# **"Institutional Immigrants"**

Deinstitutionalization and Homelessness in New York City, 1962-1982

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May 15, 2026

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## Acknowledgements

When I first sat down at the Schomburg Center reading room last year to look through the papers of Dr. June Jackson Christmas, I did not expect to find such an emotional collection. I was lucky to find her archive, but clearly New York City was even luckier to have benefited from her work. Through her papers, Dr. Christmas, who passed away in 2023, has taught me so much about mental illness, city politics, and what it means to care for your neighbor.

To Rachel, daughter of Dr. Christmas, thank you for responding to my cold email, for answering my questions, and for sharing your mother's unpublished memoir with me. Your trust means so much.

Thank you to the archivists at the New York City Municipal Archives, especially Hanan Ohayon, who just happened to be an expert in the history of asylums. Your advice, book recommendations, and lovely conversation made the archives much less solitary.

Thank you to Professor Casey Blake, whose courses made me a history major and who pointed me in the direction of the eccentric Thomas Szasz. Writing this thesis showed me how difficult it is to combine a person's biography with their body of thought, which gave me even more appreciation for the way you teach American intellectual history.

Thank you to Professor Richard John, whose teaching prompted me to rethink the purpose of government, the parameters of religion, and the meaning of a social contract.

Thank you to my advisor, Professor Tunç Şen, for your encouragement, revisions, and weekly pastries. To my thesis cohort, thank you for the questions and comments that made my work more coherent (and for teaching me so much about the history of railroads!).

To my second reader, Professor Kim Phillips-Fein, thank you for your patience in office hours, your thoughtful source suggestions, and your careful editing. I am incredibly fortunate to have studied New York City history with you.

To Eva, Ted, Hannah, Thea, and many others who let me talk their ear off about bureaucrats from the 1970s, thank you for taking an interest. Discussing my thesis with you has been one of the most rewarding parts of the project.

Most of all, thank you to my parents, who have given me a better education than I could have ever asked for. From Laura Ingalls Wilder read-alouds to Ken Burns movie nights, you have shown me how important it is to love history.

## Abbreviations

This thesis refers frequently to government departments with lengthy names. They will be abbreviated following their first reference in the text.

**CMHC:** Community Mental Health Center
**CMHSA:** Community Mental Health Services Act
**DMH:** New York City Department of Mental Health, formerly known as the Department of Mental Hygiene, Mental Retardation, and Alcoholism Services.
**HRC:** Harlem Rehabilitation Center
**SOMH:** State Office of Mental Health
**SRO:** Single Room Occupancy Hotel

This thesis also makes frequent use of documents housed at the New York City Municipal Archives and the New York Public Library's Schomburg Center archives. The collections will be cited using the acronyms below.

**CMHBM:** New York City Community Mental Health Board Minutes, 1965-1976, New York City Municipal Archives.
**DHMH:** Department of Health and Mental Hygiene Senior Administrative Records, New York City Municipal Archives, New York.
**EBD:** Elizabeth Bishop Davis Papers, Columbia University Health Sciences Library, New York.
**EIK:** Edward I. Koch Papers, New York City Municipal Archives, New York.
**JJC:** June Jackson Christmas Papers, Schomburg Center for Research in Black Culture, New York Public Library, New York.
**JVL:** John V Lindsay Department Files 1966-1973, New York City Municipal Archives.
**SLK:** Commissioner Sara L. Kellermann Subject Files, New York City Municipal Archives.

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## Introduction

In a retrospective interview about his time as mayor of New York from 1978 to 1990, Ed Koch called homelessness the "most challenging policy issue" he had faced.[1] "The thing about homelessness is that it never goes away," he said. When the interviewer quoted faith leaders and non-profits who decried his administration's failure to house the homeless, Koch said those criticisms were part of the same "liberal bullshit movement" as deinstitutionalization, which sought to discharge patients from state-run mental hospitals in the decades before he became mayor. The homeless, in his eyes, were not the city government's problem. He asked his interviewer, "Why can't the churches and synagogues take them in?"

