A Community Mental Health Project in New York State

CATHERINE COVERT STEPANEK and CHARLES V. WILLIE, Ph.D.

THE Onondaga County Board of Supervisors in 1955 established the community's first mental health board. Set up under New York State's pioneer Community Mental Health Services Act of 1954, the new board was authorized to coordinate existing mental health services and to develop a comprehensive mental health program for the community as a whole. Financing was to come half from the county and half from the State.

Members of the professional community, the social and health agencies, the major religious groups, and the interested public greeted the county supervisors' action as a major step toward an effective county mental health program.

Four years later, many of the professionals in the county mental health clinics had resigned. Stripped of its personnel, the county child guidance center announced that it would close. The directors of that clinic and of the adult clinic had resigned, although the adult clinic was able to remain open. Members of the county mental health board and the county supervisors had disagreed on the issue of autonomy for the mental health board. By November 7, 1959, shortly before election day, only concessions by the supervisors forestalled the mass resignation of the county mental health board.

Several other New York counties which embarked on mental health programs have experienced comparable difficulties (*1*). Factors in the law, in the county system of government, and in the actions of community groups are discussed below with reference to these events.

Community Background

Onondaga County, in central New York State, has a population of 422,206, including Syracuse, with 215,291 inhabitants, engaged mainly in industry and commerce. Syracuse has a major university and a small liberal arts college, a medical school operated by the State University of New York, and several voluntary teaching hospitals with residency training in almost all specialties, including psychiatry. The primary responsibility for health and welfare planning in the community has been exercised by the Community Chest and the Council of Social Agencies.

County affairs are governed by a 38-man board of supervisors, half from the 19 wards of Syracuse and the others from the 19 towns (townships). This board elects its own chairman, who acts as administrative officer of the county on a part-time basis. Department heads report to a series of committees of the supervisors who in turn make recommendations to the entire board in the form of resolutions. Once acted on favorably by the board, these resolutions in effect decide local policies within

Mrs. Stepanek is a medical writer for the Syracuse Herald-Journal. Dr. Willie, an assistant professor in the department of sociology and anthropology at Syracuse University, is also a research associate at the university's youth development center. *This article is based on a paper given at the 1961 Conference of the New York State Public Health Association, held in Rochester, June 6.*

the limits set by State law. The committees have varying degrees of power, but the two most important are the salaries committee, which decides on all county employee salaries and financial benefits, and the ways and means committee, which recommends the annual budget.

The early history of mental health activities in Onondaga County was detailed by Winslow in 1934 (*2*) beginning with the founding of the Mental Hygiene Committee of the Onondaga Health Association (a voluntary health organization) in May 1925. An experienced psychiatric social worker was appointed to serve as executive secretary of the committee in September of the same year. Educational programs began in December, and by the following year professional mental health personnel were on the staffs of several agencies, including the health department and the free dispensary. In 1930 the Syracuse State Psychopathic Hospital was opened for outpatient and inpatient services.

From the early 1930's to 1945, however, no sizable body of citizens had emerged as an effective community group in mental health affairs. The community leaders remained unconcerned with mental health planning.

Origins of Modern Services

Postwar planners in 1944 and 1945 called attention to the community's lack of diagnostic and treatment facilities for children. In 1947 the county board of supervisors moved to set up a county child guidance center under the children's court. With the appointment in 1948 of a trained psychiatrist to direct the center and of psychologists and psychiatric social workers to staff it, the clinic was a source of pride to the county supervisors. They kept in close touch with clinic personnel, gave regular increases in the initial budget of $22,548, and generously supported its services. Differences between supervisors and clinic staff, if they occurred, were usually conciliated by members of a citizens advisory committee to the center, prominent laymen and professionals in the field of health and welfare.

