Continuity in Care:

The History of Deinstitutionalization in Oklahoma's Mental Healthcare System

Sarah Capps

Honors Thesis

Dr. Metcalf

Fall 2015

List of Terms and Abbreviations

APA	American Psychiatric Association
CMHC	Community Mental Health Center
COCMHC	Central Oklahoma Community Mental Health Center
Deinstitutionalization	Nationwide process of rapidly releasing most patients from state hospitals.
NAMI	National Association on Mental Illness
OFC	Oklahoma Forensic Center
PACT (or ACT)	Program of Assertive Community Treatment

On October 27, 1894, Bishop R.K. Hargrove of the Methodist Episcopal Church travelled to Norman, Oklahoma. The Southern Methodists had been operating a women's school in Norman called High Gate College. However, the school had been struggling. The Panic of 1883 made it increasingly difficult for High Gate to compete against the nearby, tuition-free University of Oklahoma. With enrollment at High Gate already falling, University of Oklahoma President David Ross Boyd accepted a plan devised to close the school's doors for good. In December of 1893, Northern Methodist Bishop John H. Vincent suggested that Norman donate land so that Methodists could construct a dormitory for Methodist students who attended the University of Oklahoma. When Bishop Hargrove visited Norman in 1894, his purpose was to formally approve the University of Oklahoma plan and to begin the process of transferring students to this institution. By December, the High Gate building stood abandoned.[1]

While these events mark the end of High Gate College, they are also the beginning of the story of state mental health care in Oklahoma. On April 12, 1895, the Oklahoma Sanitarium Company purchased the old High Gate building, expanded and renovated the facility, and opened its doors to receive its first patients on July 27, 1895.[2] While there had been facilities for mentally ill people in Oklahoma prior to the opening of the Oklahoma Sanitarium Company, such as the asylum six miles south of Tahlequah in the Cherokee Nation, this was the first time the state or territorial government involved itself in the care and treatment of the mentally ill within territory lines.[3] Previously, the Oklahoma territorial government made contracts with the Oak Lawn Retreat for the Insane at Jacksonville, Illinois. The government paid the company

---

[1] David W. Levy, *The University of Oklahoma A History: Volume 1, 1890-1917* (Norman: University of Oklahoma Press, 2005), *97-98.*

[2] Ibid., 98-99.

[3] For more on the insane asylum in the Cherokee Nation, see Box 50 and 51 of the Cherokee Nation Papers, the Western History Collections, Norman, Oklahoma. See also Carl T. Steen, M.D., "The Home for the Insane, Deaf, Dumb and Blind of the Cherokee Nation," *Chronicles of Oklahoma* 21, no.4 (1943): 402-419. The Cherokee Home for the Insane, Deaf, Dumb and Blind was the first facility for the mentally ill in Oklahoma.

"$25.00 a month for each patient" who was transported to Illinois to receive treatment.[4] Similarly, prior to statehood the mentally ill of Indian Territory received care at St. Vincent's Hospital in St. Louis, Missouri.[5] Because the state contracted with the privately owned Oklahoma Sanitarium Company, this facility was not the first state hospital. The state merely paid for services instead of assuming complete responsibility for running the institution. However, the facility at Norman is still the longest running state-funded facility for the treatment of Oklahoma's mentally ill. In 1915, the state government ceased contracting with the Oklahoma Sanitarium Company and the facility became the Central Oklahoma State Hospital. Later, it would be renamed Griffin Memorial State Hospital after its first superintendent.[6]

The era of the psychiatric hospital in Oklahoma, which began with the closing of High Gate College, ended with the rise of community care and a messy process of deinstitutionalization. While the treatment of individuals in hospital settings seemed a promising way to treat mental illness, overtime problems arose with this treatment method. World War II and the Great Depression exacerbated issues with funding and overcrowding, making hospitals like Central State dismal places. However, World War II also sowed the seeds for the community mental health centers. War-trained psychiatrists postulated that mental illness could be treated in a community setting by addressing the environmental factors of mental illness before individuals became severely ill. This idea came to be known as "continuity theory." After World War II, community-oriented psychiatrists drew on this theory to restructure mental healthcare in the United States. The development of new psychotropic drugs, which allowed doctors to treat

---

[4] Junior Koenig Knee, "Administration of the Central Oklahoma State Hospital" (Masters thesis, University of Oklahoma, 1942), 9. The Oklahoma territorial government began making contracts with the Oak Lawn Retreat for the Insane in 1889.
[5] Ibid., 9-10.
[6] Dr. David Wilson Griffin first began working at the facility when it was still under the direction of Dr. A.T. Clark, superintendent of the Oklahoma Sanitarium Company. See Steve Sisney, photo of Dr. Griffin and Dr. Clark, date unknown in David Zizzo, "Hidden Oklahoma: Norman hospital once a 'mythical city'," *The Oklahoman,* March 13, 2011. http://newsok.com/gallery/articleid/3546956/pictures/1378987. See also Oklahoma Hall of Fame, "David Griffin," *Oklahoma Hall of Fame,* accessed October 20, 2015. http://www.oklahomahof.com/Portals/0/PDF's/HOF%20bios/Griffin,%20David.pdf

patients outside of a hospital setting, made it possible for reformers to redesign state mental healthcare systems around a new facility: the community mental health center. While there are three such facilities in Oklahoma, the scope of this paper will be limited to a focus on one: the Central Oklahoma Community Mental Health Center.

In Oklahoma, the Central Oklahoma Community Mental Health Center (COCMHC) never replaced Griffin Memorial Hospital. While Griffin remained the primary way in which severely mentally ill people without the ability to pay received necessary treatment, the process of deinstitutionalization significantly reduced the role of this state hospital as the primary provider of long-term care for Oklahoma's most severely mentally ill citizens. The COCMHC, on the other hand, fulfilled a series of important roles in Oklahoma's mental healthcare system. At the start of deinstitutionalization, the COCMHC tried to provide services for the large number of patients being dispersed from Griffin Memorial Hospital by replacing the institutionalized treatment they received with alternative treatment in room and boards and temporary hospitalization in the COCMHC itself. In later years, the COCMHC focused on treating individuals with dual diagnoses of mental illness and substance addictions, including a rising number of individuals addicted to drugs. However, since the opening of the facility, the COCMHC's largest impact has been to provide a greater number of patients with treatment programs that are near their homes. This creates less of an interruption in their daily lives. The COCMHC was able to fill these various functions over time because the legislation that established the community mental health centers intentionally avoided defining their structure. Although Oklahoma officials implemented deinstitutionalization poorly, the lasting impact of the process has been fundamentally positive because the structurally ambiguous COCMHC could reinvent its programs to respond to changing community mental health needs.

A Crumbling System

Oklahoma had established its system of four state psychiatric hospitals by the early decades of the twentieth century. The first state hospital was Western State. Located at Fort Supply, this hospital opened in 1903 but did not receive patients until 1908.[7] Western Oklahoma State Hospital cared for mentally ill people in or west of Kay, Noble, Garfield, Kingfisher, Canadian, Caddo, Comanche, and Cotton counties.[8] Additionally, the eastern portion of the state received care at Eastern Oklahoma State Hospital. Located at Vinita, this facility was approved by the Oklahoma Legislature in 1908 and opened its doors on January 28, 1913. Eastern State cared for mentally ill people in or west of Osage, Tulsa, Okmulgee, McIntosh, Pittsburg, Coal, Atoka, and Bryan counties.[9] Central State Hospital at Norman was the largest of the state hospitals for the mentally ill because it served the central and most populous part of the state. Oklahoma City and its suburbs, Guthrie, and Muskogee all fell under Central State's jurisdiction of care.[10] Finally, in 1931 the Oklahoma Legislature approved the construction of a hospital for people who were both mentally ill and African American. Prior to 1934 these patients were treated in separate wards at Central State Hospital. However, in June of that year Taft State Hospital for Negro Insane at Taft opened.[11] One graduate student justified Taft's existence by writing, "Since [Oklahoma] is a southern region, segregation of Negroes is practiced."[12] Like