Koch believed homelessness was inevitable. And yet, the kind of homelessness that grew during his mayoralty had first appeared only a few years before his election.[2] Between the 1930s and the 1970s, "vagrants," as they were usually called, were mostly older white men who had once been employed. Most had experienced a stroke of bad luck, either in the form of alcoholism or job loss, and ended up with no place to sleep but the sidewalks of the Bowery. There were only a few hundred men visible in the city on a given night, whom the policemen rounded up when temperatures dropped. Homelessness was usually temporary; most found permanent housing within a few years.[3]

That changed in 1978, when the city saw a dramatic rise in what I will call New Homelessness: the unhoused grew from a few hundred people to nearly ten thousand during Koch's first term.[4] Partly motivated by a desire to gain access to increased funds for mental

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[1] Ed Koch, interview with Sharon Zane, May 17, 1997, Columbia Center for Oral History, New York.
[2] Main, *Homelessness,* 16.
[3] Main, *Homelessness*, 13-14. For national trends, which mirrored New York's, and the methodological challenges of counting the homeless, see Jencks, *Homeless*, 13-20.
[4] Main, *Homelessness*, 18.

health treatment, the mayor blamed the increase in homelessness on deinstitutionalization, which gave mentally ill patients the right to refuse treatment. He called it the "dumbest law you can have," denouncing the new patient rights for "turning our neighborhoods into mental wards" and creating a "very real danger" for other residents.[5] Koch spent his three terms as mayor rehospitalizing the mentally ill while insisting that the deinstitutionalization movement was a mistake.

What Koch failed to acknowledge, and what I will argue in this thesis, is that patient rights were not originally part of the deinstitutionalization movement. Support for the right to refuse treatment came later, in response to economic trends and Cold War-era wariness of authoritarianism. That shift prompted the New York City government to remove the New Homeless rather than care for them.

*Origins of Deinstitutionalization*

Deinstitutionalization was a reform of a reform. In the early 19th century, only the wealthiest of the mentally ill were treated in asylums, while the majority were sent to jails and almshouses.[6] In the 1820s, doctors began to advocate for "moral treatment," founded on the belief that patients could recover from mental illness if they were removed from crowded cities. Reformers such as Dorothea Dix began to push for government-provided treatment for patients who could not afford it, which led to the first generation of state-run insane asylums. The New York City Lunatic Asylum opened on Blackwell's Island in 1839, hailed as a futuristic and innovative center of government-funded care. The intent was to rehabilitate patients and return them to their communities. But in the early 20th century, asylum populations swelled and their

[5] "Remarks by Mayor Edward I. Koch Swearing in Dr. Sara L. Kellermann," July 28, 1980, box 125, folder 1, SLK.
[6] Parsons, *Asylum to Prison*, 1-22.

facilities fell into disrepair. Care became increasingly custodial and abusive, and few Americans besides the patients ever saw the conditions inside.

That changed during World War II, when more than 3,000 conscientious objectors were assigned to work in mental hospitals in lieu of military service.[7] By 1945 there were 190 state mental hospitals in the country with a total patient population of 538,629. Most institutions were far from city centers, out of sight and mind for most of America, which is why the conscientious objectors were so shocked by what they found: overcrowded rooms with people chained to the floor, dilapidated buildings, patients often deprived of food and water. In 1946, interviews with conscientious objectors were the basis of a series of investigative pieces about asylum conditions in the *New York PM* by the journalist Albert Deutsch, who turned his series into a book titled *The Shame of the States* two years later. Deutsch argued that the hospitals institutionalized patients without making any attempt to treat them.

In a move that would be repeated by many reformers over the coming decades, Deutsch compared ineffective mental treatment to the abuse of power by a totalitarian regime. He described the conditions as comparable to "Buchenwald and Belsen" at a time when reports of the Nazi concentration camps were becoming better known to the American public.[8] His work drew the attention of millions, even landing him a citation for contempt of Congress when he refused to reveal his sources for his scathing report on the conditions inside a Veterans Administration mental hospital. Deutsch's articles galvanized his readers because the conditions so clearly violated America's postwar ideal of a free and pluralistic society.[9]

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[7] Deutsch, *Shame*, 15-19, 27, 37.
[8] Deutsch, *Shame*, 44.
[9] Parsons, *Asylum to Prison*, 30.

By the end of the 1940s, Deutsch had inspired psychiatrists to reform mental care so that patients would be rehabilitated rather than simply removed.[10] There was no talk at this point, however, of a right to refuse treatment, or of dismantling state mental hospitals.[11] Deutsch did not dispute the state's power to compel treatment of mental patients. He simply warned that such power should be used wisely.

In February 1954, governors from every state gathered in Lansing, Michigan to discuss ways to reduce the hospital population.[12] The number of institutionalized patients had risen far faster in the previous three decades than the rest of the population, and patient stays were often indefinite. To reduce the burden on their budgets, they agreed to redirect funds previously allocated for the construction of new hospitals to psychiatric research, hoping treatments would be discovered that could "empty one-half of the mental hospital beds and, more important, keep them from being filled." At the same time, they declared that there were "many patients in state hospitals" who could be cared for in imagined "outpatient clinics" which had yet to be funded or built.