The success of the child guidance center was one factor that encouraged community leaders to propose a parallel service for adults. The mental hygiene committee of the Council of Social Agencies drew up plans for a new adult psychiatric clinic, to be operated at the Syracuse Dispensary and supervised by the College of Medicine. The Onondaga Health Association offered $5,000 and the Council of Social Agencies $4,200 in private funds toward expenses of the clinic's first half year of operations. This proposal was the forerunner of a plan later adopted and incorporated into a countywide program under the State's Community Mental Health Services Act of 1954.

Thereafter, the mental health committees of the Council of Social Agencies, the Onondaga Health Association, and the medical school sought the establishment of a county mental health board to develop community mental health services. On the advice of the chairman of the board of supervisors, the community mustered impressive witnesses to testify at a public hearing in behalf of the proposed legislation.

The county's research department issued a detailed report favoring the establishment of the new board (*3*). There was no organized opposition such as had successfully fought establishment of a county health department.

The supervisors were also influenced by economic considerations. If they took no action under the Community Mental Health Services Act, the county would face the loss of approximately $18,400 being received in annual State aid for the child guidance center through the New York State Youth Commission.

Shortly after local approval of the legislation in 1955, the chairman of the board of supervisors appointed to the new county mental health board nine members representative of community groups interested in mental health. Included was the attorney who had been chairman of the Council of Social Agencies mental health committee, a woman soon to be recognized by election to the board of directors of the New York State Association of Mental Health Boards, the dean of the medical school, the diocesan director of Catholic Charities, a practicing physician, a practicing psychiatrist, and a school official. Named by law as ex officio members were the city health commissioner and the county commissioner of welfare.

Drift Into Isolation

After the mental health board was appointed, there was a separation of the general community from concern with mental health.

The citizens advisory committee to the child guidance center offered to continue, but the mental health board did not invite it to do so, despite its valuable experience in the delicate art of explaining politicians and professionals to each other. At the same time the mental health committee of the Council of Social Agencies dissolved under the impression that mental health affairs would be handled in the future by the new board. The health and hospitals division of the council had become inactive several years before. The only part of that division to continue actively was a "planning committee" whose actions were limited largely to reviewing requests from health agencies for funds from the Community Chest.

Meanwhile the Onondaga Health Association's mental health activities were largely devoted to an internal reorganization, resulting in a larger division of the association for mental health by 1959 but leaving little time until then for outside concerns.

There was meanwhile a growing concern among some local leaders that the medical school was retreating from community involvement. Long a bulwark in local health planning, the school was becoming more and more preoccupied with education, research, and its building program. Local practicing physicians who had long headed medical school departments on a part-time basis were being replaced with full-time educators who had either restricted private practices or none at all. These full-time professors were understandably more occupied with school than civic affairs.

The chairman of the department of psychiatry at the medical school, who served actively on the mental health board from 1956, stated in 1959 that medical center participation in the community program could continue only "if we are sure the program is not capricious, not subject to the whim of political change. We have no recourse other than to withdraw if the situation gets too unstable."

The threat of the withdrawal of the medical school raised the fear of no more service in community mental health clinics from physicians in the psychiatric residency program, and no further appointments on the medical school faculty for clinic professionals. These appointments had been a valuable asset in recruiting staff.

This retreat on the part of several segments of the community was noted by the first chairman of the mental health board. He said, "We tried to relate with the community, but it was like relating with a vacuum."

It had been supposed when the board was appointed that its members would represent the community in relationships with the county supervisors, serving as a bridge between community and supervisors. A certain amount of liaison between mental health board and supervisors was conscientiously maintained. But there was no systematic effort on the part of the board to explain itself or its new programs to the public at large, no press releases, no television or radio programs, and no report to the community in general except for that appended to annual budget requests.

Part of the board's inactivity can be traced to its limited staff with limited time for all but the most pressing matters. Inundated by prospective patients, the clinic did not favor any publicity that might bring more patients to the door. "We don't want any more people to find out about us," said one clinic staff member. "We have far too many patients already."

