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Steve Bogira

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Report From The Field

Starvation Diet: Coping With Shrinking Budgets In Publicly Funded Mental Health Services

Facilities in many states face closures; some consumers are fighting back.

by Steve Bogira

David Mailey, 52, has broad shoulders, a gap-toothed grin, a graying beard, and a sly wit. The pinky on his left hand is crooked, the result of a misunderstanding with a window thirty-one years ago, during his first hospitalization, in a state psychiatric facility in Tinley Park, a suburb southwest of Chicago. “Me and this other guy needed some air, so we tried to break the windows together. Those windows don’t break.”

Mailey still lives in Woodlawn, the south-side Chicago neighborhood in which he grew up. It was and remains a poor, African American area. The family was supported by welfare; Mailey, the youngest of eleven, says he frequently went hungry. He attended college in central Illinois in 1977, and enjoyed it: “There was no broken glass.” But he failed his classes because he started having “psychological problems.” His behavior grew bizarre after he returned to Woodlawn. “I was walking down the street, picking up garbage, eating it. I was doing Shakespeare on 63rd Street—‘To be or not to be,’ ‘Take thee to a nunnery.’ You don’t do Shakespeare on 63rd. My sister was concerned about my safety, and then I pulled a knife on my brother and she really didn’t like that.” She had him committed to the hospital in Tinley Park in 1978. He was diagnosed with schizophrenia.

Mailey spent much of the next ten years in psychiatric hospitals and shelters, with a few brief stretches in jail for various misdemeanors. After one hospitalization, he was released into the care of his oldest brother, who was also schizophrenic. “All he did was collect rent from my little public aid check and half my food stamps, and I had to make it as best I could at the soup kitchens.”

In the late 1980s he moved into a halfway house in Woodlawn, whose director required residents to seek day treatment at the Woodlawn Mental Health Center, run by the city of Chicago.

Mailey has been a regular at the center ever since. He gets his antipsychotic medicine there, and he takes it dependably because “if I miss one day they know—they just know.” He lives in a private, subsidized apartment now, two blocks from the center, and gets by on Supplemental Security Income (SSI).

The Woodlawn center is in a humble, one-story building that looks onto an assembly of vacant lots. The University of Chicago is a few blocks north, and President Barack Obama’s home just beyond that.

Mailey likes the staff at the center and especially enjoys his Friday group meetings with other clients. The group has become family. “We’re all like brothers and sisters and cousins...”
ins. We got our own families, but they didn't accept us. We hope to be there for each other when nobody else is." He sometimes bakes brownies or chocolate cake for the meetings. The center has been "invaluable" for him, Mailey says—the main reason he hasn't been hospitalized for going on twenty-one years.

Consolidation In Chicago

In January 2009, Dr. Terry Mason, Chicago's public health commissioner, announced that the city would be "consolidating" its mental health centers. The city had closed seven of its nineteen centers in the 1990s. Recent budget cuts had reduced services in the remaining dozen centers, but among them, they retained a loyal caseload of 6,500. Now the city intended to close four more centers by February—including the one in Woodlawn. Clients at the centers being "consolidated" would be welcome at the centers remaining open, Mason said. He blamed "severe budget shortfalls" at all levels of government—and, in particular, a recent $1.2 million state funding cut.

Clients of the centers and their advocates decried the plan. The centers were crucial for their clients, supporters said, and were needed more than ever, with the crash of the economy and the anxiety it was causing. "You don't cut back on money for snow removal after a blizzard," said one client, Fred Friedman.


Although the mayor was reducing the state to a four-letter word, the centers are, in fact, funded by both city and state: Chicago spends $6 million and Illinois, $7 million, annually to operate the twelve clinics. And Illinois officials disputed the mayor's claim that the state was the villain, saying that less money had been advanced to the city because of billing deficiencies on Chicago's part. The state has been switching from a grant-in-aid to a fee-for-service system, and the transition statewide has been difficult. Dr. Mason allowed that problems with a new computer system had resulted in delays in billing the state that led to the loss of the $1.2 million.

Advocates, noting that the four clinics slated for closing served mainly poor African Americans and Latinos, charged that both the city and the state were trying to save money at the expense of some of their least fortunate citizens. They vowed to fight the closings. At a community mental health board meeting in late January, they grilled Mason on his plan, and two days later, they protested at City Hall. Mason and the city stood firm, but the closings were postponed until early April to allow more time to inform clients.