The recommendations developed at the Governors' Conference changed the course of mental hospital reform. In 1956, the National Institute of Mental Health unveiled a new budget that neglected chronic patients and state hospitals in favor of "persons in the community with psychoneuroses." And in 1958, the American Psychiatric Association announced that state hospitals should be "liquidated" and patients treated in outpatient clinics. These community-based clinics did not yet exist, nor did concrete alternatives to hospital treatment.[13] Nonetheless,

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[10] "Community Mental Health: Current Concepts and Challenges," May 4, 1979, box 13, folder 15, JJC.
[11] Parsons, *Asylum to Prison*, 31, 40.
[12] Johnson, *Bedlam*, 27-29.
[13] Johnson, *Out of Bedlam*, 29-32.

the recommendations made by these two organizations allowed states to begin restricting admissions criteria to their state hospitals.

The move appears reckless in retrospect, but in 1954 it seemed justified by a sense of optimism driven by two innovations. The first was psychoanalysis, which seemed to reveal that mental illness occurred throughout the general population and was treatable outside the hospital.[14] For the first time, more psychiatrists were practicing outside asylums than inside. The second psychiatric innovation was the invention of Thorazine, the first antipsychotic drug to be approved by the Federal Drug Administration. Though psychiatrists already knew the drug had harsh side effects and fostered a chemical dependency in patients, its invention contributed to a rush of confidence about the future of mental health care. The innovations redeemed the possibility of a pluralistic, liberal postwar state in which patients would not be removed from society, but rather integrated into it.

By the 1980s, that attempt at integration had failed, and deinstitutionalization was denounced by politicians and psychiatrists throughout the United States as a "sham" for allowing so many patients to fall through the cracks.[15] The historical literature blames the movement's emphasis on granting patients "negative rights," such as the right to refuse harmful treatment, rather than improving the quality of the mental treatment they received. In *From Asylum to Prison*, historian Anne Parsons writes that patients were given the right to refuse treatment instead of "positive" rights, such as social services, housing, and rehabilitative treatment. In *Out of Bedlam*, psychiatrist Ann Braden Johnson similarly condemns deinstitutionalization for being hijacked by politicians' fiscal austerity efforts, beginning with the 1954 Governor's Conference, rather than staying true to the movement's initial concern for improving the effectiveness of

[14] Parsons, *Asylum to Prison*, 50, 55.
[15] Torrey, *American Psychosis*, 72, 85.

mental treatment.[16] Historian E. Fuller Torrey's *American Psychosis* focuses on the federal government's deinstitutionalization policies, which began in earnest a decade after New York State's, to claim that the movement was driven by politicians' desire to appease public outrage over conditions in asylums without delivering better care to patients. All of these historicizations frame the eventual neglect and homelessness of chronic patients as inevitable. This thesis will intervene in the existing literature in three ways.

First, it will challenge the conception of deinstitutionalization as a nationally-homogenous, and universally-flawed, movement. New York City and State, the pioneers of deinstitutionalization, met with some success in treating patients in their communities by grounding patient care in community control and a robust welfare state. New York City's unique approach was exemplified by psychiatrist Dr. June Jackson Christmas, who founded the first community mental health center (CMHC) in Harlem in 1964 before serving as the City Commissioner of the Department of Mental Hygiene (DMH) from 1972 to 1979. She later served as vice president of the American Psychiatric Association and joined President Jimmy Carter's twelve-person transition team.[17] Despite her influence, Christmas has yet to be included in the historiography on deinstitutionalization.

I have made Christmas's work the throughline of my thesis because she avoided the pitfalls that claimed other proponents of deinstitutionalization. She established a CMHC that effectively cared for the so-called "chronic patients," whose illnesses were untreatable, rather than focusing only on patients whose mental episodes were resolvable. This was exceptional; one of the most common criticisms of deinstitutionalization was that it systematically failed chronic

[16] Nine years later, the federal government passed a similar law applying to the rest of the country, the Community Mental Health Centers Act, modeled closely off New York's. Johnson, *Bedlam*, 88-89.
[17] Rachel Christmas, "Memorial Program for June Jackson Christmas," included in email message to author, March 23, 2026.

patients.[18] Christmas also conceived of mental illness as heavily determined by a patient's material and social environment, which ran counter to the field of psychiatry's embrace of antipsychotic drugs and the corresponding belief that mental illness was biologically-induced.[19] Christmas spent her career creating a system of mental treatment premised on the eradication of poverty and on community-controlled care. Her work challenges the notion that chronic patients were untreatable and, by extension, Koch's belief that deinstitutionalization inevitably leads to homelessness.