---

[7] Knee, "Administration of the Central Oklahoma State Hospital," 10-11.
[8] Ibid., 58.
[9] Ibid., 11.
[10] Clara Viola Tatge, "Social Backgrounds of One Hundred-Six Families Under Care at Central State Hospital" (Masters thesis, University of Oklahoma, 1952), 3.
[11] Knee, "Administration of the Central Oklahoma State Hospital," 12-3.
[12] Tatge, "Social Backgrounds of One Hundred-Six Families," 3.

other institutions in the South, conditions at Taft ultimately proved that separate was not equal. It was the smallest and least equipped of the four state hospitals.[13]

From their establishment and on through the early decades of the twentieth century, there was little policy defining the powers and purpose of Oklahoma's state psychiatric hospitals or their governing bodies. Beginning in 1915, the State Board of Public Affairs managed these facilities. This governing body consisted of three men appointed by the governor and approved by the State Senate. There were few checks on their power; they were even free to grant or deny petitions to sterilize patients.[14] The second tier of authority consisted of the hospital superintendents. Each was responsible for running his own facility. This was Oklahoma's structure of power for state hospitals until 1953. After this date, the administration of Oklahoma's mental healthcare system was restructured under the new Oklahoma Department of Mental Health. The first Director of Mental Health was Dr. Hayden H. Donahue, a psychiatrist and El Reno native with experience treating combat-related trauma.[15]

There were few limitations on the powers of the hospital superintendents and little to define proper treatment methods in the psychiatric hospital. Perhaps this was because the course of treatment seemed obvious to them; there were incredibly few treatment options available to doctors and their patients. Sick patients were committed to the hospital "upon a certificate of insanity and an order of admission."[16] They had no right to refuse treatment.[17] While hospitalized, patients were fed and housed until their condition improved or they died. There was little policy to define treatment because the task of providing mentally ill people with shelter and

---

[13] See The Council of State Governments, *The Mental Health Programs of the Forty-Eight States: A Report to the Governors' Conference* (Chicago: The Council of State Governments, 1950), 235, 270, 282-3, 308-9. See also Knee, "Administration of the Central Oklahoma State Hospital," 50.
[14] Knee, "Administration of the Central Oklahoma State Hospital," 51.
[15] "Dr. Hayden H. Donahue," *The Oklahoman,* November 4, 2002, Obituaries/Death Notices.
[16] Knee, "Administration of the Central Oklahoma State Hospital," 56.
[17] Chris Guffey and Chris Olsen interview by author, October, 23, 2015.

custodial care overwhelmed hospitals and their staff. There were no standards to limit hospital size or staff-to-patient ratios, so patients who needed long-term care were allowed to accumulate in hospitals without appropriate supervision. The state was wholly responsible for the few policies that did exist. The federal government did not pass any legislation related to state mental healthcare systems until the National Mental Health Act of 1946. This legislation provided states with federal funds to improve mental health services that were alternatives to hospitalization.[18] Aside from this legislation, authority over the state hospitals lay entirely with the states.

This was the state hospital system that was in place when the effects of World War II and the Great Depression strained American society and acted as catalysts for change. The Depression left psychiatric hospitals around the country with fewer funds to manage a growing problem. The outbreak of World War II also drew the nation's attention and resources away from home. These trends exacerbated problems in deteriorating hospital systems. As the historian Gerald N. Grob notes, during the 1930s "Staff-patient ratios decreased; new construction came to a halt; and normal maintenance was deferred" at a time when hospitals needed to increase their operations and improve their facilities.[19] At the same time that hospitals faced budget shortfalls, the number of patients in psychiatric hospitals rose. Between 1940 and 1946 alone, the number of patients in state hospitals across the country rose from 410,000 to 446,000. Without a simultaneous increase in the number of facilities, "the excess population over capacity, according to federal statistics, rose from 9.8 to 16.3 percent."[20] However, this might have been an underestimation of the crisis. True levels of overcrowding across the nation might have reached somewhere between 20 to 74 percent.[21] The effects of this overcrowding were felt in patient care

---

[18] Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991), 58.
[19] Ibid., 8.
[20] Ibid., 8.
[21] Ibid., 8.

as "restraint became more common; hygienic conditions deteriorated; individualized attention, medical and occupational therapy, and supervised recreation all suffered."[22] Psychiatric hospitals became dismal warehouses for the nation's mentally ill.

Although World War II and the Great Depression siphoned off the limited funds available to mental healthcare systems, citizens and officials allowed hospital conditions to deteriorate for reasons associated with the stigma surrounding mental illness. Although confining mentally ill people in psychiatric hospitals was first proposed for their own safety, once they were relegated to these institutions the mentally well did not have to see them. Nor did the general public speak about them. A person's mental illness was ideally kept a private affair. Therefore, policies and social attitudes contributed to the crisis by turning mentally ill people into an invisible population. Because few people saw the deteriorating conditions in psychiatric hospitals, few could condemn the treatment of the nation's mentally ill population. Few who could do so actually would do so. Additionally, mentally ill people who could speak for themselves were silenced and disregarded by social attitudes and a paternalistic treatment system. Doctors were convinced they knew what was best for their patients. Policies regarding patient rights had not yet been established. Furthermore, the absence of policies regarding patient population size and staff-to-patient ratios meant that the underfunding and overcrowding was perfectly legal.

Needless to say, Oklahoma did not escape the effects of this national crisis. In its 1950 report, the Council of State Governments painted a clear picture of the decades-long process of deterioration that had been plaguing Oklahoma's mental healthcare system. By January 1, 1950, Oklahoma had 6,059 hospital beds in its four state hospitals. The Oklahoma Department of

---

[22] Ibid., 9.

Mental Health estimated that the state needed another 4,119 beds to operate effectively.[23] In 1950, Central State Hospital had an average daily resident population of 2,936. This was higher than any other hospital in the state. The hospital with the next highest average daily resident population was Eastern State at Vinita with 2,397, followed by Western State at Fort Supply with 1,318, and finally Taft with an average of 810 patients.[24] Even though it was housing almost 3,000 patients on average, Central State was rated as having a capacity of only 1,803. This means that the hospital had an excess population of 1,133 patients and was operating at 63 percent over capacity. Eastern and Western State Hospitals were both operating at 14 percent over capacity, while Taft had the lowest excess population at 60 patients, or 8 percent over capacity.[25]

In addition to failing to provide adequate physical space and facilities in which to hospitalize these patients, Oklahoma also failed to provide the necessary funds to treat them properly. In 1939, Oklahoma was ranked 31st in the nation in state spending per resident patient in its state hospitals, having spent only $219.62 per patient that year. Relative funding levels only deteriorated over time. Although by 1949 Oklahoma had increased its per resident patient spending to $443.22, the state was not keeping pace with the rest of the nation. That year, Oklahoma ranked 44th in the nation in per resident patient spending.[26] These low levels of state funding were not balanced by funds from patients for services rendered. In 1949, only 244 patients paid for their treatment. The Department of Mental Health received $68,654 from these paying patients. This paid for 2.1 percent of the Department's total maintenance costs of $3,298,421.[27]

[23] The Council of State Governments, *The Mental Health Programs of the Forty-Eight States,* 38.
[24] Ibid., *235.*
[25] Ibid., *326*
[26] Ibid., *262.*
[27] Ibid., *263.*

To compensate for insufficient funding, Central State Hospital had a 590-acre farm to decrease the amount of money spent on food. While experienced farmers supervised this farm, it was Central State's patients who supplied much of the labor. The hospital's administration considered farm work to be part of some patients' treatment programs. However, utilizing farm work as therapy meant that some patients spent much of their time at Central State performing tasks that were necessary to run the hospital. In 1942, Government graduate student Junior Koenig Knee recorded that an average of 78 patients were employed on this farm.[28] Patients grew crops, such as "Irish and sweet potatoes, roasting ear corn, black-eyed peas . . . ensilage alfalfa hay, corn, oats, sweet clover seed, straw, sudan hay, and cotton."[29] They also raised the farm's 800 laying hens, 150 hogs, and "150 registered and high grade holstein [sic] cows, 57 heifers, 39 calves, and 5 bulls."[30] According to Knee, the Central State cattle herd was "recognized as one of the best herds in the state."[31] This farm supplied a full twenty-five percent of the hospital's food with another two percent coming from government surplus. Because the hospital raised crops with the aid of patient labor, in 1949 the facility only spent 78 cents per diem per patient on raw food.[32] Although cutting down the cost of food was a commendable achievement, the reliance on the cheapest raw foodstuffs led to a monotonous diet and often gastronomically confusing meals for patients. For example, on Monday, August 18, 1941, Central State provided its patients with a dinner that consisted of bread, milk, fresh tomatoes, pumpkin, pinto beans, peanut butter, and peaches. The following day they ate bread, milk, peaches, bologna, and beet pickles.[33]

[28] Knee, "Administration of the Central Oklahoma State Hospital," 93.
[29] Ibid., 93.
[30] Ibid., 94-5. Central State Hospital's cattle were raised where soccer fields are now located in Griffin Community Park, just north of East Robinson Street. The farm's old silos are still there today.
[31] Ibid., 95.
[32] The Council of State Governments, *The Mental Health Programs of the Forty-Eight States,* 301.
[33] Knee, "Administration of the Central Oklahoma State Hospital," 79.