The Situation Nationwide

Thanks to Medicaid and private insurance, spending on mental health increased dramatically in the latter half of the twentieth century.1 And as Sherry Glied and Richard Frank observe in this issue, many of the gains continued from 1996 through 2006.2 But a lot has happened since 2006—not much of it good for people with mental illnesses who can't afford care and lack private coverage. State budget cuts have imperiled mental health services across the nation.

Chicago wasn't the only government body trying to make ends meet by closing mental health facilities. A fight was brewing in Virginia, where advocates were challenging the governor's plan, announced in December 2008, to close its only remaining psychiatric hospital for children. In January, Maryland officials said they planned to close Baltimore's only public psychiatric hospital, which served thousands of outpatients annually and provided fifty-one inpatient beds. January 31 was the last day of operations for Massachusetts' Goldfarb Behavioral Health Clinic, in Boston, which served 370 clients in 2008. Officials in Riverside County, California, said in February that they would close three mental health clinics, including an outpatient clinic that annually saw 2,400 people.

The fallout from the states' financial troubles extends beyond the government-run facilities. Most private mental health providers depend on the money doled out through their state mental health agency (SMHA). In a
study last fall by the Research Institute of the National Association of State Mental Health Program Directors, thirty-two of forty-two SMHAs responding said their budgets were being cut this year and next. The 2009 cuts averaged 4.9 percent; the agencies anticipated cuts in 2010 averaging 8.2 percent. Thirteen of the responding SMHAs said they already expected budget cuts two years from now. Agencies were coping with the cuts by freezing hiring and trimming staff, pruning administrative costs, reducing services and the number of people served, and closing state hospitals. The vast majority of states were anticipating Medicaid cuts as well, and many were reducing provider rates. Ted Lutterman, director of research analysis, says the institute is already planning to update the study because “the situation has gotten much more dire” since it was conducted.

In Illinois, then Governor Rod Blagojevich slashed mental health funding by 8 percent and substance abuse treatment funding by 41 percent last July. Under pressure from the public and the legislature, he restored most of that money in November, but in the interim, many Illinois providers had to lay off staff, close programs, and turn away clients. “It’s like a slow bankruptcy,” says Frank Anselmo, chief executive officer of Community Behavioral Healthcare Association of Illinois. The association represents 90 of the state’s 150 community-based, not-for-profit mental health and substance abuse treatment providers. The outlook for mental health funding in the next Illinois budget was no brighter. “We’re squeezing a lemon that’s already dry,” Anselmo says. Consumers who do get served by providers will likely have to wait longer for it, he says, which is “a little different from waiting for a car repair.”

The Illinois association’s national counterpart, the National Council for Community Behavioral Healthcare, reports similar difficulties. The council represents 1,600 community mental health and addiction treatment agencies. Even in more prosperous times, these agencies typically operate with margins of only 0.5 or 1 percent, according to Chuck Ingoglia, vice president of public policy. So the pressure on them now is enormous, he says—and it’s exacerbated by the credit crunch, since the agencies often rely on bridge loans to get by. Few agencies have closed, but many have laid off staff and cut services.

Linda Rosenberg, the council’s president and CEO, told a House Appropriations subcommittee in March about the predicament of mental health care providers in a time of fewer resources and greater need: “My members are caught in a policy vise, with declining state support on the one hand and steadily increasing patient caseloads on the other.”

Advocates maintain that the current financial crisis has only exposed a long-standing stinginess on the part of state government regarding mental health. Anselmo isn’t alone in asserting that his state “has always underfunded behavioral health. It was underfunding behavioral health when it had record revenues.”

“Underfunding” is a subjective judgment. But it’s clearly true that state spending on mental health had been stagnant for years preceding this economic nosedive. From 1981 through 2005, SMHA spending, adjusted for inflation, grew 0.9 percent annually. Adjusted for population growth as well, SMHA spending actually declined 0.2 percent a year during those twenty-four years. It also lost a little ground compared with other state programs, declining from 2.09 percent of all state spending in 1981 to 1.98 percent in 2005.

Not that the federal government has aided mental health much, either, in recent years, other than its matching of the states’ Medicaid spending. As of 2005, the federal Community Mental Health Block Grant accounted for a grand total of 1.4 percent of states’ mental health spending. In Rosenberg’s testimony to the appropriations subcommittee, she asked for a $100 million increase in the block grant, noting that it hadn’t received an appropriations increase in almost a decade and had lost half of its purchasing capacity over that time.