Second, this thesis will consider the influence of the Cold War on American conceptions of individual rights, an influence that has previously been excluded from the literature on deinstitutionalization.[20] Beginning in the 1960s, sensational reports spread through the American media about the Soviet government's practice of involuntarily treating political dissidents for mental illness. The reports vindicated the work of intellectuals such as Thomas Szasz, a radical libertarian and psychiatrist who had rested his argument against mental institutions on warnings of their potential for abuse by totalitarian governments. While Szasz's work is rarely taken seriously by historians of deinstitutionalization, he was cited in multiple court cases that attributed increased rights to mental patients in the United States in the 1970s. I will use his influence as evidence that deinstitutionalization's emphasis on negative, rather than positive, patient rights was partly a consequence of Americans' Cold War fears. As Americans grew increasingly concerned about the ethics of involuntary treatment, the hospitalization of mental patients became an indictment of the country's ability to maintain a pluralist liberal state.

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[18] Johnson, *Bedlam*, 76.
[19] Johnson, *Bedlam*, 38-52.
[20] Only histories focused specifically on the Soviet Union have considered the influence of the Soviet government's involuntary treatment of political dissidents on American opinion. See Nathans, *Hopeless Cause,* 412-415.

Third, this thesis will address the historiography's contradictory descriptions of the population that I call New Homelessness. The existing literature describes the unhoused New Yorkers that first appeared in the late 1970s in two different ways. The first, exemplified by Soffer, claims that the majority were incurably mentally ill and innately different from other city residents.[21] The second, exemplified by Main and Holtzman, plays down the mental illness of the New Homeless, claiming that a small minority had any history of psychiatric treatment.[22] Such a characterization holds massive implications for the city's responsibility for the homeless because, prior to deinstitutionalization, the acutely mentally ill were assumed to be the state's responsibility. By casting the unhoused as more insane and less able to be rehabilitated, this view holds the city to be less culpable for New Homelessness.

In line with this divide, the historians who pathologize the homeless also downplay city-level contributors to homelessness, while historians who paint the homeless as treatable point to city policies that affected them. Soffer, for example, de-emphasizes city-level contributors such as the shortage of shelter space and the elimination of low-cost housing by claiming that these trends were national phenomena over which the city had no control.[23] In this narrative, city-level policies are less responsible for the creation of the New Homeless than the state's policies of deinstitutionalization. Meanwhile, the other camp focuses on the decisions of city leaders that exacerbated the loss of low-cost housing and reduced the vocational opportunities for the unemployed.[24] Such a characterization increases the fault of the city for failing to connect the

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[21] Soffer, *Ed Koch,* 280.
[22] Main, *Homelessness*, 32. Main cites the controversial 1982 Keener Study which found only 10% of the New Homeless to be acutely mentally ill and 30% to have any history of psychiatric treatment.
[23] Soffer calls New York City's reduction in affordable housing stock an "inevitable" product of national economic trends. Soffer, *Ed Koch*, 281.
[24] Holtzman, *The Long Crisis*, 83.

New Homeless with housing, education, and jobs, but also overlooks the fact that many chronic patients needed mental treatment.

This inconsistency shows that historians tend to frame the city's responsibility for the homeless as contingent on the mental state of the individual. Historians who play down the mental illness of the New Homeless shine a more positive light on the city's efforts to shelter and rehabilitate them, while historians who emphasize their mental illness see such services as outside the purview of the city. This thesis seeks to move beyond this debate by showing that deinstitutionalized care was originally intended to include both municipal social services and paternalistic treatment for mental illness—a vision that does not fit neatly into either narrative.

In preparation for this work, I have reviewed the speeches, notes, and correspondences of Dr. June Jackson Christmas, Mayor Ed Koch, and Mental Health Commissioner Sara Kellermann, as well as the papers from the DMH during the Lindsay, Beame, and Koch administrations. I will include events that have not previously received attention from historians, such as the Community Mental Health Board meetings, the Tripwire Agreement of 1981, and the beginnings of Project HELP, to trace the initial reactions by the city and state to the New Homeless.