The board, largely through its director and assistant director, met with many community groups in an attempt to work out the best ways of utilizing board services. But these administrators found it difficult to interest other agencies in the board's problems, agencies which were primarily concerned with their own problems. The board continued its mandated tasks. Few knew much about them. The board faced them alone.

The Board's Predicament

The board's problems were rooted in three general situations: (*a*) situations stemming from the board's own actions; (*b*) requirements of the Community Mental Health Services Act; and (*c*) exigencies of local forms and traditions of county government

Of the situations created by the board itself, one generally criticized in afteryears was the

hiring of a director of the new mental health program on a part-time basis only. He was the same psychiatrist who had served since 1948 as head of the child guidance clinic. He continued full time in that post, adding the duties of the mental health program director to his already overburdened schedule.

This original action was taken because of the dearth of other suitable psychiatrists. But it obliged this one psychiatrist to fit numerous meetings and administrative duties in and around his diagnostic and therapeutic sessions with patients in the child guidance clinic. He had too little time for administration and for community associations. More responsibility was consequently thrown on the full-time assistant director, who found herself without commensurate authority.

In retrospect, it seems it was an error when, after several years of operation, the board decided to bar professionals from sessions with members of the county board of supervisors in order to reduce the turbulence of the meetings. The mental health program had to be presented to the supervisors entirely by the mental health board, and could not be explained at budget time by those who knew it best, the director and assistant director of the mental health program.

The Community Mental Health Services Act had been predicated on the conviction that a local mental health program could succeed only to the extent that local citizens accepted and identified with it (*5*). The weakness of relationships with the community was previously discussed.

A primary flaw in the law seems to have been the phrasing which made possible an ambiguous relationship between the mental health board and the county board of supervisors.

The county mental health board members believed that the Community Mental Health Services Act invested the board with policy-making powers for local mental health services. The mental health board was given the power by the act to "submit to the . . . (county) governing body a program of community mental health services and facilities; (and) within amounts appropriated therefor, execute such program and maintain such services and facilities as may be authorized under such appropriations" (*4*).

The mental health board members interpreted the law to mean that they were to execute the programs authorized within the appropriation. "Executing the programs" they interpreted to mean that they might determine the number and nature of the professional positions and set salaries within the total amount appropriated for mental health services.

On the other hand, the supervisors contested this view, preferring to keep a line-by-line budget control, as in other areas of county government.

A second provision of the law specified that two members of any county mental health board must be a health officer and a welfare commissioner. In Onondaga County, the city health commissioner and the county welfare commissioner served. This provision was designed to cut through departmental lines in the coordination of mental health programs. Nevertheless, as governmental employees, charged with requesting budgets for their own departments, these board members were more constrained than private citizens in negotiations with the supervisors.

The law required that a new mental health board must be established as a separate segment of county government. It was not permitted to become part of any previously established agency, such as a health department, with prior experience in government administration. The psychiatrist in charge could not rely on an experienced administrator such as a health commissioner for aid nor could he delegate administrative details to experienced personnel.

As to the nature and customs of government in Onondaga County, the board of supervisors exercises both executive and legislative powers, appropriating money and then determining to a great extent how it shall be spent.

The Onondaga supervisors were here confronted with a county board whose members confidently expected autonomy within a prescribed budget.

In the majority, the supervisors were not prepared by experience or training for judging the value of a program that could not easily be expressed statistically. A majority were not equipped to evaluate claims of possible delinquency averted, possible commitments to State institutions forestalled, or elusive behavior

problems alleviated. Supervisors complained that they were not provided with enough information about accomplishments and that the information they were given was not in terms they could easily understand. "How many people have you cured?" was a question posed on one occasion when supervisors met professionals. It was a question that seemed simple enough to many supervisors. The professionals found it difficult to explain why a clinician could not label a person as definitely "cured" and summarize his year's results in such terms.