Anselmo says that despite “slow progress” in fighting the stigma of mental illness, mental health remains an unpopular cause. In Illinois,
advocates who attend state hearings on issues involving physical disabilities outnumber those who show up when mental health is on the agenda “ten or twenty to one,” he says.

David Shern, president and CEO of the advocacy group Mental Health America, considers the nation’s present mental health care circumstances a “public health emergency.” He notes the lack of widespread outrage despite accounts of clinics and hospitals closing, agencies shutting down programs, and people with mental health crises being turned away from care. “We wouldn't tolerate people with infectious diseases not getting access to simple antibiotics,” he says. “If at the emergency room they said, ‘Geez, it looks like you're having a heart attack, but we're sorry, we just don’t treat that here’—we wouldn't tolerate that, either. But we routinely tolerate it when it’s behavioral health conditions.”

Shern attributes this to a belief that mental illness “reflects moral weakness”—an idea that still prevails despite “enormous progress in demonstrating the legitimacy of these disorders as treatable medical conditions.” A socioeconomic factor is also at work, he says. Because poor people are more vulnerable to mental illness—both because of the harsh circumstances of their lives and because they have “fewer resources they can bring to their defense”—the mentally ill are disproportionately poor, he says, and the association with poverty makes the “moral weakness” notion even harder to overcome. Shern thinks this will only be surmounted by “a continuing public education effort to establish the legitimacy of these conditions.”

**Staying Afloat In Chicago**

Dr. Carl Bell, a member of the Chicago Board of Health and a prominent Chicago psychiatrist, backs the city’s plan to close the four centers. Early in his career, Dr. Bell worked part time for three years in one of the city clinics—mainly “dishing meds,” he says. Now he is president and CEO of the Community Mental Health Council, a not-for-profit community mental health center on Chicago’s southeast side with thousands of clients and a $21 million budget. His agency took over one of the city clinics in the 1980s, resulting, by all accounts, in vastly improved services.

The city’s centers provide “decent” care for patients who are “in a groove,” Bell says—“people who are age fifty or sixty and who have been suffering from schizophrenia for thirty years, and everything is stable—their housing, income, medication, friends. But the chronic, young, new schizophrenic, who’s bouncing all over, needs somebody who can meet their comprehensive needs.” His agency offers twenty-four-hour emergency care and help with housing, and it has linkages with local hospital psychiatric units—more than the bare-bones city centers can provide, he says.

But who will care for the older, chronic patients if the city keeps closing its centers? Bell says private agencies like his will: “Those patients are easy—I can do that in my sleep.”

Supporters of the city centers, however, doubted that private agencies would pick up the slack, noting that those agencies, too, are subject to declining aid from the state.

Dr. Bell allows that it’s been “hard as hell” to stay afloat recently. The state’s switch to fee-for-service has resulted in his clinical staff’s spending patient-care time on paperwork instead. “And then to make matters worse, the state pays you a month, two months, three months late. We’re always sweating bullets at payroll time because of cash flow.”

Notwithstanding his view that the city ought to close centers, he sympathizes with patients who fear they’ll be left out in the cold. “I’m scared, too, that the city will stiff everybody they can to save money—what the hell do they care? Mentally ill people don’t vote.”

**Centers Of Compassion**

Chicago opened its public mental health centers in the 1960s, and by the late 1970s it had twenty-two of them. As in the city’s other departments, the centers were infected with patronage; a nod from the ward boss was often key to a staff position. The psychiatrists were part-timers. (“Drive-by docs,” Bell calls them.) Case management and therapy were handled
mostly by social workers and people with master’s degrees in psychology or counseling.

The centers have been vital for their clients regardless, says Badonna Reingold, a social worker in the Woodlawn center in the 1970s and on its board ever since. The Woodlawn center has always been a “warm, welcoming place” for patients, she says. “You’d walk in the door, you knew you wouldn’t be turned away.”

“We stressed compassion,” says Jan Gilmore, a therapist at Woodlawn since 1980. He says clients like David Mailey made great strides over the years because of the “caring, supportive environment. It wasn’t just the medication.”

