #
Detroit News	2/29/80	Probe Finds Violations at Foster Center (B1)
Free Press	3/02/80	Where the Words 'Violently Ill' Take on New Meaning
Detroit News	3/04/80	State Charges Abuse at Private Mental Home
Detroit News	3/16/80	Michigan Had 3,000 Sterilized in 1929-50
Detroit News	3/24/80	Sterilization Victim, 63, Still Asks 'Why'
Detroit News	3/25/80	State Harasses Center, Doctor Says
Detroit News	3/26/80	Court Rules on Prisoner Transfer to Mental Hospital (C2)
Detroit News	4/02/80	Mental-Patient Housing (BW2)
State Journal	4/04/80	Fencing of Mental Unit Asked #
Detroit News	4/18/80	Psychiatric Hospital to Be Closed (A1)
State Journal	4/24/80	Mental Facility Aides Say Layoffs a Danger (B6) #
Detroit News	5/13/80	News Series Wins Anti-Bigotry Award (A3)
Detroit News	5/13/80	Judge Lifts Ban on Layoffs by the State (BD2)
Detroit News	5/15/80	Suburbs See Peril to Dream (A1)
Detroit News	5/17/80	70-Year-Old Man Among 8 Foster Parents Saluted (B2)
Detroit News	5/18/80	Born Mongoloid, And It Doesn't Matter (C1)
State Journal	5/21/80	Jackson Slayer Wins Quick Release
Detroit News	5/23/80	Hospitals Notify Staffs of Cutbacks (All)
Free Press	6/07/80	Retarded Patients Win Their Fight Against Eviction (A3)
Detroit News	6/11/80	Handicapped Woman Turns the Tables (A1)
Detroit News	6/12/80	Foster Home Program Hit (BDW2)
Detroit News	6/17/80	Man Beats 'Retarded' Label
Detroit News	6/23/80	Kelley to Battle Blues: Michigan Wants State Mental Hospitals Paid (A1)
Detroit News	6/25/80	Slump Breeds Mental Ills
Free Press	6/25/80	Judge Puts Brakes on Mental Case Processing (A3)
Detroit News	6/29/80	Doctors Ask Delay on Pay Raises (BD11)
Detroit News	6/30/80	Fight Looms on Retardeds' Rights (BD6)
Free Press	7/05/80	Child Slayer Skips Mental Center, May be Free Man
Detroit News	7/06/80	Coffeehouse Caters to Needs of Retarded
Detroit News	7/07/80	Mental Hospital Escapee Found (BW2)
Detroit News	7/07/80	Panel Seeks to End Mental Care Dispute (B1)
Free Press	7/09/80	New Aid for Retarded Works - But Not For All

State Journal	7/24/80	Mental Health Workers Eye Public-Private Cooperation (B6)
Detroit News	8/01/80	State Officials Warn Against Budget Cuts (BW2)
Detroit News	8/05/80	Mental Health Director Protests Cuts in Budget #
Detroit News	8/05/80	Budget Cuts Imperil Mental Health Units (B1)
Free Press	8/05/80	Mental Health Cuts Will Hurt, Says Chief (A3) #
State Journal	8/10/80	Care Aides 'Afraid for Their Lives' (B1) #
Detroit News	8/12/80	Homes Lose License (BW2)
Detroit News	8/14/80	'Incompetency' Voids Marriage (B8)
Detroit News	8/21/80	More Housing Sought for Retarded (BE11)
State Journal	8/24/80	Missing Reports Cloud Details of 10 Deaths (B1)
Detroit News	9/12/80	Mental Health Dollars Sought (A10)
State Journal	9/14/80	MSU Med Chief Joins Probe (B1)
Detroit News	9/23/80	Probe Brings Firing (BW2)
Detroit News	9/24/80	State Warns of Threat to Retarded (BDE2)
State Journal	10/03/80	Mental Health Cuts Set
Detroit News	10/09/80	Judge Dismisses Lawsuit (BD19)
State Journal	10/12/80	Hillcrest Report Said Incomplete
Free Press	10/13/80	Injuries Up at Mental Institutions (A3) #
State Journal	10/14/80	Mental Health Faces Another Cut #
State Journal	10/14/80	Cutbacks Increase Danger (B5)
State Journal	10/16/80	'Fiddling' to Davis, Service to Nash #
Detroit News	10/26/80	Mom Sues to Sterilize Daughter (B4)
Detroit News	10/26/80	Scanner Provides Peek Inside Brain (B5)*
Detroit News	10/28/80	Hearing on Sterilization (BD2)
Detroit News	10/30/80	Court Ruling Due on Sterilization Plea (BN2)
Detroit News	11/03/80	Home for Handicapped Torched (BN4)
Detroit News	11/04/80	Home's Torching Shocks Neighbors (A1)
Detroit News	11/05/80	Arsonists Were Meticulous (B8)
Detroit News	11/07/80	Buzz and Jean's Love Can't Beat the Courts (A1)
Free Press	11/07/80	Lafayette Clinic Seeks Old Luster (C1)*
Detroit News	11/13/80	Milliken Seeks Another Big Slash in Spending (A1)
Detroit News	11/16/80	A Mixed Welcome: Group Homes Slowly Blend Into Community (A1)
Detroit News	11/23/80	Wonder Woman: She Works Magic With Retarded (B1)
Detroit News	11/23/80	Ed: Unfounded Fears
Detroit News	12/05/80	Fire Hits Home Slated for Retarded Adults (BDN2)
Detroit News	12/06/80	FBI to Investigate Fire At Home for Retarded (B1)
Detroit News	12/09/80	Ruling Delays Group Home (B5)
Detroit News	12/10/80	Tough Blow to Retarded (B1)
Detroit News	12/11/80	Mental Health Cuts Force Layoffs (B13)
Detroit News	12/13/80	Ideas On Setting Up Homes for Retarded (A3)
Detroit News	12/18/80	Gifts of Love Cheer Handicapped (B7)
Detroit News	12/21/80	Group Home Faces Suit By Dearborn
State Journal	12/28/80	States Belt Tightening Will Squeeze Everyone (B1) #