In addition to the problems of overcrowding and underfunding, Oklahoma's state hospitals were also understaffed. To provide care for Central State Hospital's almost 3,000 residents, the hospital employed only six full-time physicians and one consulting physician. Although they had smaller resident populations, Western and Eastern each employed seven physicians as well. Taft employed two physicians. Therefore, Central State Hospital had a 1:489 physician-to-patient ratio.[34] By comparison, in 1942 the American Psychiatric Association (APA) recommended that hospitals try to maintain a ratio of one physician for every 150 patients.[35] Unfortunately, the APA's recommendation did not carry the power of law. To support its doctors, Central State also employed 14 graduate nurses. However, there were still 210 patients for every nurse. Oklahoma's understaffed hospitals therefore relied on attendants to closely monitor patients. Because Central State employed 280 attendants, there were only 10 patients for every one attendant.[36] This staff structure was problematic because attendants were less trained to provide adequate treatment for patients. Of the full-time psychiatrists at Central State, 67 percent had completed psychiatric residencies and were members of the APA. Additionally, all 14 nurses had received graduate psychiatric training. In contrast, only 2 of the 280 attendants had completed pre- or in-service training.[37]

The abundance of patients, combined with the inadequacy of both staff and funds meant that conditions were ripe for an exposé. In 1946, a reporter from the *Daily Oklahoman* thrust Central State into the national spotlight. His name was Mike Gorman. Originally from New York City, Gorman moved to Oklahoma following his 1945 army discharge. Shortly after he began working at the *Daily Oklahoman,* the paper's editor received a complaint about poor conditions

---

[34] The Council of State Governments, *The Mental Health Programs of the Forty-Eight States,* 282.
[35] Knee, "Administration of the Central Oklahoma State Hospital," 102.
[36] The Council of State Governments, *The Mental Health Programs of the Forty-Eight States,* 282.
[37] Ibid., 290.

at the nearby Central State Hospital. Although Gorman had not previously had any connection with mental illness or mentally ill people, he was sent to investigate.[38]

Gorman described conditions in Oklahoma's psychiatric hospitals in an article titled "Misery Rules in State Shadowland." What he found was too many patients, not enough staff, inadequate facilities, and a whole host of problems that could be attributed to these factors. Because of overcrowding, at Fort Supply "Bed space [was] at such a premium that beds [had] been squeezed into porches, day rooms, and even adjoining the hydrotherapy tubs."[39] Overcrowding led to poor living conditions such as "Broken wooden floors, cracked walls, and falling plaster," which were "the rule rather than the exception."[40] To fit all the necessary beds into the Central State buildings, "the beds were double-decked, in violation of every standard of mental and physical hygiene."[41] Additionally, "Because every ward [had] almost double the number of beds it should, there [was] a frightful odor. On the hottest of summer days, there [was] practically no ventilation—not one fan in any ward."[42] He also found that physical restraint was used far too often. Gorman wrote, "Practically every doctor in the Oklahoma mental hospitals is opposed to this excessive use of restraint, but explains it is due to the shortage of attendants."[43] He also found that there was an overwhelming presence of chronic patients, including of elderly, non-mentally ill patients. He described:

> Over 1,000 seniles jammed to the bursting point the limited facilities of the Norman hospital [sic]. It didn't matter that they didn't belong there—that they were admitted because the state had provided no other place for them. They were there, all over the place, and they gave the entire hospital that hopeless, tired atmosphere one finds in homes for the aged.[44]

---

[38] Grob, *From Asylum to Community*, 76.
[39] Mike Gorman, "Misery Rules in State Shadowland," reprinted from *The Daily Oklahoman,* September 22, 1946, 4. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/TGBBGW
[40] Ibid., 4.
[41] Ibid., 5.
[42] Ibid., 4.
[43] Ibid., 2.
[44] Ibid., 5.

Overall, Gorman's visit convinced him that Oklahoma's hospitals were being used as warehouses for the mentally ill and elderly that society failed or did not know how to treat. His conclusion was correct, too. Oklahoma's psychiatric hospitals were the last line of care for people with schizophrenia or age-related mental disabilities. There was no way to treat these people, so they accumulated in state hospitals over the decades. Gorman left Central State worried that the shocking conditions in Oklahoma's psychiatric hospitals were likely to exacerbate a sensitive patient's mental illness. To correct the failures he witnessed, Gorman advocated for the creation of new facilities for the elderly. He also championed the use of electro-shock therapy and new medications like Metrazol, both of which had had promising results.[45]

Gorman pursued his newfound interest in the treatment of the mentally ill in Oklahoma by writing a series of articles on the conditions in the state's psychiatric hospitals. These articles were serialized in the *Daily Oklahoman.* He also signed a contract with the University of Oklahoma Press to write a full-length book on the subject, titled *Oklahoma Attacks Its Snakepits*. When "internal problems" blocked the publication of the book, a condensed form of the work was published in the *Reader's Digest.* In his writing, Gorman characterized the conditions in Oklahoma's state hospitals as some of the worst in the nation. His articles placed both himself and Oklahoma's state hospitals in the national spotlight.[46] The *Reader's Digest* piece caught the attention of Mary Lasker, a wealthy reformer. She had established the Albert Lasker Foundation for Medical Research and had connections to both the Planned Parenthood Federation and the

---

[45] Ibid., 7-8.
[46] Grob, *From Asylum to Community*, 76.

American Cancer Society.[47] Gorman's work convinced reformers like Lasker that the nation's psychiatric hospitals were in desperate need of improvement. With her help, Gorman became a nationally prominent mental healthcare lobbyist and embarked upon a new career to convince both politicians and the public that mental healthcare in the United States was in desperate need of reform.

National Changes

While reporters and philanthropists like Gorman and Lasker were developing public opinion in favor of a new standard in psychiatric treatment, psychiatrists were developing a new model of psychiatry that would herald community psychiatric clinics as the best way to treat mental illness. During World War II, psychiatrists observed that the environment was a significant factor in the cause of mental illness. Soldiers who had shown no sign of illness suffered psychological breakdowns on the battlefield. Removing soldiers from the war environment ultimately aided recovery.[48] This led to the development of a continuum theory of mental illness. As the historian Edward Shorter explains, many American psychiatrists began to believe that "only one form of psychiatric illness existed, and that this form exhibited mere quantitative differences on the basis of how severely one had failed to adapt to the environment."[49] Of course, this type of thinking ignored evidence that there were organic factors to mental illness. As continuum theory gained supporters, the transition between illness and wellbeing therefore became a "slippery slope rather than an absolute line between the ill and the

---

[47] U.S. National Library of Medicine, "The Mary Lasker Papers: Biographical Information," *Profiles in Science,* accessed October 27, 2015. http://profiles.nlm.nih.gov/ps/retrieve/Narrative/TL/p-nid/199
[48] Grob, *From Asylum to Community*, 17-18.
[49] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), 179.

well."[50] Continuum theory posited that intervening in the environment would allow psychiatrists to treat individuals before they manifested symptoms of mental illness, thereby making the psychiatric hospital itself an obsolete institution.[51] Therefore, it was the new continuum theory which was the foundation of deinstitutionalization.