Mailey is “resilient and resourceful enough” to manage the transition to another center, Gilmore says—but some of his other clients are less capable of adapting. He worries that the change may unshelve them, set them on a course that leads to homelessness or jail. For the mentally ill in Chicago, the consequences of going to jail can be severe. Arrestees often end up in the Cook County Jail, the sprawling southwest-side complex that typically holds 10,000 defendants who can’t make bail. In a report published last July, the U.S. Justice Department blasted conditions in the jail—denouncing its mental health care in particular. Suicide prevention practices were “grossly inadequate,” and mental health care was inadequately staffed, supported, trained, and supervised, the report said. The screening process used to identify mentally ill inmates was “completely inadequate”—based on “virtually no” records, and on an interview of less than five minutes by an insufficiently trained mental health “specialist.” Mental health records accumulated during an inmate’s stay were often “incomplete, unfiled, and inaccurate,” leading to conflicting diagnoses and erroneous prescriptions—and, ultimately, “mental health deterioration and unnecessary suffering,” the report found.

Need For Prevention, Not ‘Iron Lung’ Machines

Dr. Bell wishes that advocates would holler not just about the closing of clinics but also about the lack of funding for prevention in mental health treatment. He points to growing research suggesting that family interventions can reduce violence, substance abuse, teen pregnancy, high school dropout, depression, and post-traumatic stress disorder (PTSD). He thinks clinicians should pay more attention to the children of clients with affective disorders, who are at risk of developing the disorders themselves. But clinicians don’t do that because they don’t get paid to do it, he says—they get paid, mainly, to treat the chronically mentally ill. “We’ve got to do more on the front end,” he says. “We’re all in the iron lung business—the psychiatrists, the social workers, the city clinic employees. That includes me; I’m the CEO of an iron lung machine. If I could blow this sucker up I would do it—if I could take the money and do prevention.”

For anyone who recalls the origins of the community mental health center movement, this call for a focus on prevention may have a familiar ring. Prevention was part of the mission of the community centers in their early years—and nowhere was this more true than in the Woodlawn center now slated for closing. Founded in 1962 by three Yale psychiatrists, Woodlawn was originally a “laboratory in social and community psychiatry” as well as a center for treatment of the chronically mentally ill. It was sponsored jointly by the University of Chicago and the city.

One of the founders, Dr. Sheppard Kellam—now a professor emeritus at the John Hopkins Bloomberg School of Public Health—recalls that when he and his colleagues came to Woodlawn, they were mainly interested in providing comprehensive community care for the severely mentally ill. But community leaders in Woodlawn “pushed us hard to work on prevention. We told them we didn’t know anything about prevention. Their response was, ‘You guys are smart, you’ll figure it out.’ They weren’t interested in us just putting Band-Aids on social wounds.”

Kellam and his colleagues focused on first graders in Woodlawn, fostering a collaboration between a child and his or her family and teacher—a collaboration he says helped im-
prove the child’s behavior and success in school. After Kellam left Chicago in 1982, he further developed his early-intervention program in Baltimore elementary schools.

The Woodlawn center also treated the neighborhood’s chronically mentally ill, identifying them with the help of community outreach workers. It was able to play such a broad role because it had the money to do it. It was supported mainly by federal and state grants in its early years. But the funding didn’t last—for Woodlawn or for its counterparts across the country. The original plans for community mental health centers called for declining proportions of federal funds and increasing proportions of local support—and only the former happened. In 1981, President Ronald Reagan delegated to the states the responsibility for community mental health services through block grants. The meager funds the states then steered to providers were targeted at the population that states had traditionally felt most comfortable serving: the chronically ill. Prevention programs became an anachronism.

**Children’s Facilities In Virginia**

Workers at the Commonwealth Center for Children and Adolescents, in Staunton, Virginia, got the news by e-mail on the morning of December 17, 2008: Gov. Tim Kaine planned to close the center by the end of June 2009. The e-mail was from James Reinhard, commissioner of Virginia’s Department of Mental Health, Mental Retardation, and Substance Abuse Services. Reinhard, like heads of the state’s other agencies, had been directed by Governor Kaine to propose reductions to help cover a nearly $3 billion shortfall in the state’s 2009–2010 budget. Reinhard had suggested closing the forty-eight-bed Commonwealth Center and a sixteen-bed unit for adolescents in Marion. In the past two decades, Virginia had closed or transferred to private entities its other state-run psychiatric beds for children—and now it was proposing to close the state’s remaining sixty-four beds. The closings would save Virginia $7.6 million annually.