State Journal	1/02/81	1,500 Mental Health Layoffs Rescinded (A1)
Detroit News	1/03/81	Mental Health Layoffs Are Canceled (D8)
Detroit News	1/05/81	Mental Health Staff Cut Is Retained By State (BD2)
Detroit News	1/08/81	Home for Retarded Gains (B4)
Detroit News	1/10/81	Group Homes for Mentally Ill Face Hard Fight (A1)
Detroit News	1/16/81	Health Unit Cuts Raise New Fears (A1)
State Journal	1/18/81	Mental Health System Slammed (B1)
Free Press	1/26/81	Strange Behavior, But No Recourse (A1)
State Journal	1/26/81	Hillcrest Probe Offers Institutional Reforms (B1)
Detroit News	1/27/81	No Negligence Found At Center (C18)
State Journal	1/28/81	Economic Woes Force Hospital Closing #
Detroit News	1/30/81	Agency Transfers Spur Talk On Future of Chief (BW2)
Detroit News	2/01/81	Ochberg Asks Inquiry In Files' Use (B2)
Detroit News	2/03/81	Cuts Peril Mental Facilities (B1)* #
Detroit News	2/05/81	Audit Adds Fire to State Debate on the Retarded (B1)
Detroit News	2/06/81	Center Director Beaten (BD2)
Detroit News	2/06/81	Court Upholds Mental Hospital Layoffs (B5)
Detroit News	2/06/81	Pact Near on Cuts at Plymouth (B1)
Free Press	2/08/81	On the Boulevard, Empty Days of Despair (A1)
Free Press	2/09/81	State Mix-Ups Can Be Fatal to Residents (A1)
Free Press	2/10/81	Shots, Fires Greet Retarded at New Home
Detroit News	2/12/81	Center Agrees to Staff Cuts (B3)
Detroit News	2/13/81	Hypnotized Against Her Will, State Aide Says (B1)
Detroit News	2/13/81	More Layoff Suits Possible (BEO2)
Detroit News	2/18/81	Suburb Plans Fight On Home for Retarded (E3)
Free Press	2/23/81	Judging Insanity: A Maddening Dilemma (A3)
State Journal	2/24/81	Ochberg Urges Business Help
State Journal	3/09/81	Mental Patient Probed in 2 Rapes (A1)
Detroit News	3/15/81	State Agrees to Costly Lease for Foster Home (B3)
Detroit News	3/19/81	Budget Slashes Worsen Woes of Psychiatric Care (B1)
Detroit News	3/20/81	More Mental Health Layoffs Assailed (BDW2)
Detroit News	3/23/81	Do Mentally Ill have Role In Society? (A1)
Detroit News	3/23/81	She Spent 10 Years in Mental 'Prisons' (A1)
Detroit News	3/24/81	Ailing Health Care: Clinic State Layoffs Shortchange the Mentally Ill (B1)
Detroit News	3/25/81	Counties Lack Facilities to Handle Hospital Exodus
Detroit News	3/25/81	Trying to Find His Way Back (E12)
Detroit News	3/27/81	Foster Care Home Leases Face Inquiry (B1)
State Journal	3/27/81	Mental Health Budget Still in Air
Detroit News	4/02/81	Group Home Foes Lose (BD2)
Detroit News	4/02/81	State Faces Encounter With Volatile Situation (C20)
Detroit News	4/15/81	Mental Health Shift Criticized (B9)
Detroit News	4/16/81	Challenges Rise Against Group Homes (B1)
Detroit News	4/21/81	Court Limits Rights of Retarded (A4)
Detroit News	4/22/81	Court Puts Limits on Retarded (A1)
Detroit News	4/22/81	Home's Owners May Sue (B1)
Detroit News	4/23/81	Study Reports Jails Hold Mentally Ill (B1)
Detroit News	4/30/81	State Justice Urges Treatment, Not Jail for the Mentally Ill (BOD14)
Detroit News	4/30/81	Unusual Heroine: Group Home Resident Saves Man's Life (B1)