*Thesis Overview*

Before deinstitutionalization, New York City only offered public mental health care at weekly psychiatric walk-in clinics at five general hospitals. But the city also had an unusually progressive social contract, formally established during the Great Depression when Mayor La Guardia amended the state constitution to provide for the "aid and care of the needy."[25] So, when the state moved to deinstitutionalize its hospitals as inspired by the Governors' Conference, New

[25] Stout, "Unusual Amendment to State Constitution," *New York Times*.

York State created something exceptional: it aspired to endow discharged mental patients with a right not only to more humane medical treatment but to robust social services and integration into their communities. The state's Community Mental Health Services Act (CMHSA) proposed positive rights built into a vision of mental health care delivered at the community level rather than in centralized asylums. The new system, which was to receive half of the state's mental health budget, would be controlled by a newly-established Community Mental Health Board and based on a neighborhood's specific needs.[26]

The first chapter of my thesis follows the implementation of deinstitutionalization in New York City as seen in the Harlem Rehabilitation Center (HRC) established by Christmas. Opened in 1964, the HRC would become nationally renowned for the treatment philosophy Christmas developed—one that she applied to the entire city as Commissioner beginning in 1972. I will argue that deinstitutionalization, in the hands of Christmas, did not originally imply patient rights. Instead, it was premised on a paternalistic notion of the community's responsibility for citizens' mental health. Where deinstitutionalization sought to minimize the power of the government over the mentally ill, the community was enlisted to take over responsibility.

The second chapter will show that this notion of paternalistic community-based mental treatment came under fire from two directions. First, Americans became increasingly wary of the potential for psychiatry to be abused as a tool of government control, which led to court rulings that gave mental patients the right to refuse treatment altogether. And second, rapidly-gentrifying communities pushed out the mental patients who were appearing in their neighborhoods. These two forces culminated in the *Callahan Consent Decree* in 1981, which granted a legal right to shelter to all homeless men. Despite being heralded at the time as a victory of New York's

[26] "Actions Taken by the NYCCMHC to Implement Features of the Mayor's Platform Pertaining to Mental Health Services," April 15, 1965, box 2, folder 6, DHMH.

progressive welfare state, I will argue that the decree had the opposite effect: It allowed the city government and local communities to shirk responsibility for the mentally ill by giving them rights rather than services.

The third chapter will trace the conflation by politicians, the media, and community members of homelessness with incurable mental illness in the early 1980s, even as other factors such as the reduction in affordable housing and social services contributed to the New Homeless population. Rather than expanding local mental treatment, the city was incentivized by the state's funding mechanisms to label the unhoused as deeply mentally ill so that they would be readmitted, on the state's dime, to mental hospitals. These battles between neighborhoods, the city, and the state contradicted the ethos of deinstitutionalization by casting the New Homeless out of New York City's social contract. Ultimately, I will argue that deinstitutionalization was premised on paternalistic health care and an expansive welfare state, but as the city transitioned from New Deal progressivism to neoliberalism, the movement became one of negative rights. This reorientation shaped the city's response to New Homelessness.

In this thesis, I hope to show just how many of deinstitutionalization's consequences were unintended. Reformers like Christmas never called for patients to be so recklessly discharged. Intellectuals like Szasz would not have endorsed the criminalization of homelessness that followed from patient rights. New York State did not plan to incentivize the city's rehospitalization of the homeless mentally ill. Rather, the movement was characterized by ambivalence, such that neither funding nor public concern followed the thousands of discharged mental hospital patients as they made their way home.

## Chapter 1: "To Restore Purpose to the Community"

In October of 1962, Dr. June Jackson Christmas got a phone call from Dr. Beth Davis, the head of the newly-established Department of Psychiatry at Harlem Hospital.[27] Davis asked her to design one of the nation's first CMHCs, which were clinics where mental patients could receive treatment in their own neighborhoods rather than in state-run asylums. With the 1954 CMHSA, New York had been the first state to deinstitutionalize, and Davis was now preparing for a wave of patients to be discharged from the state mental hospitals into New York City—part of a movement that was retroactively named "deinstitutionalization."[28]

Davis's motivations in establishing this CMHC, which would become the HRC, were not altogether altruistic. Christmas later alleged that Davis only facilitated its creation so that the chronically ill would not overwhelm the rest of her department.[29] So-called "chronic patients" occupy a tragic place in psychiatry: they are the most in need of care, but also the least likely to respond to treatment. Because they rarely become success stories, they are neglected by psychiatric research and practice.[30] Davis did not want her department to be dogged by the sense of failure that tended to follow the chronic patients.