The therapists, social workers, and other staff at the Commonwealth Center were flabbergasted. The center accepts children in crises, who have been turned away from or turned out of other facilities. Says Barbara Shue, the center’s social work director: “We take the kids who don’t have insurance, or who have exhausted their insurance, or whose behavior is such that they could have the best insurance in the world and no private hospital is going to touch them. So it came as a huge surprise for us when the commissioner decided he was just going to lop off this service.”

Reinhard also instructed the Commonwealth Center to stop taking admissions immediately—an order that further dumbfounded the center’s staff. What would happen in the short term to the kids no one else would take? Reinhard rescinded the order later in the day.

That proved pivotal for Staunton resident Julie Irvine and her nine-year-old son. The following day, December 18, her son, whose turbulent behavior had led to several previous hospitalizations, was in turmoil again, threatening to hurt others and vowing to kill himself. Irvine took him to the emergency room of her local hospital. Her son’s other hospitalizations in 2008 had depleted her insurance coverage; she says she was told by ER staff that no hospital in Virginia would admit him. He was sedated and sent home. The next morning, Irvine managed to get her son admitted to the psychiatric ward of a hospital in Roanoke. He had another outburst in that hospital, requiring restraints and sedation, Irvine says; but on Christmas Eve, after he’d been in the hospital five days, she was informed that unless she could find a facility to which her son could be transferred, he would be released that day. Irvine eventually found the one place in Virginia that would take him: the Commonwealth Center.

Shortly after his arrival at the center, Irvine says, her son tried to put himself through a window and attacked a nurse. But in her daily visits, she saw him gradually calm—“not enough for him to come home, but he definitely improved. One day he was even laughing and smiling.” After three weeks, she was able to get him into a residential hospital just over...
an hour's drive from her home. She isn't sure how long he'll have to remain there, and her debt for his hospitalization is mounting. But the care he got at the Commonwealth Center put him on a hopeful track, she says.

The situation in Virginia is the flip side of the situation in Chicago, but the root problem is the same: insufficient funding for community mental health care.

For years, child advocates have been prodding Virginia to shift from state mental health facilities toward community-based care. But even these advocates decried as premature the plan to close the Commonwealth Center and the unit in Marion. “You can't close those facilities until you have the community alternatives in place,” says John Morgan, executive director of Voices for Virginia's Children. “And those community alternatives have not yet been developed anywhere in Virginia. Some places aren’t even thinking about those services yet—because they lack the resources.”

“Moving kids toward the community makes sense,” says Jeffrey Aaron, a clinical psychologist who directs one of the adolescent units at the Commonwealth Center. But closing the state facilities before the resources are in place “is like saying, ‘We don’t think kids should be cared for in intensive care units, we think they should all get good primary care—so we’re going to close the intensive care units’.”

Commonwealth Center supporters crammed the center's gym on a morning in early January, when Commissioner Reinhard and his boss, Marilyn Tavenner, secretary of health and human services, visited to defend the proposed closing. Their PowerPoint presentation failed to sway Irvine and other parents, who gave the state officials an earful about the center's importance. “The outpouring of support for this place was overwhelming,” social work director Shue says.

A Successful Model

Children brought to the Commonwealth Center are divided into four units of a dozen children or fewer—units each staffed by a psychiatrist, a psychologist, and two social workers, with nurses available around the clock. The children attend a public school in the center, in classes of no more than six.

In 1982, when Shue came to the center, thirty-five children were admitted annually, and they stayed eight months to a year. As the preference for community-based treatment grew, the center's mission changed dramatically, to short-term stabilization; now the center admits 600 children a year and keeps them only two or three weeks. Shue and other social workers start planning for a child's release almost the moment he or she arrives. In Virginia, mental health treatment is allocated through forty community services boards (CSBs). Shue and her social workers hold conference calls with members of the boards, with school officials, and with parents, to determine what services will be available for children when they leave the center. Often, there isn't much. And although most funding for the CSBs comes from the state, they are also partly dependent on local dollars, creating a wide variance in services between wealthy and poor areas. Some programs for children are restricted to those eligible for Medicaid, so finding services for uninsured kids is a particular challenge.

Says Shue, “Sometimes we’re pedaling as fast as we can, trying to figure out how we can get a child out so we can bring in another child who needs us, and feeling frustrated because communities don't have the necessary resources.” On occasion, she says, “we discharge kids who we think could benefit from being in treatment longer, because we have to make room for more kids. We end up seeing some of these kids over again. Do I think we're providing as good treatment as we did ten, fifteen years ago? No. Because then we could keep kids longer, and they were a little more stable when they left.”