Detroit News	5/06/81	Hearing Set on Layoffs, Job Shifts of 11 Blacks (BD2)
Free Press	5/06/81	Cuts in Mental Health Peril Richards' Liberty (A3)
Detroit News	5/10/81	Suit Spurs Inquiry Into Foster Homes (B5)
Detroit News	6/04/81	Retarded Tot's Parents Also Learn to Cope (B4)
Detroit News	6/08/81	Group Home Ordered Closed (BNO2)
Detroit News	6/11/81	Sinai Psychiatric Unit: Stereotype Smasher (A1)
Detroit News	6/11/81	State Audit Report to Cite Waste (B1)
Detroit News	6/12/81	Legislators Seek Foster Home Quiz (B1)
Free Press	6/18/81	Road to Mental Health is Tough on Women (C1)
Detroit News	6/19/81	Psychiatrist Ordered to Pay \$500,000 (B1)
Detroit News	6/24/81	Ed: Cashing in on Group Homes (A12)
Detroit News	6/24/81	'I'm Not Scared Anymore' (G1)
Detroit News	6/26/81	Community Placement Zeroed (All)
Detroit News	7/13/81	Jobs Set Up for Impaired (B1)
Detroit News	7/17/81	Ochberg's Expenses Questioned (B1)
Detroit News	7/18/81	Ochberg Disputes Criticism That He Travels Too Much (B2)
Detroit News	7/22/81	Mental Health Director Quits Under Pressure (A1)
Detroit News	7/23/81	Legislator Wants Babcock for Post (B2)
Free Press	7/23/81	Ochberg: He moved mental care in directions the state should continue to pursue
Detroit News	7/24/81	Dr. Ochberg's Departure
Detroit News	7/24/81	State Pay Deal For Ochberg Stirs Legislator's Ire (BW2)
Detroit News	7/25/81	Audit Lists Placement Home Waste (B3)
Detroit News	7/26/81	Audit Cites Mental Staff Travel Costs (B1)
Detroit News	7/29/81	Ochberg to Repay Money to the State (B20)
Free Press	8/02/81	Help is Hard to Find (D1)
Detroit News	8/03/81	New Chief Backs Group Home Policy (A3)
Detroit News	8/03/81	Ochberg Out, Group Homes Stay
Detroit News	8/04/81	New Mental Health Chief Appoints 3 (BW6)
State Journal	8/05/81	Directors Promise an End to Abuses
Detroit News	8/06/81	Judge Voids Group Home Lease (BD5)
Detroit News	8/06/81	Placements of Patients Win Support
State Journal	8/06/81	Area Mental Health Board to Ask for \$16.5 Million
State Journal	8/06/81	Audit Finds Problems at Center (B8)
Detroit News	8/09/81	Groups Say Mind Drugs Kill Patients (B1)
Detroit News	8/11/81	Size Bars Home for Retarded (A1)
Detroit News	8/14/81	Judge Bars Homes for 'Mentally Ill' (A3)
Detroit News	8/17/81	3 Target of Ethics Inquiry (A3)
Detroit News	8/20/81	120 Died in State Hospitals in '80 (BE14)
Detroit News	8/21/81	Boss Doubts High Mental Death Rate (A3)
Free Press	9/11/81	Separate Agency Urged to Oversee All Group Homes (A1)
State Journal	9/13/81	State Firms Mental Care Rule (A1)
Detroit News	9/14/81	Paper Reports Doctor Quit in Hospital Deaths (BW6)
Detroit News	9/15/81	Mental Unit in Trouble, Official Says (A3)
State Journal	9/15/81	He Won't Walk in Ochberg's Shoes
State Journal	9/15/81	Hillcrest Awaited Bad News
Free Press	9/16/81	Group Home Issue: A Case in Point (A3)
Detroit News	9/22/81	Parent's Sue in Son's Baffling Death (A3)

Detroit News	9/22/81	Woman Battles for Job: She Says 2 Home Patients Got Drug Overdoses (A3)
Detroit News	9/23/81	No Charges Are Expected in Mental Patient's Death (BW14)
Detroit News	9/25/81	State Fails to Relocate 216 Plymouth Patients
State Journal	9/28/81	Ex-Patient Will 'Star' at Coldwater (A1)
Detroit News	9/29/81	Parents Sue in Northville Death (A18)
State Journal	10/04/81	Mental Health Sends Budget Warning (B1)*
Detroit News	10/07/81	3 Hospital Deaths Bring Reprimand (BW6)
Detroit News	10/13/81	Mental Health Chief Pleads for Bigger Budget (BD8)
Detroit News	10/14/81	Group Homes Fight Lost by Township (A3)
Free Press	10/14/81	Group Care Homes Win Lawsuit on Zoning
Detroit News	10/18/81	A Rewarded Job for Caring People (B7)
Detroit News	10/29/81	Senate Confirms Walker as Director of Public Health (C18)
Detroit News	11/08/81	Retarded Folks Get Home Outside Hospital (BE8)
Free Press	11/10/81	Young, Black Lives ... Forever Lost (B1)
Detroit News	11/25/81	Tears and Triumph in Jamie's World (B1)
Detroit News	12/07/81	A 'Normal' World is a Faraway Place (C1)