Deinstitutionalization became an option for treating mental illness in civilian communities when a new generation of war-trained psychiatrists began to apply what they had learned in war to civilian life. These psychiatrists believed that mental illness could be treated by manipulating the environment in civilian communities in a fashion similar to the way illness had been treated during World War II. One of these psychiatrists was Colonel Albert Julius Glass. Glass firmly believed that the environment played a factor in mental illness. Even individuals who exhibited no predispositions toward mental illness could become ill after prolonged exposure to a war environment. He noted that "the unreliability of individual psychiatric screening" was "so well demonstrated" that "the routine examination of inductees by psychiatrists was abandoned by the Army soon after the end of World War II and was not even reinstituted during the Korean War."[52] Glass summarized the lessons learned from World War II by writing, "It should always be remembered that modern war produces two unique types of casualties in large numbers; namely, injuries and psychiatric disorders, both of which are caused by traumatic forces set forth by a changing and hostile environment."[53]

The continuum theory that psychiatrists such as Glass developed during wartime became influential as it was imparted to an upcoming generation of doctors and social workers. In her

---

[50] Ibid., 179.
[51] Grob, *From Asylum to Community*, 18.
[52] U.S. Army Medical Department, *Neuropsychiatry in World War II* (Washington, D.C.: Office of the Surgeon General, Dept. of the Army, 1966), 741. For a summary of the career of Dr. Glass, see Jane C. Morris, "Albert Julius Glass, 1908-1983," in *Builders of Trust: Biographical Profiles from the Medical Corps Coin*, ed. Sanders Marble (Fort Detrick, Maryland: Borden Institute, 2011), 135-144.
[53] Ibid., 739.

1952 masters thesis, Clara Viola Tatge quoted from *The Psychological Aspects of War* by R.D. Gillespie. On the topic of the experiences of servicemen Gillespie wrote, "When the rationalized mechanism of social life collapses in times of crises, the individual cannot repair it by his own insight. Instead, his own impotence reduces him to a state of terrifying helplessness."[54] Tatge integrated this quote into her analysis of patients at Central State by writing, "While this description of mental breakdown referred to the individual exposed to the stress of war, it may also apply to the person who is caught in an environment which he cannot control, and to which he is unable to adjust."[55] Therefore, the generations of mental health professionals that came of age following World War II were taught to apply the lessons of war to civilian life. Although there was little to prove that the battlefield could be equated with daily life in civilian communities, mental health professionals learned that intervention in the community setting could help an individual adjust to their environment and prevent the manifestation of symptoms of mental illness.

In addition to continuum theory, the development of new psychotropic drugs made a policy of deinstitutionalization possible for the first time. In 1949, a French naval surgeon named Henri Laborit conducted experiments with synthetic antihistamines in an attempt to improve the success rate of operations performed on patients who were in shock. Although he was not interested in psychosis, when Laborit began experimenting with antihistamines in the phenothiazine family, he noted that "some of his patients became quite indifferent to the world about them."[56] In 1951, Laborit continued his experiments on shock with a new form of phenothiazine, which Rhône-Poulenc drug company had developed. Charpentier, a company chemist, named the compound "chlorpromazine." During his experiments, Laborit confirmed

---

[54] R.D. Gillespie, *Psychological Aspects of War* (New York: W.W. Norton, 1942), 134.
[55] Tatge, "Social Backgrounds of One Hundred-Six Families," 77.
[56] Shorter, *A History of Psychiatry,* 248.

that this drug caused patients to feel uninterested and relaxed. On January 19, 1952, psychiatrists gave chlorpromazine to a 24-year-old patient named Jacques L. who suffered from mania. For three weeks, Jacques received the drug as part of his treatment regimen. By February, he was able to resume a fairly normal life.[57]

Once it was applied to psychiatry, chlorpromazine gained popularity in a few short years. Most famously, Jean Delay and Pierre Deniker of the Ste-Anne mental hospital conducted more tests on the effectiveness of chlorpromazine. After exclusively administering chlorpromazine to eight different patients, the two psychiatrists found that the drug "was much better than ECT, insulin, and the rest of the physical therapies, much less dangerous, and easily tolerated by the patients."[58] After Delay and Deniker's study, chlorpromazine spread throughout the French mental healthcare system before Rhône-Poulenc introduced the drug into North American psychiatry. The company provided samples to Dr. Ruth Koeppe-Kajander of Ontario General Hospital and Heinz Lehmann at Verdun Hospital in Montreal in two separate studies conducted during 1953. While studying the effects of chlorpromazine on 71 patients, Lehmann was stunned to find several patients with schizophrenia were symptom-free after a few weeks. In 1952, a drug house named Smith Kline & French bought the drug under the name "Thorazine" and began to market it in the United States.[59] After Thorazine, a multitude of other drugs, such as Haldol, followed. Thus, in the United States Thorazine became the first of the new psychotropic drugs to hit the market and alter professional views regarding what constituted treatable illnesses. The drug was a breakthrough because it offered the hope that even the most severely mentally ill patients who were once thought to be untreatable, such as those with schizophrenia, could

[57] Ibid., 248-9.
[58] Ibid., 250. The abbreviation "ECT" stands for "electroconvulsive therapy," which is also known as electro-shock therapy.
[59] Ibid., 249-54.

potentially resume normal lives outside of psychiatric institutions.[60]

Equipped with treatments that promised to make their theories reality, new community-oriented psychiatrists turned to a sympathetic president to turn their reform ideas into national policy. President Kennedy's sister Rosemary was mildly mentally retarded. However, in 1940 her conditioned worsened and it became difficult for her parents, Rose and Joseph, to control her at home. In a final effort to keep his daughter out of a psychiatric institution, Joe Kennedy permitted doctors to give Rosemary a lobotomy. Rosemary was never informed of this decision. Rose was not informed until 1961. Unfortunately, but predictably, the surgery only made Rosemary's condition worse.[61] Rosemary's experience was central to the Kennedy-Shriver family's later philanthropic and political focus on the stigma surrounding mental retardation and mental illness.[62] The Kennedy administration chose to make the treatment of mental illness and mental retardation the focus of a new policy initiative and on February 5, 1963, Kennedy delivered his Special Message to the Congress on Mental Illness and Mental Retardation.

In his speech, Kennedy lamented the current state of mental healthcare and created a vision for changes to come. In a decade where Kennedy saw other bodily illnesses treated more effectively than ever, he simultaneously understood that mental illness and mental retardation "require[d] more prolonged treatment, cause[d] more suffering by the families of the afflicted, waste[d] more of our human resources, and constitute[d] more financial drain upon both the public treasury and the personal finances of the individual families than any other single

---

[60] Thorazine and other early psychotropic drugs were not without side effects. Some patients developed an irreversible shuffling gait and involuntary movements of the tongue, lips, hands, and trunk (tardive dyskinesia).

[61] Edward Shorter, *The Kennedy Family and the Story of Mental Retardation* (Philadelphia: Temple University Press, 2000), 32-3.

[62] While there were other factors that also contributed to John F. Kennedy's endorsement of a new mental health policy, a more complete discussion of these influences is beyond the scope of this paper. For more information on the Kennedy family and mental health policy in the United States, see Shorter, *The Kennedy Family and the Story of Mental Retardation* and Grob, *From Asylum to Community,* 209-238.

condition."[63] Because the treatment of mental illness and mental retardation cost taxpayers "over $2.4 billion a year in direct public outlays for services," Kennedy advised his audience that "prevention [was] far more desirable . . . It is far more economical and it is far more likely to be successful."[64] Kennedy's reform solutions were firmly grounded in the new continuum theory of mental illness. They centered around plans for a new preventive system of mental healthcare in the United States. For the Kennedy administration, prevention rested on a "range" of "community based" services such as "diagnostic and evaluation services, emergency psychiatric units, outpatient services, inpatient services, day and night care, foster home care, rehabilitation, consultative services to other community agencies, and mental health information and education."[65] Kennedy predicted that these community-oriented reforms could "do much to eliminate or correct the harsh environmental conditions which often are associated with mental retardation and mental illness."[66] He proposed legislation to fund the creation of Community Mental Health Centers (CMHCs) across the nation in the hope that these facilities would integrate services, respond to community needs, and ideally prevent mental illness altogether.