The situation was further complicated by the fact that the major center of power in the board of supervisors lay with the chairman, the majority leader of the dominant party, and the chairman of the ways and means committee. Yet the mental health board was required to deal primarily with the mental health committee of the supervisors, where final power did not reside. It was necessary for the mental health board to maintain liaison both with the supervisors' mental health committee which made recommendations and with the three who determined final policy.

Major Issues

Apart from the issue of the legal right and responsibility of the supervisors to exercise line-by-line control over the budget of the mental health board, a continuing controversy centered around the salaries to be paid psychiatrists, psychologists, and psychiatric social workers. There was no declared policy on annual increments. Each increase had to be negotiated separately with the supervisors by the mental health board. As other counties in New York set up similar services and as other States followed suit, the supply of professionals grew ever shorter. Salary expectations rose. By 1959 psychiatrists heading Onondaga County clinics received $15,000. Principal clinical psychologists received $8,000; principal psychiatric social workers, $6,500. These levels were unsatisfactory to professionals who knew that their professional talents were in great demand (*6*).

Faced with taxpayer complaints and with increasing demands for funds on every side, the supervisors asked the mental health board to give up anticipated salary increases for a second year. Disagreement also continued over the amount of salary a professional person should be paid in comparison to the nonprofessionals on county payrolls. "After all, we're paying our chief psychiatrists $15,000," said the chairman of the supervisors' ways and means committee. "Our county auditor is paid only $12,000; the sheriff, only $9,000. We have to take care of all our people fairly."

A further difference centered in the employment conditions of professionals. The supervisors and others questioned the amount of time spent during working hours by clinic professionals in paid consultations, study, research, and teaching. "If you give someone a salary, you do it with the reasonable expectation of getting a full-time person," commented the majority leader of the supervisors. "This part-time business bothers people. It's difficult to explain to those concerned about the uses of the tax dollar."

Professionals replied that consulting, teaching, and research were a vital part of their professional lives, necessary to a creative approach to community mental health services.

Crisis

Meanwhile, there was growing professional concern over the adequacy of the services within the allotted budget. More and more demands came in. There were requests from courts, penitentiaries, schools, voluntary agencies, and the welfare department as well as lengthening lines of privately referred patients.

Intake at the clinics was limited. Clinics turned away many individual referrals from agencies. Requests for consultative services also were sometimes refused. In many cases, professionals explained that these refusals were due to lack of funds and personnel.

The supervisors' dissatisfaction with the explanations focused mainly on the assistant director who frequently served as spokesman in dealing with requests.

Individual supervisors felt strongly that their interest and contributions to mental health were being discredited. They had increased annual mental health spending from $124,225 in 1956 to $244,333 four years later.

And yet, they contended, all they heard were reports of inadequate funds and personnel, which they called "negativism."

In the fall of 1959 the supervisors, considering the 1960 budget proposed by the mental health board, refused salary increases for a second year and eliminated the salary appropriation for the assistant director of the mental health program. Instead they increased the appropriation for the director's salary, without consulting the mental health board. They were motivated, supervisors said, by a desire to obtain a full-time professional as director of the mental health service.

The mental health board proposed to resign if it were not permitted to spend the money allocated as it saw fit.

A newspaper story under a prominent headline reported that the board of supervisors was charged by the mental health board with "crippling the local mental health program, and usurping the administrative functions of the county mental health board." This was the first full disclosure to the community of the critical situation. Quoted as authority for the story was a board "spokesman" who preferred to remain anonymous. According to this source the board also protested the supervisors' action in proposing to give the mental health program approximately $2,000 less than it did in 1959, and in declining to approve additional psychiatric residents in the adult clinic.

At the same time the Onondaga Health Association became alarmed over the situation and in turn called numerous interested citizens and organizations about the plight of the mental health services. These people responded by inundating supervisors with demands that they increase the mental health budget and with accusations that the supervisors were "trying to scuttle the mental health program." The board was subjected to this pressure shortly before election day. With 3 days to go, the supervisors changed their stand. They continued the 1959 budget unchanged for another year and restored the assistant director's post.