Detroit News	1/03/82	Mom, Child Separate After 60 Caring Years (B1)
Detroit News	2/03/82	Many State Mental Care Units Lack Accreditation (AD12)
Detroit News	2/10/82	Retarded Child May Aid a Marriage, Study Finds (F4)
Detroit News	2/27/82	Judge Rules Psychiatrist Killer Insane (A5)
Free Press	2/28/82	Michigan Mental Care 'On Ledge', Chief Says (A3)
Free Press	3/04/82	Breaking Point: A Bare Minimum Isn't Enough for Mental Care
Detroit News	3/08/82	Milliken's 'Liberal' Sticks With His Beliefs (A3)
Detroit News	3/12/82	Talk Cites Boy's Plight in Bid to Keep Services
State Journal	3/19/82	Laws Delay Help for Mentally Ill (B3)
Detroit News	3/20/82	Ruling Blocks Canton Homes for Mentally Ill (A5)
State Journal	3/24/82	Is Placement Really A Bail Out? (D1)
Detroit News	4/11/82	The New Neighbors (MAG12)
State Journal	4/15/82	Community Placement Plan Saving Mental Health Funds
Detroit News	4/28/82	Training Program Serves Special Needs (ED6)
Detroit News	4/30/82	Arson Hits House Planned for Retarded (A3)
Detroit News	5/04/82	Bill's Got a Good Life Now (A1)
Detroit News	5/04/82	Treating Schizophrenia 'Bargain Basement' Way (A17)
Detroit News	5/05/82	The Mentally Ill Are Dispossessed (A15)
Detroit News	5/07/82	Handicapped Yes; Retarded, No (A15)
State Journal	5/09/82	Gentle Justice Goal for Patients' Voice (D1)
Detroit News	5/12/82	Women Sue State Over Layoffs (C2)
Detroit News	5/13/82	Victims of the System (A19)
State Journal	5/16/82	Groups Fight 'Mental Patient' Tag (D1)
Detroit News	5/19/82	The Retarded Child: Acceptance First, Then a Terrible Decision: Home or Institution Care (F1)
Detroit News	5/21/82	State Budget Cuts Hit Schools, Cities (A1)
State Journal	6/02/82	Mental Health Code Complaints Aired (B5)
Detroit News	6/05/82	God's Children: 'Love is the Message We Want to Teach Them' (A17)
Detroit News	6/10/82	Official Links Cuts to Northville Woes (BW15)
Detroit News	6/11/82	Woman Wins Sex Bias Suit (A8)
Free Press	6/11/82	Judge Blocks Men Only Job at Mental Unit (A3)
Free Press	6/11/82	Mental Health Workers Decry Layoffs (A3)*
Detroit News	6/17/82	Should the Insanity Plea As a Defense Be Abolished? (A19)
Detroit News	6/19/82	High Court Boosts Rights of Retarded (A1)
Free Press	6/20/82	Michigan's Insanity Verdict Under Fire (A3)
Detroit News	6/22/82	'Bumping' Will Hold Up State Layoffs (A3)
Detroit News	6/22/82	Mentally Ill Get New Friends (A13)
Detroit News	6/27/82	U.S. Constitution Now Embraces the Retarded (A13)
Detroit News	8/05/82	Mental Health Cuts Take Toll (BW14)
Detroit News	8/06/82	U.S. Could Cut Funds for Mentally Disabled (A3)
State Journal	8/06/82	New DMH Placement Airing No Threat, Babcock Insists (B4)
State Journal	8/06/82	Mentally Handicapped Face Cuts (B4)
State Journal	8/10/82	All Hillcrest Residents in New Homes (B3)
Detroit News	8/18/82	Milliken Maps Bid to Save Hospital (BN6)
Free Press	8/18/82	Aid Sought for Mental Care Centers
Detroit News	8/24/82	Study Rips Mental Health Cuts (BD10)

State Journal	8/24/82	Mental Care Worsening
Detroit News	8/26/82	Northville's Unsolved Worry (DW1)
Detroit News	8/26/82	Fight Erupts Over Mental Health Job
State Journal	8/26/82	Hundreds Plead for More Mental Health Funds (B1)
Detroit News	8/27/82	Mentally Ill Not Forgotten (A13)
Free Press	8/29/82	Kids in Depression from Chemicals in Brain Get Some Help*
Free Press	8/29/82	Self-Esteem Grows Along With the Flowers and Vegetables (F3)
Detroit News	9/01/82	500 Mental Patients Protest Budget Cuts (BW6)
State Journal	9/01/82	Mental Health Cuts Protested (B1)
Detroit News	9/06/82	Ex-Mental Patients Aid Others (A1)
Detroit News	9/10/82	Reforms Sought in 'Room and Board' Homes
Detroit News	9/13/82	Mental Laws Assailed in Slaying Case (BW4)
Detroit News	9/30/82	Suit Seeks Higher Pay for Mental Hospital Aides (BW5)
Detroit News	10/07/82	Rehiring is Upheld on Appeal (BW4)
State Journal	10/14/82	Hillcrest Center Awaits Buyer
State Journal	11/07/82	Hospital Deaths Puzzling (B1)*
Detroit News	12/08/82	Relatives, Friends of the Mentally Ill Need Caring, Too (D1)
Detroit News	12/17/82	Milliken Orders 40-Point Plan in Drive to Help State's Needy (A1)
Detroit News	12/17/82	U.S. Probes Hospital At Northville (A3)
Free Press	12/18/82	U.S. to Check How Patients are Treated at Northville (A3)