The Mental Retardation and Community Mental Health Centers Construction Act of 1963 sought to implement this vision by providing grants for the construction of CMHC buildings and funds for staffing. The bill proposed that Congress appropriate $6,000,000 for the fiscal year ending June 30, 1964, and $8,000,000 for the following fiscal year for the express purpose of "meeting the costs of construction of facilities for research, or research and related purposes, relating to human development, whether biological, medical, social, or behavioral, which may assist in finding the causes, and means of prevention, of mental retardation, or in

---

[63] John F. Kennedy, "Special Message to the Congress on Mental Illness and Mental Retardation," February 5, 1963. *The American Presidency Project*. http://www.presidency.ucsb.edu/ws/?pid=9546.
[64] Ibid.
[65] Ibid.
[66] Ibid.

finding means of ameliorating the effects of mental retardation."[67] During 1966 and 1967, appropriations would decrease to $6,000,000 once again.[68] State mental healthcare systems had to submit applications to receive these building funds. To submit an application, the Act required that states create an advisory council and designate a single state agency to administer or supervise the construction and operation of the CMHC.[69] The act also stipulated that facilities that had been constructed with these funds had to remain mental healthcare facilities for at least twenty years after their construction.[70] In the event of non-compliance, funds would be withheld.[71] Although the original Act of 1963 did not contain provisions to appropriate funds to help staff these centers, in 1965 Congress passed an amendment to the act to provide funds to staff the CMHCs for the first four years of operation.[72] After this time, the state government would assume the costs of running these facilities. President Kennedy signed The Mental Retardation and Community Mental Health Centers Construction Act into law on October 31, 1963.

The passage of this Act signaled a shift in national attitudes toward mental health policy. With the development of a welfare system in the early decades of the twentieth century, citizens increasingly saw the government as having a role in maintaining the well-being of individuals. This included the care and treatment of impoverished mentally ill persons. While this task had been part of the jurisdiction of the state governments, an increasing awareness of the poor conditions found in state psychiatric hospitals convinced many that state governments were no

---

[67] Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Public Law 88-164, U.S. Statutes at Large 77 Stat. 282. 88th Congress, 1st Session (1963): 282.
[68] Although the act stipulated that these amounts should be appropriated, the Vietnam War and the Great Society Programs drained government funds. As a result, the implementation of the Community Mental Health Center Act of 1963 lagged behind expectations. See Grob, *From Asylum to Community,* 250.
[69] Community Mental Health Centers Construction Act of 1963, 287-8.
[70] Ibid., 282.
[71] Ibid., 289.
[72] Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, Public Law 89-105, U.S. Statutes at Large 79 Stat. 427 (1965): 428.

longer capable of being the sole providers of care. As Dr. Alfred M. Freedman noted, if community or state governments could not longer afford to care for these individuals, then "the responsibility for providing the funds must be assumed by another governmental level, namely, the federal government."[73] By passing The Community Mental Health Centers Construction Act, the federal government accepted a temporary and limited responsibility for the care of the mentally ill. The Act provided federal funds to operate mental healthcare programs on a local level, which essentially bypassed state governments.[74] The Act was a central part of the deinstitutionalization process being implemented across the nation. At its roots, deinstitutionalization was an effort to impose standards and accountability where there had not been any before. The process of reducing patient populations and transferring some treatment responsibilities from hospitals to outpatient facilities proved to be a painful experience for everyone involved.

Community Care in Oklahoma

By the 1950s, the state of Oklahoma was implementing elements of deinstitutionalization. Dr. Hayden Donahue, the first Director of Oklahoma's Department of Mental Health, began reducing the patient population in the four state hospitals. He did this in part with new treatment methods, such as electro-shock therapy and, for the first time, the use of medications such as Thorazine.[75] With the start of the 1960s came the appointment of a new Director; Dr. Donahue had resigned in 1959.[76] Upon his retirement from the military, The

---

[73] Alfred M. Freedman, "Historical and Political Roots of the Community Mental Health Centers Act," *American Journal of Orthopsychiatry* 37, no. 3 (1967): 5.
[74] Grob, *From Asylum to Community,* 235.
[75] *Oklahoma Report: An Informative Documentary on the Progress Achieved in the Treatment of Oklahoma's Mentally Ill*, (Oklahoma Mental Health Association, 1950), 16 mm film, from Oklahoma Historical Society Film and Video Archive, AVI video, 25 min., 48 sec., https://www.youtube.com/watch?v=Vg5sLuSYpdE&feature=youtu.be.
[76] "Dr. Hayden H. Donahue," *The Oklahoman,* November 4, 2002, Obituaries/Death Notices.

University Oklahoma offered Dr. Albert J. Glass a position as both a professor of clinical psychology and neurology and as the Director of the Department of Mental Health.[77] It is unsurprising that Dr. Glass, a figure central to military psychology and the development of continuum theory, desired to restructure Oklahoma's mental healthcare system to conform to an environmental theory of the cause of mental illness. Because of his long career focused on designing psychiatric medical units in the military, Dr. Glass's experiences reinforced his belief that community services could help address the psychiatric needs of individuals before they became ill enough to be admitted to a hospital.

With the arrival of Dr. Glass, Oklahoma's mental healthcare system underwent rapid change. In 1950, the four state hospitals had a combined resident population of almost 8,000 patients. By 1966, that number had been reduced to 4,900.[78] Dr. Medford Peterson, then the superintendent of Eastern State Hospital, told reporters that the patient census at his hospital had been cut from 2,074 to 1,700 since he had been appointed to the position a short eighteen months earlier.[79] By this time, Dr. Glass had also submitted a request for a grant to build a new CMHC in Norman under the new Community Mental Health Centers Construction Act. This CMHC would operate in connection with Central State Hospital, renamed Griffin Memorial Hospital upon Dr. Griffin's retirement. Plans were already underway for two more CMHCs; one was to be located "at Muskogee, operated in connection with the mental hospital at Taft and one at Woodward to be operated in connection with Western State Hospital" at Vinita.[80] Dr. Glass saw these changes as part of an effort to deinstitutionalize Oklahoma's mental healthcare system and restructure it around theories of community psychiatry. He told *The Oklahoman,* the "magic

[77] Morris, "Albert Julius Glass, 1908-1983," 136.
[78] "State Hospitals Eye Legislation for Medicare," *The Oklahoman,* May 19, 1966.
[79] "Mental Board Picks Official," *The Oklahoman,* May 19, 1966.
[80] "State Hospitals Eye Legislation for Medicare," *The Oklahoman,* May 19, 1966. To offset the cost of new services not covered by the Community Mental Health Center Construction Act, Dr. Glass expected to receive more money from paying patients ensured by the federal government's new Medicare program.

word is continuity" and expressed a belief that "community care" and the CMHCs would be the future of mental healthcare.[81]

Many psychiatrists, lobbyists, and politicians shared Dr. Glass's beliefs in the importance of the "continuity of care." While some hoped that CMHCs would eventually and completely eliminate the need for hospitals, for many the "presumption was that community services would supplement but not replace traditional mental hospital services."[82] Instead, they believed CMHCs and community programs would work with hospitals to provide pre-care and after-care services. By doing so, they would make it simpler for patients to move through mental healthcare systems to receive different levels or intensities of care in response to their immediate needs.[83]

Although Glass's Department of Mental Health submitted an application for funds to build a CMHC in Norman, the Mental Health Board did not wait for approval to begin offering services. On March 1, 1967, the Central Oklahoma Community Mental Health Center began offering services in a temporary space in Griffin's 31 A and B buildings.[84] The first Director of the COCMHC was a German psychiatrist named Dr. Wolfgang Huber.[85]

Eventually, the federal government accepted Oklahoma's application and construction began. The contract to design the building was awarded to Smith, Day and Davies, Architects and Engineers. They submitted a design based on a cluster of four buildings which would have unique functions, such as outpatient services, a day hospital, a recreational space and cafeteria, and an inpatient unit.[86] The design of the inpatient unit enabled the COCMHC to treat a total of 32 patients. The building was evenly split between men's and women's rooms, allowing for the

---

[81] "Mental Board Picks Official," *The Oklahoman,* May 19, 1966.
[82] Grob, *From Asylum to Community,* 157.
[83] Ibid., 146.
[84] According to Oklahoma's Department of Mental Health, the COCMHC was the first CMHC in the nation because services were provided before the COCMHC had its own facility.
[85] Lachriscia "Chris" Guffy and Julia "Chris" Olsen. Interview by author, Central Oklahoma Community Mental Health Center, October, 23, 2015.
[86] Smith, Day and Davies, Architects and Engineers, "Architectural drawings for Central State Community Mental Health Center in Norman, Oklahoma," BLUEPRINT 0054, 9 items, Architecture Library, The University of Oklahoma.