Yet, under the leadership of Christmas, the HRC would go on to become a national model precisely because it did not overlook the chronically ill. By providing social, vocational, and family services, the center successfully reintegrated many of its chronic patients into the community. I argue in this chapter that the unique approach to mental health that Christmas pioneered at the HRC, premised on mental illness as environmentally determined and on

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[27] June Jackson Christmas, interview, June 27, 1985, Sc DVD-2108, Schomburg Center for Research in Black Culture, New York.
[28] Johnson, *Bedlam*, 37.
[29] Christmas, interview.
[30] Johnson, *Bedlam*, 78.

treatment as community controlled, was based in New York City's exceptional tradition of public welfare. Deinstitutionalization did not originally advocate for total patient freedom but was instead premised on a paternalistic vision of the government's role in its citizens' mental health, which would eventually expose the movement to criticism from Cold War-era intellectuals and fiscally prudent politicians.

*Waves of Deinstitutionalization*

As the population of New York State mental hospitals patients fell 90% between 1960 and 1980, the forces that drove deinstitutionalization changed dramatically.[31] The first wave, triggered by the 1954 CMHSA, was primarily a result of psychiatrists' new treatment philosophy, which sought to continue paternalistic mental treatment but transfer patients to a more rehabilitative setting.[32] Beginning only with those who were less acutely ill and had family members to return to, state hospitals discharged patients to their home communities with the expectation that they would receive consistent outpatient care. Psychiatrists prescribed Thorazine and other antipsychotic drugs to those they discharged, which were only recommended for patients who could be constantly monitored, and recommended physical therapies that were effective only when they were performed with regularity. Both treatments require the patient to receive frequent and highly-structured care.[33] The psychiatrists who supported the transition from asylum to CMHC believed that they could offer higher quality care to their patients in a community-based setting, but did not seek to cut them loose completely.

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[31] "The New York State Level of Care Survey in Community Mental Health Centers and New York State's Psychiatric Centers," 1982, box 123, folder 4, SLK.
[32] Jencks, *The Homeless*, 28.
[33] Johnson, *Bedlam*, 49.

While New York State had already begun to reduce its patient count, hospital populations declined nationally after the 1964 passage of Medicaid. States could receive federal aid by transferring patients from hospitals to nursing homes—a move New York State took full advantage of. Older patients were discharged, many of whom were calmer and used to the rhythm of institutional care.[34] While the state may have acted out of financial interest, the patients in these first two waves were better suited to their new environments. As Christmas wrote in 1974, "for a large number of the mentally ill, the most effective treatment can be provided in community-based residential and rehabilitative services rather than in large state institutions."[35] Though its initial motivations were convoluted, the experiment of deinstitutionalization proved that state hospitals were not the most effective way to care for patients.

The third round of discharges came in 1972 when Congress created Supplemental Security Income, for which the mentally ill could qualify as outpatients. This wave avoided discharging those who were too ill to function outside of asylums because New York City law required police to bring patients who ended up on the streets back to the hospital that had discharged them, which became a disincentive to discharge too liberally. New York State's discharge criteria also prohibited a hospital from discharging a patient who had no home.[36] The number of patients in state hospitals across the country fell 60% between 1965 and 1975, and this round, for the most part, succeeded in discharging only the patients who had a home outside of the institution.[37]

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[34] Jencks, *Homeless*, 26.
[35] "The Future of Mental Hygiene Services in NYC: Public Policy and Public Concern," May 1976, box 12, folder 18, JJC.
[36] "Rights and Responsibilities for Aftercare," October 1977, box 1, folder 3, EBD.
[37] Jencks, *Homeless*, 28.

It was the late stages of deinstitutionalization that tainted the movement's legacy. Reports surfaced in the late 1960s of the Soviet Union's hospitalization of political dissidents, galvanizing a movement among American intellectuals to give mentally ill patients the right to refuse treatment. Meanwhile, New York State politicians reneged on their promise of funding for deinstitutionalized care. Mental hospitals restricted their admissions criteria but did not arrange for housing or services for those discharged. By 1980, New York State mental hospitals' patient populations had fallen by 90%, leaving only those who were deemed dangerous to themselves or others. Those discharged in the final years, between 1975 and 1980, were the most mentally ill and often had no home to return to, which is why a 1982 State Office of Mental Health (SOMH) report observed that "those who the CMHCs are treating are increasingly more disabled, poor, and in need of the kind of care once thought only to be found in the state-run hospital."[38] At the same time, patients had been given new rights and autonomy, meaning that the government expected them to file for disability and Supplemental Security Income checks on their own, budget this money properly, and find their own housing.[39] It was out of these final stages of deinstitutionalization that New Homelessness would be born.