State Journal	1/02/83	Abbott Offers Mentally Ill a Chance at Life (B1)
Free Press	1/10/83	A Mind Lost In the Maze (A1)
Free Press	1/10/83	Whose Fault? Enough Blame for Everyone (A1)
Free Press	1/11/83	Mental Patient's Death Ruled Accidental (A3)
Free Press	1/12/83	Ed: Mental Code: Somehow the System Failed Beuford Walton and His Family (A8)
Free Press	1/12/83	Retarded Or Not? Man Can Sue State (A3)
Detroit News	1/23/83	Ex-Legislator Named to State Post (BD5)
Detroit News	1/25/83	Hypocrites and the Homeless (A17)
Free Press	1/26/83	Simmons Hired for State Job at \$53,500 (A3)
Free Press	1/28/83	Ed: Insanity Plea: Even Psychiatrists Find Flaws in the System (A6)
Free Press	1/31/83	Too Much Mothering? She Did Everything for Jimmy, But Now She's Gone (A3)
Detroit News	2/02/83	Planned Mental Health Cuts Draw Fire (CD7)
Detroit News	2/03/83	Cuts in Mental Health Assailed (CD5)*
Detroit News	2/08/83	Babcock Stays As Mental Health Chief - It's His 4th Agency (B6)
Detroit News	2/14/83	The Case Against 'Guilty But Ill' (A11)
State Journal	2/15/83	Mental Health Cuts Held Down
Detroit News	2/24/83	State's Mental Health Program is in Bad Shape (B8)
Detroit News	3/05/83	'Group Homes' Pose Dilemma (A3)
Detroit News	3/06/83	Last Chance Family - Love For Disabled (E1)
Detroit News	3/10/83	Patients Find Special Friend (BN1)
Detroit News	3/14/83	Fire Kills 5 in Foster Care Home (A1)
Detroit News	3/15/83	Dead Teen Drugged, Kin Charge (A3)
Detroit News	3/17/83	Mother Asks Probe of Juvenile Center (A3)
Detroit News	3/20/83	Deaths Don't Reflect on Center - State Aide (B5)
Detroit News	3/23/83	Group Can Point With Pride Over Its Help For The Retarded (GD6)
Free Press	3/23/83	Long on Patience: Her Job is Teaching the Mentally Handicapped (A3)
Detroit News	3/27/83	Abuse, Neglect and Death: A Mental Hospital's Struggle (A1)
Detroit News	3/27/83	Body Parts Taken Without Approval (A4)
Detroit News	3/27/83	Hospital Staffers Also Are Victims (A4)
Free Press	3/27/83	Ed: Mental Care: Patients Pay Severe Price for Cutbacks (B2)
Detroit News	3/28/83	Hospital, Families At Odds Over 'Unexplained' Deaths (A1)
Detroit News	3/29/83	Rapes, Assaults on Patients Rarely End in Prosecution (A1)
Detroit News	3/30/83	Did Misuse of Drugs Cause Deaths? (A1)
Free Press	3/30/83	'Mentally Ill' Plea Not Working (A1)
Detroit News	3/31/83	Foreign Doctors Get Blame for Northville Culture Gap (A1)
Detroit News	3/31/83	Lawmakers Clear Blanchard's Cuts (A1)
Detroit News	4/03/83	State Offers 4-Point Plan for Northville (B1)
Free Press	4/05/83	Plan Would Bolster Mental Health (B4)
Detroit News	4/07/83	Benefit Cuts Hit Mentally Ill (A9)
Free Press	4/22/83	Resolving Troubled Fates (A1)

Detroit News	4/26/83	Journalists Spotlighting Misery of Mentally Ill (A17)
State Journal	5/01/83	Waiting for 'Sore' Leads to Suicides?
Free Press	5/02/83	Despair Takes Its Toll: 11 Suicides in Four Days (A3)
Free Press	5/03/83	LSD: A Help For the Mentally Ill? (A1)
Detroit News	5/05/83	New Hope for Mental Patients (BN1)
Detroit News	5/15/83	Lawyers Still Rely on Insanity Plea (A3)
Detroit News	5/22/83	Group Points Proudly to Its Help for the Retarded (HN6)
Free Press	5/23/83	To Have or Have Not As Witnesses for Insanity Defense (A3)
Detroit News	5/25/83	Ed: Deinstitutionalization, Part II (A10)
State Journal	6/03/83	State Joins Disability Benefits Battle
Detroit News	6/06/83	Indecision: Debate Delays Plymouth Center Shutdown (A3)
Detroit News	6/10/83	Group Home Septic Failure Stirs Alarm (AD12)
Free Press	6/10/83	Ed: Mental Health: Funding Cuts Cripple Promising Program (A10)
Detroit News	6/12/83	State Plans More Cash for Northville (A3)
Detroit News	6/15/83	Panel Shapes Bill on Mental Care (BE7)
Detroit News	6/22/83	Plymouth Center Plan Called For By July 1 (BD7)
Detroit News	6/22/83	State Withholds County's Revenue-Sharing Money (BD7)
State Journal	6/26/83	Hillcrest Center Now in Shambles
Detroit News	7/14/83	Plymouth Center in Last Days (FW1)
State Journal	7/24/83	Cut Price Sought For Hillcrest (B3)
State Journal	7/29/83	Relocation Plan Delayed by Mental Health Board
State Journal	7/31/83	Mental Health Director Plans Few Midnight Staff Meetings (B2)
Detroit News	8/04/83	Teacher Begins Firm for Students (GE1)
Free Press	8/11/83	"I Think I Need Help, But..." (B1)
Detroit News	8/23/83	Comp Case Insanity Plea Denied (BD6)
State Journal	8/25/83	Judge Denies Union Bid For Layoff Block (B2)
Detroit News	8/28/83	Psychologists Laud Heroine of Battle for Retarded Kids (A1)
Detroit News	9/01/83	County Agency Moves to Northville (BW2)
Detroit News	9/08/83	Plymouth Center to Remain Open (ED2)
Free Press	9/17/83	Ed: At Home: Retarded Persons Have Another Reason to Hope for More Useful Lives (A6)
State Journal	9/18/83	Babcock Moves to Protect Patients (B8)
State Journal	9/18/83	Probe May Provide Clues to Mental Patients Deaths (B1)
State Journal	9/25/83	Stabenow Would Bolster Mental Health Aid to Kids (B1)
Detroit News	9/29/83	Sexual Assault Revives Group Homes Dispute (A3)
Detroit News	9/29/83	Somebody Cares: Volunteer Honored, But wants More for Mental Patients (EE2)
Detroit News	10/01/83	Rape Prompts Study of Policy at Group Homes (A2)
State Journal	10/02/83	Mental Health Boss Optimistic (B3)
Detroit News	10/04/83	Retarded Man Faces Sex Case Trial (AN14)
Detroit News	10/05/83	Ed: Mental Health Mistakes (A10)
Free Press	11/08/83	Mental State is a Key in Kidnap Trial
Detroit News	11/05/83	Appeals Court Upholds Benefits for Mentally Ill (C14)
Detroit News	11/17/83	Attack Spurs Care Home Talks (BN1)
Detroit News	11/23/83	Right to Life With Dignity (A11)