Fighting Back

A coalition to oppose the closings formed in January, including Voices for Virginia's Children, the Virginia Poverty Law Center, the Virginia chapter of the National Alliance on Mental Illness, the Virginia Coalition for Juvenile Justice, and the American Academy of Pediat-
The proposal to close the centers came less than two years after the massacre of 16 April 2007—the day a student with a severe anxiety disorder shot to death thirty-two people, and himself, on the Virginia Tech campus in Blacksburg. That led to a clamor in the state for mental health reform and, last year, a $42 million boost in mental health funding.

Virginia had hardly been a leader in mental health services before the massacre. Even with increased spending from 1997 through 2006, Virginia had an underfunded system full of gaps, as Richard Bonnie notes. The increased funding and reforms enacted in 2008 are “only a few steps along a difficult path,” according to Bonnie. “The question is whether the momentum for reform can be sustained as the memory of April 16 recedes.”

Children's mental health reform in Virginia has lagged far behind reforms aiding adults. Of the 2008 funding increase, “kids’ services ended up with a pittance—about 8 percent,” Shue says. Adds Morgan of Voices: “For the last dozen years, folks in the child mental health field have been saying, ‘When is it going to be our turn? When is Virginia going to do as much to help kids?’”

Morgan believes that an advocacy group—his or another—needs to lead a campaign to make children’s mental health a greater priority in Virginia. Other children’s issues—education, day care—“have champions in government, so we’re making significant progress on those,” Morgan says. “But there are very few champions here for children’s mental health. We haven’t yet cultivated leaders to make this a prominent issue.” With children’s mental health, as with juvenile justice, he says, “There’s just not a lot of political capital to be gained from championing the cause.”

Pushback In Chicago

In Chicago in March 2009, the fight for the city centers hadn’t lost steam. Supporters of the centers persuaded the City Council health committee to hold a hearing at City Hall on the planned closings. The hearing room was packed with clients and their advocates.

Commissioner Mason opened the meeting with a PowerPoint presentation of the facts and figures leading to his decision to recommend the “consolidations.” (“We don’t like to say closings; these are consolidations,” he told the aldermen, eliciting snickers from the audience.) “We’re trying to do the best we can with what we have,” Dr. Mason said. “Our system nationally is broken—and it’s not within the city’s purview to fix it.”

Dr. Bell sat with Mason in the front row and voiced support for his plan. He made his pitch for more emphasis on prevention in mental health, using his iron lung analogy, which
was greeted with nods from several aldermen and angry murmurs from the crowd.

When members of the audience were allowed to address the committee, an African American woman spoke on behalf of her sister, a Woodlawn client: “Woodlawn has done good for my sister. She’s able to function now—she can ride the EL [Chicago’s elevated rail system], she can ride the bus. Now they’ve taken away her counselor, so I’m looking at her going backwards again.”

Fred Friedman, a client at a center that was remaining open, also addressed the aldermen. Bearded and graying, Friedman wore a t-shirt that said, “I Am One Of Those People.” “I am poor and sick, and those facts are of course related,” he told the aldermen. He said his illness “waxes and wanes,” but that the acute stages were paralyzing. “If someone told me I had to go three more miles, or see a different psychiatrist, I just couldn’t do it.”

Friedman then responded to Dr. Bell’s comments about prevention. “If there’s a vaccine that can prevent serious mental illness, that’s wonderful,” he said. He received a hearty cheer from the crowd when he added, “But you don’t kick people out of the iron lung so you can build a vaccine.”

At a forum in a Woodlawn church two nights later, Dr. Mason tried again to explain his decision, but he was shouted down by some in the boisterous crowd of 100. Two aldermen in attendance promised to do what they could to keep the centers open.

David Mailey was at the church forum to lend his support to the cause. He said he was better at rolling with the punches than some of his comrades at the center and was at the forum mainly to fight for them. If the Woodlawn center did indeed close, he said he’d probably just start taking the bus two miles west to the city’s Englewood mental health center, which is remaining open. Then he allowed that he, too, was anxious about the whole thing: “It’s scary. Some of us is gonna end up in jail, or in the hospital, or dying. Some of us is not gonna make it. I hope to be one of them that do.”

NOTES
5. Ibid.