### *The Politics of Dr. Christmas*

By the time Christmas was designing the HRC, hundreds of discharged patients were arriving in Harlem each week—more than anywhere else in New York City.[40] Despite this pressure, Christmas designed an unorthodox center that would become a national model for reintegrating former mental patients into city life. Central to the success of the HRC was her belief that mental treatment was inseparable from race politics.

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[38] "Level of Care," SLK.
[39] Johnson, *Bedlam*, 115.
[40] Johnson, *Bedlam*, 32; June Jackson Christmas, Draft of Unpublished Memoir, July 14, 2017.

Christmas, who was born in Cambridge, Massachusetts in 1924, was the daughter of a Black postal clerk. She remembered watching her father repeatedly be denied a promotion, despite receiving the top score on his civil service exam. It was only after he joined the National Alliance of Postal Workers, made up of Black postal workers who were excluded from the all-white union, that he became post office supervisor in 1941. That same year, Christmas became one of the first Black students to enroll at Vassar College, where she was involved in the Double V Campaign, a national movement that advocated against racial discrimination during World War II.[41] She earned her medical degree at Boston University in a class that included only six other women, and completed her psychiatric residency at Bellevue Hospital. Her residency was briefly paused when her supervisor accused her of being affiliated with the Communist Party—allegations that were dismissed once a McCarthy-era federal loyalty program cleared her name.[42]

During her residency, Christmas was involved in efforts to establish a tuberculosis treatment center in Harlem. Tuberculosis, which tended to occur in crowded, poorer neighborhoods, was nearly four times as prevalent in Harlem as the rest of Manhattan by 1950.[43] Christmas and her fellow activists called for increased access to clinics and drug treatments for Harlem residents who could not afford to be treated in sanitariums. The hospital never came to fruition, but it would not be the last time Christmas called for localized medical treatment in Harlem.

It was in this milieu that Christmas worked, aiming to "make life better for Black people."[44] She connected her race politics to her psychiatric practice through her belief that one's

[41] Christmas was joined by two other girls to integrate the college that year. However, Anita Hemmings, who passed as white, was technically the first Black student to graduate in 1897.
[42] Vassar College, "June Jackson Christmas."
[43] *Tuberculosis in New York City*, DOH.
[44] Christmas, interview.

material environment influenced one's mental state.[45] By 1963, Blacks were overrepresented in state hospital populations by a factor of three, and Harlem would receive some of the highest rates of discharged mental patients in the country.[46] In a document outlining her priorities for the center, Christmas worried that the neighborhood's deprivation would only reinforce that illness. "There is no mind-body dichotomy," she wrote, claiming instead that "the stressors of poverty" and "deteriorated housing" in Harlem were detrimental to mental health.[47]

Christmas designed the center's treatment accordingly: "We were tending to those factors like housing, whether a patient lived in a fourth floor walkup, and income, to consider the affordability of a medicine or diet," she recalled.[48] That approach was not popular in the 1960s; other forms of psychiatric determinism, like Freudian psychoanalysis, were being criticized and even debunked. She was aware of these criticisms, but later wrote that the success of her approach at the HRC confirmed her hypothesis: "Some people would say that my concern with social issues is too broad … I would say that is false. We have to understand how economic and social factors influence the growth and development of all of us."[49] In order to succeed, Christmas believed deinstitutionalized care must account for a patient's material environment.

Her philosophy was inseparable from New York City's tradition of New Deal Liberalism. By the time Christmas was designing the HRC, the city had erected an exceptional social contract in which the material conditions of city life were matters of public concern.[50] The city's progressive reformers and labor movements, as well as the consolidations of physical and intellectual capital, established a new level of entitlement to the public provision of goods such

[45] Christmas, Unpublished Memoir.
[46] CDC, "Effects of Desegregation."
[47] "Pride, Prejudice, and the Heritage of Homelessness," April 1988, MG 78, box 15, folder 5, JJC.
[48] Christmas, interview.
[49] "Current Concepts and Challenges," JJC.
[50] Wallace, *Greater Gotham*, 49-61, 505-575.

as housing, employment, and libraries. During the Depression, Mayor Fiorello La Guardia partnered with President Franklin Roosevelt to make New York City the "49th state" of the federal government's New Deal, using programs like the Works Progress Administration and the National Housing Act to improve the standard of living of the city's residents.[51]

That contract was legally cemented in 1938, when La Guardia pushed the state legislature to amend the constitution such that the "aid, care and support of the needy are public concerns," and would be "provided by the state and by such of its subdivisions." La Guardia justified the city government's duty to care for, house, and employ the poor with an economic argument: The provision of such services saved the government money in the long run.[52] With that logic, rent control, employment opportunities, and even health insurance became the duty of the municipal government. From the postwar years to the fiscal crisis of the mid-1970s, New York City took on an unusually ambitious role in providing its citizens with a basic standard of living.