Detroit News	11/25/83	'Decade of the Disabled': Mental Hospital 'Graduate' Pursues A Dream (A3)
Detroit News	11/30/83	Kelly and Friends ... A Love Story (D1)
State Journal	12/01/83	Newberry Center Seeks Owner (B7)
Detroit News	12/15/83	New Clinic Offers Mental Health (ED1)*
Detroit News	12/16/83	Law Will Subsidize Handicapped Kept Home (B6)
Detroit News	12/20/83	Ypsilanti Hospital Probe Set (A3)
Detroit News	12/22/83	Pets Offer Therapy to Old, Ill (EW1)
Detroit News	12/23/83	Split Over Allen Park Group Home Widens (BD3)

\* This article mentions Lafayette Clinic

# This article mentions Michigan Institute for Mental Health

## MICHIGAN MENTAL HEALTH CHRONOLOGY

- 1832 Wayne County General Hospital (Eloise, Walter A. Reuther) opens as Wayne County "Pest House" for cholera victims.
- 1834 Wayne County establishes the first Board of Superintendents for the Poor, converting the Pest House to a Poorhouse accepting "lunatic persons".
- 1841 Wayne County Poorhouse receives the first person in Michigan adjudged legally insane.
- 1848 The Michigan legislature provides for establishment of a state asylum for the insane. However, no money is appropriated.
- 1859 Michigan Asylum for the Insane in Kalamazoo (Kalamazoo Regional Psychiatric Hospital) accepts its first patients.
- 1873 The Michigan legislature appropriates money for the Eastern Michigan Asylum (Clinton Valley Center) at Pontiac.
- 1878 Eastern Michigan Asylum opens with a bed capacity of 400.
- 1881 The legislature approves Northern Michigan Asylum (Traverse City Regional Psychiatric Hospital).
- 1883 Legislature authorizes establishment of a facility for violent criminals and sexual offenders.
- 1885 Sept. Michigan Asylum for Insane Criminals (Ionia State Hospital) opens.
- 1885 Nov. Northern Michigan Asylum opens with its first 445 patients.
- 1895 The first facility for "feeble-minded and epileptic" (Oakdale Center for Developmental Disabilities, Lapeer) opens.
- 1895 Nov. Upper Peninsula Asylum for Insane (Newberry Regional Mental Health Center) opens in Traverse City.



- 1906 State Psychopathic Hospital at the University of Michigan (Ann Arbor Neuropsychiatric Institute) is established. Michigan becomes the first state to provide special facilities for instruction of medical students in treating the mentally ill.
- 1906 Mechanical restraints are abolished in state facilities.
- 1911 Legislation changes the names of asylums to state hospitals.
- 1914 Michigan Farm Colony for Epileptics is established in Wahjamega (Caro Regional Center).
- 1916 Three Michigan outpatient clinics are established.
- 1920 County Departments of Social Services are developed.
- 1923 The first State Hospital Commission, an advisory board, is authorized within the Welfare Department. Public Act 151 attempts to consolidate the mental health care system and laws organizing state hospitals.
- 1929 The Hartmann Act provides \$19,517,200 for hospital construction during the next four years.
- 1931 Construction program is reviewed and funds cut.  
Ypsilanti State Hospital (Ypsilanti Regional Psychiatric Hospital) opens.
- 1933 Hartmann Act repealed; construction stops.
- 1935 Coldwater State Home and Training School (Coldwater Regional Center for Developmental Disabilities) opens.
- 1937 Public Act 104 separates the State Hospital Commission from the State Welfare Department. A Central Office with authority for operating state hospitals is established in 1937, November. Joseph E. Barrett, M.D. is appointed the first Director of State Hospitals.