COCMHC to treat sixteen men and sixteen women.[87] On July 3, 1969, the building opened for services.

Initially, the COCMHC staff was preoccupied with managing the disastrous effects of the rapid deinstitutionalization of Oklahoma's mental healthcare system. The majority of patients were discharged from the state hospitals with little preparation to help them reintegrate themselves into the community. For decades, some patients had considered the state hospital to be their permanent residence. They had not expected to live life outside of the institution ever again. Then they were discharged. How would they feed themselves? Where would they live? Had their families moved on with their lives while they were in the hospital? Did they even have families to go back to? Patients suddenly found themselves faced with this harsh reality. Although many had difficulty caring for themselves, in a short amount of time deinstitutionalization made them responsible for their own housing and care.

In the Department of Mental Health's efforts to decrease the inpatient hospital population, some elderly patients were released to nursing homes in a "lateral shift" of care following the expansion of federal welfare funds.[88] The federal government provided more funds for nursing home treatment than the states provided for treatment in their psychiatric hospitals.[89] Additionally, new medications allowed some patients to be treated effectively outside of a hospital setting.

However, these shifting patterns in care did not account for all of the patients released during the process of deinstitutionalization. The magnitude of the drop in the inpatient population was staggering. Within a decade, the inpatient population was nearly cut in half, with

---

[87] Chris Guffey and Chris Olsen interview by author, October, 23, 2015.
[88] Grob, *From Asylum to Community*, 269.
[89] Ibid., 269.

a large portion of the decrease occurring in only a few months.[90] The reductions were so large and conducted so quickly that Chris Guffey, then a mental health aid at Griffin and later the COCMHC, referred to deinstitutionalization as "when they emptied the state hospital."[91] The ramifications for this rapid and badly-conducted dispersal were enormous. Guffey recalled that most patients "had been [at Griffin] years and years and years and they were institutionalized and then all of a sudden they were out in the community, able to walk and go free. And they weren't used to that. And that didn't work well at all."[92] Her colleague Chris Olsen, then a nurse manager at Griffin and later the COCMHC, agreed that deinstitutionalization was "devastating for staff and the people."[93] She explained, "Staff were angry and devastated because these were their people and had been their people for twenty and thirty years. And they took care of them like they were family and suddenly these people were ripped out and sent to all these room and boards."[94] The COCMHC was expected to help deinstitutionalized patients cope with life outside of the hospital. However, this facility was in its fledgling stages and was not equipped to counterbalance the ill effects of the rapidly shifting structure of mental healthcare. In the face of literally thousands of discharged and disoriented patients, the COCMHC facility only had the space to treat thirty-two people at a time. Therefore, staff could only implement programs to help moderate the effects of deinstitutionalization on high-risk patients.

To care for a dispersed mentally ill population with an inadequate support system, no consistent residence, and limited mobility, the staff opened room and boards and satellite areas

[90] These reductions were likely inspired by the Joint Commission on Mental Health, which recommended that hospital populations be kept under 1,000 patients. See Joint Commission on Mental Illness and Health, *Action for Mental Health: Final Report, 1961* (New York: Basic Books, 1961) 267-75.
[91] Chris Guffey and Chris Olsen interview by author, October, 23, 2015.
[92] Ibid.
[93] Ibid.
[94] Ibid.

across the southern fourth of Oklahoma County as well as Cleveland and McClain Counties.[95] There were satellite areas in Oklahoma City, Del City, and Midwest City. There also were COCMHC-affiliated room and boards in cities such as Oklahoma City, Purcell, and Lexington. There were two room and boards in Noble. [96] Room and boards provided temporary housing while satellite areas offered some of the same treatments the COCMHC offered but in areas which were closer to where patients lived.

At the facility in Norman, the COCMHC offered a number of treatments. There were a few seclusion rooms as well as a small inpatient hospital for the treatment of severely mentally ill patients. However, the most severely mentally ill patients who walked through the doors of the COCMHC were often sent straight on to Griffin until they were well enough to be released for subsequent treatment at the COCMHC on an outpatient basis. For outpatient treatment, COCMHC staff relied upon medications, such as Thorazine, Haldol, and fluphenazine (Prolixin). While today patients may choose not to take their medications, during the early days of the COCMHC it was mandatory that patients take the medications prescribed to them. By seeing outpatients regularly, staff determined which personalized services a patient needed, such as case management, individual therapy, group therapy, or recreational therapy.[97]

While the COCMHC was originally concerned with following the recently-released Griffin patients, the focus of care quickly shifted to include services for new types of mentally ill patients. Although it had not been a large part of care prior to community psychiatry, the treatment of substance abuse and addiction became a major focus of Oklahoma's Department of Mental Health. Olsen remarked, "on Friday nights they would go out to the bars, they'd get drunk, they'd get in fights. And they'd end up—we used to call them the Friday Nighters. And

---

[95] This was the part of the state the COCMHC served.
[96] Chris Guffey and Chris Olsen interview by author, October, 23, 2015.
[97] Ibid.

sometimes, once they sobered up the next morning they could go home or go to jail. Whichever. But, yes. We had the Friday Nighters."[98] Because the COCMHC was never certified as a substance abuse treatment program, Friday Nighters who were not mentally ill had their basic needs met. Sometimes, the structure of the program alone helped to stabilize them. However, with the increased use of illicit drugs later in the 1960s, the COCMHC increasingly devoted its resources to the treatment of individuals with dual diagnoses of drug addiction and mental illness. Guffey remarked, "drugs have really just taken over. It's like everybody."

The COCHMC has responded to the increase in the incidence of substance abuse in part by restructuring its treatment programs. After implementing the Thunderbird Clubhouse program, the COCMHC allowed it to become a private-not-for-profit organization.[99] By doing so, the COCMHC helped provide for the treatment of substance addiction while also freeing its own resources. Additionally, the COCMHC has allowed other state and private substance addiction treatment programs to emerge, rather than seek certification as a substance abuse treatment program itself. Olsen recalled that the COCMHC changed when "the Anna McBride clinic came into force. She had a son who committed suicide. And this was about fifteen, twenty years ago. So a whole shift came there in terms of having mental health court and drug court to keep these people out of the hospital."[100] These new programs allowed the COCMHC to prioritize people discharged from the hospital or jail, "extremely fragile" people who seek treatment, and people who are in drug court or mental health court.[101]

Many historians have seen this increased focus on substance abuse as part of a trend of deemphasizing the treatment of severely mentally ill patients in state mental health systems. For

[98] Ibid.
[99] "Our History," Thunderbird Clubhouse, accessed December 6, 2015, https://www.thunderbirdclubhouse.org/our-history.
[100] Chris Guffey and Chris Olsen interview by author, October, 23, 2015.
[101] Ibid.

this reason, they are critical of community psychiatry and the CMHCs. Grob notes, "Severely and chronically mentally ill persons were now scattered throughout the mental healthcare system, but no single organization accepted longitudinal responsibility to provide for their basic needs."[102] Edward Shorter concurs with this analysis. He writes, "The CMHC's soon became diverted to psychotherapy sessions for the walking well, and in the first decades of deinstitutionalization no administrative arrangements were made to receive the actively ill patients who were simply being pushed out of mental-hospital doors."[103] This analysis leads him to dub deinstitutionalization the "shame of the states."[104] However, the scholars Richard G. Frank and Sherry Glied view changes in mental healthcare policy after 1950 in terms of exceptionalism and mainstreaming. They define exceptionalism as "Maintaining an exceptional, dedicated public mental health system" that "ensures the existence of caregivers of last resort."[105] The process of mainstreaming, however, broadens the scope of care to include funding for an increasing variety of patients and severity of illnesses. For Frank and Glied, community psychiatry and the CMHCs were part of a mainstreaming of mental illness and mental healthcare which they saw as generally positive. They write, "Our review of the past fifty years provides considerable evidence that . . . Inclusiveness and mainstreaming of people with even the most serious mental illnesses has resulted in tremendous gains in economic support for mental health care through SSI, SSDI, Medicare, and Medicaid."[106] However, the problem they see with community treatment is that, while "The economic tide created by mainstreaming improved the economic circumstances of people with mental illness," it also "swept the institutional structure

[102] Grob, *From Asylum to Community*, 264.
[103] Shorter, *A History of Psychiatry*, 280.
[104] Ibid., 280.
[105] Frank, Richard G., and Sherry A. Glied. *Better But Not Well: Mental Health Policy in the United States Since 1950* (Baltimore: Johns Hopkins University Press, 2006), 142.
[106] Ibid., 142.

of exceptionalism away with it."[107] Therefore, scholars generally agree that deinstitutionalization weakened the role of state psychiatric hospitals, which were the last institutions able to provide long-term care to those individuals with the worst mental illnesses.