Aftermath

But the mental health service suffered. Hampered by resignations and unable to find replacements at the salaries authorized, the child guidance clinic closed. The psychiatrist who had served since 1948 as director of the child guidance clinic and since 1955 as director of the mental health program resigned. The director of the adult clinic had already resigned and left town, although the service continued to function. The only remaining clinic which accepted children for treatment was a contract clinic at St. Joseph's Hospital.

At this point, the Council of Social Agencies was completely absorbed, its executives explained, in its own reorganization.

It was left to small groups of citizens to take spontaneous action. One group including both lay people and leading professionals banded together, met several times, and decided to urge the Metropolitan Health Council to appoint a citizens committee on mental health. The Metropolitan Health Council was a newly established division of the Council of Social Agencies. Such a committee, it was felt, might be able to take some action to bolster the faltering mental health board, and to rescue the community program from disintegration. The Metropolitan Health Council appointed a citizens group to take action in the mental health crisis. The appointments were made in association with the president of the Onondaga Health Association's new mental health division.

At its early meetings the new committee adopted as its objectives: (*a*) urging appropriate community agencies to develop broadly conceived mental health programs; (*b*) assisting "in appropriate ways" the supervisors, the mental health board, and other agencies in strengthening mental health services; (*c*) serving as a forum for community organizations interested in mental health; and (*d*) encouraging organizations interested in mental health research. The new group was welcomed publicly by the mental health board, the president of the Council of Social Agencies, and the new chairman of the supervisors' mental health committee. By this means a unified community interest in the mental health program was reasserted.

Implications

This study points up the mounting strain imposed on the supervisory form of county government by the increasing complexity of

metropolitan development, by the necessity for maintaining large groups of professionals on public payrolls, and by the need to delegate authority to quasi-official governmental bodies such as the mental health board. Moreover, county boards of supervisors, originally legislative groups, have tended to assume administrative functions.

With reference to citizen initiative in governmental affairs, this case study demonstrates the need of continuing community surveillance and support of semi-official boards that are set up as representatives of the public's interest. There is also an evident reciprocal responsibility of governmental units to seek out and cultivate citizen interest in public affairs.

The facts also indicate a need for training or experience in public health administration for any psychiatrist who essays to direct community mental health programs.

REFERENCES

(1) Crises in Westchester County psychiatric clinics. Bull. New York State District Branches. Am. Psychiat. A. 2: 3, April 1960.

(2) Winslow, C.-E. A.: A city set on a hill. The significance of the health demonstration at Syracuse, New York. Doubleday, Doran & Co., Garden City, N.Y., 1934, pp. 304–329.

(3) Ames, C., and Sedgwick, R.: Onondaga County and the Community Mental Health Services Act. Syracuse, N.Y., 1955, p. 35.

(4) New York State Department of Mental Hygiene: Mental hygiene law and general orders. Community Mental Health Services Act. State Hospitals Press, Utica, N.Y., 1955, pp. 145–154.

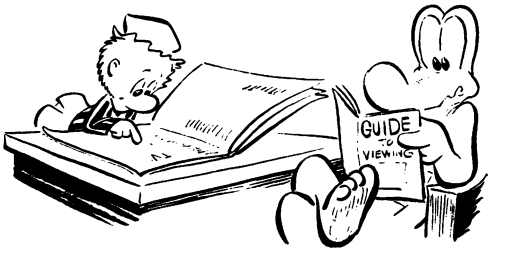
(5) Hunt, R. C., and Forstenzer, H. M.: The New York State Community Mental Health Services Act: Its birth and early development. Am. J. Psychiat. 113: 680–685, February 1957.

(6) Hume, P. B.: The Short-Doyle Act for community mental health services. California State Department of Mental Hygiene, Sacramento, 1957.