- 1938 Federal Public Works Administration grants are made available for hospital construction.
- 1939 A change in statutes abolishes the position of  
Mar. Director of State Hospitals and creates that of Executive Secretary, to which Charles F. Wagg is appointed.
- A central department to direct the state mental health program is developed.
- 1941 Michigan Writer's Project is sponsored by the State Administrative Board and the Federal Works Project Administration.
- 1945 Act 271 abolishes the State Hospital Commission  
Sept. and establishes a Department of Mental Health (DMH) which must be headed by a psychiatrist.
- 1946 The U.S. Congress passes the National Mental Health Act and offers federal assistance in supporting community services, research and training of mental health professionals.
- 1946 Charles A. Zeller, M.D. becomes Mental Health  
Mar. Director.
- 1947 Charles F. Wagg is appointed Acting DMH  
July Director.
- 1948 R.L. Dixon, M.D. Superintendent of the Caro  
Jan. State Hospital is appointed Acting DMH Director while continuing to serve as facility Administrator.
- 1949 Charles F. Wagg is again appointed DMH Director  
June after the legislature changes statutes governing qualifications.
- 1950 DMH Director Wagg presents the legislature with a comprehensive plan for expanding facilities by more than 14,000 beds during the next ten years.
- 1952 Northville State Hospital (Northville Regional Psychiatric Hospital) opens.
- 1954 Act 217 establishes Lafayette Clinic as a combined psychiatric hospital and research facility.
- 1955 Lafayette Clinic opens. Jacques Gottlieb, M.D.,

is appointed Director.

Nationwide, state hospital populations reach their peak. U.S. Congress passes the Mental Health Study Act which forms a Joint Commission on Mental Illness and Mental Health.

Psychotropic drugs are introduced for the first time on a large scale basis.

1956 Hawthorn Center, Northville is completed. The legislature appropriates funds for the Plymouth State Home and Training School, Northville (Plymouth Center for Human Development).

Seventeen children's and five adult community mental health clinics serve approximately 8,000 persons state-wide.

1959 A Citizen's Mental Health Inquiry Board is  
Jan. appointed to investigate charges of abuse of patients in the State's mental institutions.

1960 Plymouth Center officially opens with 1,000  
beds. Alpine Regional Center for Developmental Disabilities, Gaylord, opens.

1960 The final report of the Citizen's Mental Health  
Dec. Inquiry Board is submitted, recommending centralization of DMH administration. The Federal Joint Commission on Mental Illness releases the findings of its six-year study and calls for greater utilization of community programs.

1963 President John F. Kennedy calls for a more  
Feb. comprehensive, community-based approach to the care of the mentally disabled. The U.S. Congress passes the Mental Retardation Facilities and Community Mental Health Centers Construction Act (P.L. 88-164) which creates a funding mechanism for community mental health centers.

1963 The Michigan legislature passes the Community  
Mental Health Services Act (P.A. 54) which provides for development of community mental health boards as agencies of county government, responsible for developing local mental health services and funded on a 75% state, 25% local matching basis.

- 1964 Robert A. Kimmich, M.D. is appointed DMH Director.
- \$1.5 million is appropriated to the five established community mental health boards.
- 1965 DMH is granted National Institute of Mental Health funds for comprehensive mental health planning. Two reports "Michigan State Plan for Construction of Community Mental Health Facilities" and "The Development of a Comprehensive Mental Health Program in Michigan" are developed in collaboration with the Department of Health.
- 1966 Vernon Stehman, M.D. is appointed Acting DMH Director.
- Legislation is adopted to establish a center for forensic psychiatry.
- 1967 A House committee recommends gradual phase-out of Ionia State Hospital and treatment of criminally insane patients at other state agencies.
- William Anderson, M.D. is appointed DMH Director.
- 1967 Aug. A comprehensive State Health Planning Commission is created by Executive Order to serve as the official state long-range health planning agency, under the federal Partnership for Health legislation. It is chaired by the Director of the Department of Public Health, with the DMH Director as a member.
- 1967 Sept. The first state mental health plan is filed in compliance with Section 314(d) of P.L. 89-749.
- 1967 Oct. Departments of Corrections and Mental Health officials request permission to build a joint facility at Ypsilanti for the criminally insane.
- 1968 May Michigan State Employee's Union holds a meeting in Pontiac where the decision is made to set the Department of Mental Health as a target for union organization, with Pontiac to be the first facility struck.

- 1968  
May 10 "The Department is under constantly increasing pressure to complete its transition to the PPB system. Governor Romney has told his department heads that he considers them to be responsible for the efficiency of their agencies and that he believes PPB gives them both the means and the authority to carry out this responsibility" (Minutes of Superintendent's meeting).
- 1968 DMH Director, William Anderson, M.D. submits to Governor William G. Milliken recommendations for a major legislative program that would rewrite Michigan's mental health laws.
- 1969  
May The Mental Health Program and State Review Commission is established by Executive Order.
- 1970 E. Gordon Yudashkin, M.D. is appointed DMH Director and establishes deinstitutionalization as a DMH program goal.
- 1972  
Mar. Mental Health Program and State Review Commission submits its report to the Governor, including an integrated mental health code.
- 1973 Act 194 Michigan's Mandatory Special Education Law is passed.
- 1973 The Special Senate Committee to Study and Investigate the Programs and Policies of the Department of Mental Health is established by SR 353.
- Psychosurgery concerning patients at Lafayette Clinic becomes a media issue.
- 1973 The Social Security Act establishes provisions for Medicaid reimbursement to states for developmentally disabled patients residing in state institutions.
- 1974  
Feb. The Office of Health and Medical Affairs issues a report, "Community Placement Program, an Examination of the Process and Outcomes of Community Placement of Adults and Children from Mental Health Institutions in Michigan."
- 1974  
June Dr. E. Gordon Yudashkin resigns under fire and Donald C. Smith, M.D. is appointed Acting DMH Director.