Although it is undeniable that the CMHCs weakened the role of the state hospital, it is arguable whether the long-term effect of this power shift was negative. Prior to deinstitutionalization, there were no standards in place to limit hospital sizes and protect patient rights. Although mental health officials lacked sufficient planning when they reduced inpatient populations, the reduction itself was a positive development. Psychiatric hospitals could not operate with thousands of long-term patients and still treat residents humanely. Even with today's improved treatment methods, a patient population in the thousands would be incredibly difficult to manage. Griffin's history has demonstrated that a rise in the inpatient population also leads to a decrease in proper supervision and an increase in physical restraint. Therefore, mental health officials had to limit hospital sizes by reducing both patient populations and the average length of stay. While this meant that hospitals had to admit high-risk patients continually over their lifetimes rather than just once, it also meant that hospitals had to develop programs to help patients live outside of the hospital when they were well. Such programs simply did not exist prior to deinstitutionalization. With treatment, many people with chronic mental illness experience periods of debilitating illness followed by periods of relative wellness in which they are capable of functioning in their communities. Other diseases, such as severe diabetes, have a similar effect on those who live with them. One would not suggest that a person with severe diabetes remain in the hospital when their blood sugar is under control simply because they will have to return eventually. It is no more humane to suggest that people with mental illness remain in the hospital during periods of relative wellness just because one expects that they will relapse

[107] Ibid., 142-3.

into illness. The overall effect of the CMHCs was therefore positive. For the first time, the CMHCs helped people with chronic mental illness live life in their communities when they were well and provided some structure to help them return for more intensive treatment when they were not.

Therefore, the problem lies not with the fundamental goals of deinstitutionalization, but rather with the disjointed way in which it was implemented. During the early years of the COCMHC, there certainly were no programs to meet the long-term care needs of severely and mentally ill patients Mental health professionals have tried to correct this problem by introducing new programs over time. One such COCMHC program is Program of Assertive Community Treatment (PACT or ACT). In this program, teams of doctors, nurses, therapists, case managers, and recovering patients assist groups of 100 outpatients. To be eligible for treatment with a PACT team, a patient must have schizophrenia, bipolar disorder, major depression with psychotic features, or another comparatively severe and debilitating mental illness. PACT teams help their 100 patients treat their illness by providing daily follow-ups and case management and by assisting with daily living requirements. The National Association on Mental Illness (NAMI) describes this program as “mostly used for people who have transferred out of an inpatient setting but would benefit from a similar level of care and having the comfort of living a more independent life than would be possible with inpatient care.”[108]

Although many historians criticize community programs for disrupting the hospital’s role as the consistent provider of care for severely and chronically mentally ill people, programs such as PACT provide a promising alternative to hospitalization. NAMI notes that “Studies have shown that ACT is more effective than traditional treatment for people experiencing mental

---

[108] “Psychosocial Treatments,” NAMI: National Alliance on Mental Illness, accessed November 9, 2015, https://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments.

illnesses such as schizophrenia and schizoaffective disorder and can reduce hospitalizations by 20%."[109] Grob notes that programs like PACT were part of a shift from an emphasis on cure to "the need to limit disability and to preserve function."[110] Initially, Grob was highly critical of the way the CMHCs' treatment of substance abuse overshadowed the care of severely and chronically mentally ill patients. However, in a subsequent book Grob softens his criticism of the changes wrought by community psychiatry. He writes, "The persistence of problems . . . should not be permitted to conceal the more important fact that a large proportion of severely and persistently mentally ill persons have made a more or less successful transition to community life as a result of the expansion of federal disability and entitlement programs."[111] Therefore, through the use of programs such as PACT, the COCMHC has had some success in its efforts to help severely and persistently ill patients manage their mental illness on a long-term outpatient basis.

One constant in the analysis of the effects of community programs is that there are at least two ways to view any change: a positive and a negative one. For example, eliminating and introducing new programs in response to trends or the actions of private-not-for-profit organizations was often difficult for patients and staff. Too many changes led to sense of inconsistency. As soon as patients and staff became used to a program, it seemed that administration phased the program out. Chris Guffey remembered the day hospital at the COCMHC as "a good program" for patients, which was eventually shut down "like everything else."[112] On the other hand, this inconsistency can be viewed as the very type of adaptation for which the CMHCs were uniquely capable. Unlike psychiatric hospitals, CMHCs had no definite structure. In fact, there were only five National Institute of Mental Health requirements for

[109] Ibid.
[110] Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (NewYork: The Free Press, 1994), 306.
[111] Ibid., 308-9.
[112] Chris Guffey and Chris Olsen interview by author, October, 23, 2015.

CMHC structures and services. These were that CMHCs

> provide at least 5 essential services (expanded to 12 in later years) - inpatient, outpatient, partial hospitalization, emergency . . . consultation and education; serve a 'catchment' area of no less then [sic] 75 000 and no more than 200 000 people (what would become a controversial issue); ensure continuity of care between the services; be accessible to the population to be served; serve people regardless of their ability or inability to pay.[113]

Clearly, CMHCs were intentionally ill-defined institutions. The officials who drafted the legislation hoped this ambiguity would make it easier for the legislation to pass Congress. However, vague terms such as "be accessible" also permitted communities to experiment when determining the shape of their CMHC.[114] Ambiguity of structure allowed these facilities to reinvent their programs in response to community needs, which changed over time. Eventually, the COCMHC did not need a day hospital because Griffin, general hospitals, and other facilities were providing similar services. The COCMHC day hospital was therefore an unnecessary use of funds which could be abandoned. Instead, Oklahoma was in need of a program that provided long-term care to help seriously mentally ill people live in a community setting. When this became apparent, the COCMHC had the structural freedom to implement PACT in response to this community need.

Similarly, the broadening of services had both positive and negative effects. Severely and persistently mentally ill people no longer had one institution providing all of their healthcare needs. Nevertheless, through the use of programs like PACT, the COCMHC began to construct a framework to help even these patients live outside of a hospital setting. This process is ongoing. Additionally, the broadening of services allowed more people to receive help. Prior to the rise of community psychiatry, individuals experiencing mild or moderate mental illness had no

---

[113] Saul Feldman, "Reflections on the 40th Anniversary of the US Community Mental Health Centers Act," *Australian & New Zealand Journal Of Psychiatry* 37, no. 6 (December 2003): 663.
[114] Ibid., 663.

treatment options other than state psychiatric hospitals if they could not afford to pay a psychiatrist in private practice. With the conditions of state hospitals as dire as they were, it seems safe to assume that at least some individuals went without treatment rather than check into a state psychiatric hospital. It seems incorrect to imply that these people should have gone without aid just because their symptoms were not completely and thoroughly debilitating. While acknowledging that severely mentally ill people deserve priority, it should also be noted that CMHCs affected positive change by extending treatment opportunities to people who previously had to choose between no treatment or treatment in a facility whose conditions potentially rendered treatment more harmful than their mental illness itself.