Parents' Primer on Television

Some of the recommendations of the 1960 White House Conference on Children and Youth on what parents should do in regard to their children's television watching have been put into a simple and amusing form in "Pogo Primer for Parents (TV Division)" by Walt Kelly and published by the Children's Bureau, U.S. Department of Health, Education, and Welfare.

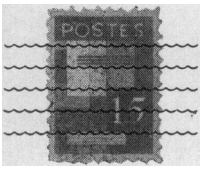
The main theme of the booklet is that television is probably here to stay, but it should be kept in its place in a child's life. It points out that a child should be guided in watching television as in his other activities if he is to be protected from abnormal influences. Katherine B. Oettinger, chief of the Children's Bureau, says in the foreword to the booklet, "Parental selectivity of television fare for children can be a means of broadening their understanding of the world we live in and the culture which is our heritage."



Parents can find out what is best for a child to watch on t.v. If a child is not to be injured, he needs help.

The Primer warns against using the television set as an automatic babysitter for children, and asserts the basic principle of child development that children need love and guidance above all if they are to grow up mentally and socially healthy.

Copies of "Pogo Primer" may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., for 20 cents each.



INTERNATIONAL MAIL POUCH

Growing Pains

Although the malaria eradication campaign in Honduras completed its third cycle of DDT spraying ahead of schedule, the southern part of the country experienced a marked increase in malaria, including falciparum cases.

The granting of land titles in the Departments of Choluteca and Valle was followed by the construction of houses for persons immigrating from other departments and El Salvador, and the construction of new highways, with the flooding of borderline. This whirl of activity had the side effect of creating new breeding places for mosquitoes.

—ELROY A. BARREDA, *chief public health adviser, U.S. Operations Mission, Honduras.*

Epidemic in Kedungwaringin

An epidemic of uncertain origin in the village of Kedungwaringin in the Kedunggede area, Indonesia, affected 130 persons in more than 90 families. The death count totaled 78. The epidemic was eventually termed "enteritis necroticus," and *Clostridium welchii* was tentatively implicated.

In the wake of the epidemic, the U.S. Operations Mission gave demonstrations and lectures on sanitation, conducted a cleanup campaign, and installed two sanitary wells. Bed care and other services were provided by a team of nurses.

—ROY M. HARRIS, *chief, public health division, U.S. Operations Mission, Indonesia.*

Chloroquinated Salt

An epidemiologic study of the use of chloroquinated table salt as a malaria deterrent has been recommended for Brazil's Amazon Basin. Limited area studies have established that consumption of the medicated salt reduces the incidence of malaria but have not proved that chloroquine in table salt eradicates the disease.

The proposed study envisages selection of a representative area in the State of Pará and another in the State of Amazonas, which have not been sprayed with DDT within the preceding year. Health workers would conduct a preliminary survey of salt consumption in the areas and apprise the public of the plan.

—DR. VERNON J. FORNEY, *chief, public health division, U.S. Operations Mission, Brazil.*

Miner's Malady

Thirty percent of the cost of a hookworm control project in Taiwan has been advanced by the mine operators. The control of hookworm in the coal miners of Taiwan has long been a major occupational health activity. Each year a different coal mine has been picked as the site for the control project, which engineers the construction of water supply systems and latrines and the decontamination of infested areas. The Shan-Ho coal mine is the site of the 1961 control project.

—WALTER S. SHURKIN, M.S., *industrial hygiene adviser, U.S. Operations Mission, Taiwan.*

Water Level Indicator

A readily portable, relatively cheap, and easily assembled water level indicator has been put to use in Brazil. The apparatus, built of local components, measures the depth of water in wells. The assemblage consists of a probe, an electric wire with foot markings, a reel, a transistor unit, a lamp, and five flashlight batteries. Cost of parts is less than $5.

While the idea is not original, the engineering is unique. Because high voltage batteries are not readily available in Brazil, the transistor is used to amplify the current from the flashlight batteries to light a 100 milliampere bulb.

—JAMES G. BLEVINS, *well-drilling consultant, U.S. Operations Mission, Brazil.*