- 1974 Aug. The State Legislature passes Act 258, "The Mental Health Code," which is signed into law by Governor William G. Milliken. Chapters 4, 5 and 8 concerning admissions and discharges take effect November 6.
- 1974 Oct. David A. Ethridge, M.D. is appointed Ionia Riverside Superintendent after serving as Chief, DMH Bureau of Operational Planning.
- 1974 Michigan's Adult Foster Care Licensing Act is passed.
- 1975 Aug. The majority of Public Act 258 of 1974 goes into effect.
- 1975 Michigan's 1975-76 Fiscal Year is extended from June 30, 1975 to September 30, 1976 to create a 15-month budget year.
- 1976 DMH publishes the first "Michigan State Plan for Comprehensive Mental Health Services", an HEW requirement under P.L. 94-63, for awarding grant monies to states.
- 1976 Aug. Regionalization of the mental health system occurs through the 1976 DMH reorganization plan. The first two Regional Directors are appointed by Dr. Donald C. Smith.
- 1976 A Staffing Needs Assessment Process (SNAP) is established by DMH to provide objective standards for comparing facility staffing levels. DMH issues Program Policy Guidelines (PPG) to be used in formulating service requirements for the 1977-78 Fiscal Year.
- 1976 First year Medicaid payments for Michigan institutional services for the developmentally disabled reach \$80 million.
- 1977 Mar. The first patients are admitted to the New Riverside Center, Dimondale (Michigan Institute for Mental Health).
- 1977 June Final regulations for Medicaid Intermediate Care Facilities for the Mentally Retarded (ICF/MR) payments to states go into effect.
- 1977 Macomb-Oakland Regional Center is opened.

- 1977  
Nov. Oakdale Center for the Developmentally Disabled, Lapeer comes under investigation regarding allegations of patient abuse. Several staff are fired.
- 1977 The requirement that hospital superintendents be physicians is eliminated.
- 1978 Vern Stehman, M.D. is appointed Acting DMH Director.
- 1978  
Feb. Allegations of abuse surface at Plymouth Center for Human Development. The Detroit Free Press  
Mar. begins a series of exposes of the Center. Dr. Vern Stehman resigns.
- 1978 Michigan Institute for Mental Health (MIMH) receives one year JCAH accreditation. Lafayette Clinic receives two year accreditation.
- 1979  
Jan. In his State of the State message, Governor Milliken appoints a committee, chaired by Acting DMH Director Stehman, to study unification of the public mental health system stating, "The Michigan Mental Health code provides for the delivery of service through two separately administered systems at the state and county level, but requires that the Department of Mental Health coordinate and integrate these two systems."
- 1979 Frank Ochberg, M.D. is appointed DMH Director. Community homes in the Detroit area are under considerable fire.
- DMH initiates a System Assessment Scheme, Service Objective Matrix to assist providers in analyzing their mix of service elements so that state-wide planning can be based on local information.
- DSS relinquishes responsibility for home finding. DMH does not receive legislative funding to pick up this function.
- 1979 St. Clair, Alger-Marquette, Washtenaw and Kent county community mental health boards are chosen to participate in a pilot study as "full management boards" responsible for caring for all county residents in need (regardless of their placement) through a lump sum grant of

annual operating funds. In pilot counties money is no longer directly appropriated to state institutions.

- 1979 Plymouth Center is ordered closed by the court.  
Aug.
- 1979 MIMH receives two year JCAH accreditation.  
Oct.
- 1980 Samuel Gershon, M.D. is selected as Lafayette  
Jan. Clinic Director.
- 1980 The Governor's Committee on Unification of the  
Public Mental Health System presents its final  
report and recommendations.
- 1980 DMH Director Frank Ochberg, M.D. proposes  
"domiciliary care" because of increasing budget  
cutbacks.
- 1980 Dr. Ochberg resigns as DMH Director.  
July
- 1980 Governor William Milliken orders Michigan  
Oct. Institute closed during a televised budget  
address.
- 1981 The Global Assessment Scale is selected as a  
Mar. Departmental tool for classifying clients  
needing services.
- 1981 Michigan Institute for Mental Health is closed.  
Apr.
- 1981 An Auditor General report of the Department of  
Mental Health finds evidence of mismanagement  
and possible fraud in the community placement  
program.
- 1981 A legislative committee is established to  
investigate allegations of improper management  
and misspent monies within the Department of  
Mental Health. The Governor appoints an  
Interagency Council to work with the committee  
in response to the legislative inquiry.
- 1981 C. Patrick Babcock is appointed DMH Director.  
Sept.
- 1982 The Regional Director system is discontinued.



- 1983      The Family Support Subsidy Act, an entitlement program for families of developmentally disabled children cared for at home, amends the Mental Health Code.
- 1984      The State Legislature amends the Mental Health Code to include a separate chapter 4A for mentally ill minors, adding protections and defining suitability for hospitalization.
- 1984      Within the state there are a total of 55 community mental health boards and 25 state hospitals, divided into six geographic regions. Twenty five of the CMH boards are full management.

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