Since the 1960s, community programs have increasingly become the standard of psychiatric care in Oklahoma. Mental health professionals still subscribe to a foundational view of care which assumes that outpatient care is preferable to inpatient care and that mental illness can sometimes be prevented by early intervention in the community environment. Far from believing that the way to improve the care of severely and chronically mentally ill people is to increase the size of state hospitals, mental healthcare professionals cannot fathom returning to the standard of care which existed in Oklahoma during the 1950s. On the contrary, in the state psychiatric hospitals the inpatient space available to people with severe mental illnesses is smaller than ever. Taft was shut down while Eastern State Hospital at Vinita was converted to the Oklahoma Forensic Center (OFC). In addition to the fact that this facility reduced its inpatient population to 200, the OFC's patients are limited to those "who have been found incompetent for adjudication or adjudicated as Not Guilty by Reason of Insanity."[115] Fort Supply is now the site of a small inpatient and residential program for the Northwest Center for

[115] "Oklahoma Forensic Center," Oklahoma Department of Mental Health and Substance Abuse Services, accessed November 11, 2015, http://ok.gov/odmhsas/Mental_Health/Oklahoma_Forensic_Center.html.

Behavioral Health, which has a main facility in Woodward. Griffin Memorial Hospital decreased its inpatient population from almost 3,000 to only 120.[116] While the rise of psychiatric clinics in general hospitals has offset the loss of some of these services, these units only serve paying patients. Those who are unable to pay rely increasingly on outpatient programs like the COCMHC. All of Oklahoma's state psychiatric facilities must meet the challenge of providing care for both Oklahoma's most severely mentally ill persons as well as individuals whose illnesses could become worse over time. Unlike general hospitals, they must do so despite the fact that many of their patients are unable to pay for services. Oklahoma's CMHCs will continue to be a central element of Oklahoma's mental healthcare system. Because they are more adaptable institutions than state hospitals, these facilities are crucial participants in the state's efforts to develop programs to integrate mental healthcare and physical care and, by doing so, continue to improve healthcare moving forward.

[116] Griffin can treat forty-five females and seventy-five males.

Fig. 1 *Dayroom scene of patients at the State Hospital for the Negro Insane at Taft, Oklahoma*, July 27, 1946, The Mike Gorman Papers, U.S. National Library of Medicine, National Institutes of Health, Maryland. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/TGBBGW.

Fig. 2 *Ward for violent female mental patients at Central State Hospital, Norman, Oklahoma*, July 20, 1946, The Mike Gorman Papers, U.S. National Library of Medicine, National Institutes of Health, Maryland. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/TGBBGW

Bibliography

Primary Sources

The Council of State Governments. *The Mental Health Programs of the Forty-Eight States: A Report to the Governors' Conference.* Chicago: The Council of State Governments, 1950.

Dayroom scene of patients at the State Hospital for the Negro Insane at Taft, Oklahoma. July 27, 1946. The Mike Gorman Papers, U.S. National Library of Medicine, National Institutes of Health, Maryland. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/TGBBGW.

Gillespie, R.D. *Psychological Aspects of War.* New York: W.W. Norton, 1942.

Gorman, Mike. "Misery Rules in State Shadowland." Reprinted from *The Daily Oklahoman,* September 22, 1946. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/TGBBGW

Guffy, Lachriscia "Chris" and Julia "Chris" Olsen. Interview by author. Central Oklahoma Community Mental Health Center, October, 23, 2015.

Joint Commission on Mental Illness and Health. *Action for Mental Health: Final Report, 1961.* New York: Basic Books, 1961.

Kennedy, John F. "Special Message to the Congress on Mental Illness and Mental Retardation." February 5, 1963. *The American Presidency Project*. http://www.presidency.ucsb.edu/ws/?pid=9546.

Knee, Junior Koenig. "Administration of the Central Oklahoma State Hospital." Masters thesis, University of Oklahoma, 1942.

"Mental Board Picks Official." *The Oklahoman,* January 20, 1966.

Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. Public Law 88-164. U.S. Statutes at Large 77 Stat. 282. 88th Congress, 1st Session (1963): 282-299.

Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965. Public Law 89-105. U.S. Statutes at Large 79 Stat. 427 (1965): 427-430.

Oklahoma Report: An Informative Documentary on the Progress Achieved in the Treatment of Oklahoma's Mentally Ill. Oklahoma Mental Health Association, 1950, 16 mm film. From Oklahoma Historical Society Film and Video Archive. AVI video, 25 min., 48 sec. https://www.youtube.com/watch?v=Vg5sLuSYpdE&feature=youtu.be.

Sisney, Steve. Photo of Dr. Griffin and Dr. Clark. Date unknown. Included in Zizzo, David. "Hidden Oklahoma: Norman hospital once a 'mythical city'." *The Oklahoman,* March 13, 2011. http://newsok.com/gallery/articleid/3546956/pictures/1378987.

Smith, Day and Davies, Architects and Engineers. "Architectural drawings for Central State Community Mental Health Center in Norman, Oklahoma." BLUEPRINT 0054, 9 items, Architecture Library, The University of Oklahoma.

"State Hospitals Eye Legislation for Medicare." *The Oklahoman,* May 19, 1966.

Tatge, Clara Viola. "Social Backgrounds of One Hundred-Six Families Under Care at Central State Hospital." Masters thesis, University of Oklahoma, 1952.

U.S. Army Medical Department. *Neuropsychiatry in World War II.* Washington, D.C.: Office of the Surgeon General, Dept. of the Army, 1966.

Ward for violent female mental patients at Central State Hospital, Norman, Oklahoma. July 20, 1946. The Mike Gorman Papers, U.S. National Library of Medicine, National Institutes of Health, Maryland. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/TGBBGW.

Secondary Sources

Articles

"Dr. Hayden H. Donahue." *The Oklahoman,* November 4, 2002, Obituaries/Death Notices.

Feldman, Saul. "Reflections on the 40th Anniversary of the US Community Mental Health Centers Act." *Australian & New Zealand Journal Of Psychiatry* 37, no. 6 (December 2003): 662-667.

Freedman, Alfred M. "Historical and Political Roots of the Community Mental Health Centers Act." *American Journal of Orthopsychiatry* 37, no. 3 (1967): 487-494.

Morris, Jane C. "Albert Julius Glass, 1908-1983." In *Builders of Trust: Biographical Profiles from the Medical Corps Coin*, edited by Sanders Marble, 135-144. Fort Detrick, Maryland: Borden Institute, 2011.

"Oklahoma Forensic Center." Oklahoma Department of Mental Health and Substance Abuse Services. Accessed November 11, 2015. http://ok.gov/odmhsas/Mental_Health/Oklahoma_Forensic_Center.html.

Oklahoma Hall of Fame. "David Griffin." *Oklahoma Hall of Fame.* Accessed October 20, 2015. http://www.oklahomahof.com/Portals/0/PDF's/HOF%20bios/Griffin,%20David.pdf

"Our History." Thunderbird Clubhouse. Accessed December 6, 2015. https://www.thunderbirdclubhouse.org/our-history.

"Psychosocial Treatments." NAMI: National Alliance on Mental Illness. Accessed November 9, 2015. https://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments.

Steen M.D, Carl T. "The Home for the Insane, Deaf, Dumb and Blind of the Cherokee Nation." *Chronicles of Oklahoma* 21, no.4 (1943): 402-419.

U.S. National Library of Medicine. "The Mary Lasker Papers: Biographical Information." *Profiles in Science.* Accessed October 27, 2015. http://profiles.nlm.nih.gov/ps/retrieve/Narrative/TL/p-nid/199

Books

Frank, Richard G., and Sherry A. Glied. *Better But Not Well: Mental Health Policy in the United States Since 1950.* Baltimore: Johns Hopkins University Press, 2006.

Grob, Gerald N. *From Asylum to Community: Mental Health Policy in Modern America.* Princeton: Princeton University Press, 1991.

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

Levy, David W. *The University of Oklahoma A History: Volume 1, 1890-1917.* Norman: University of Oklahoma Press, 2005.

Shorter, Edward. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac.* New York: John Wiley & Sons, 1997.

Shorter, Edward. *The Kennedy Family and the Story of Mental Retardation.* Philadelphia: Temple University Press, 2000.