Christmas built her philosophy of deinstitutionalized care on this conception of the government's role. She secured the center's initial funding from a War on Poverty program, which was inspired by the New Deal. During New York's 1975 fiscal crisis, she argued that the city should not cut funding for mental treatment because it would only increase demand for other social services, such as welfare checks, police, or schools.[53] Like La Guardia, Christmas believed the combination of social services with mental treatment was not only generous but also efficient. If patients went untreated, they would become financial liabilities for other city agencies. For similar reasons, she said the city should coordinate housing, entry-level jobs, and

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[51] Williams, *City of Ambition*, 47.
[52] Stout, "Unusual Amendment to State Constitution," *New York Times*.
[53] "Future of Mental Hygiene Services," JJC.

social security payments. Christmas envisioned an expansive welfare state that integrated social services and tracked mental patients long after they were discharged.[54]

That vision was reflected in her sustained interest in the potential of communist countries to deliver better care. She toured the mental treatment facilities in Cuba in 1974 and China in 1979. Upon returning from Havana, Christmas said at a conference of the American Public Health Association that the revolution had enshrined the notion among Cubans that the health of the population is the responsibility of the state.[55] Cuban psychiatric hospitals used labor as occupational therapy, requiring patients to build houses, raise poultry, and harvest sugar cane. Patients could graduate to higher salary levels as their health improved. Christmas praised the Cuban mental treatment system for imbuing the mentally ill with a sense of responsibility. Though her reflections on China were less positive, marred by observations of the country's stigmatization of mental illness and high rates of depression, she similarly praised Chinese psychiatrists' "successful use of social and political goals as personal goals" to create in patients a sense of "belonging to something bigger than one's self."[56] Her admiration of psychiatric treatment in Cuba and China was reflected at the HRC, where she first wrote that mental health care could bring "purpose" to the larger community.[57]

Christmas's vision of mental health as intertwined with social welfare was also notable because it was not shared by the wider field of psychiatry at the time. Since the invention of new anti-psychotic drugs postwar, psychiatrists began to see mental illness as biologically-determined rather than environmentally-induced. Other kinds of mental treatments became less innovative, despite the tendency of Thorazine and other drugs to engender a dependency that some called a

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[54] "Heritage of Homelessness," JJC.
[55] "U.S.-Cuba Health Exchange Press Release," November 1974, box 2, folder 4, JJC.
[56] "Overview of Medical Tour of the People's Republic of China," January 30, 1979, box 2, folder 5, JJC.
[57] "Core Curriculum: Man and Society," 1964, box 2, folder 1, JJC.

"chemical strait-jacket."[58] While her peers resigned themselves to the idea that severely mentally ill patients could only be subdued, not healed, Christmas insisted that mental illness was partly a product of material conditions. Both she and Davis commissioned studies which claimed that mental illnesses like schizophrenia could be healed by addressing "racialized poverty."[59]

Eventually, that attitude shaped the care offered throughout the state. In a 1965 letter to the governor that cites Christmas's research, the State Mental Hygiene invoked this psychiatric determinism to support an appeal for a larger budget:

> Serious social and cultural deprivation is at the root of at least 85 percent of mental retardation. Are we not then confronted with the fact that imperfections in our society are the prime cause of mental retardation – imperfections which we must strive to overcome and can overcome as an affluent society, if we will?[60]

In a city where care for the poor was the government's responsibility, untreated mental illness became an indictment of that government's delivery of social services.

*Opening the Harlem Rehabilitation Center*

The HRC integrated the robust welfare state into its mental treatment. In a document titled "The Philosophical Orientation of Harlem Rehabilitation Center," Christmas wrote that the center had as its premise "the belief that services exist as a means to change." The center's daily itinerary emphasized the social as well as the medical, teaching the families of patients to care for them and providing high-functioning patients with job training. Christmas also created a "paraprofessionals" program that "pioneered in rescuing minority group members from welfare or from menial or dead-end jobs, and bringing them into new careers in health and human

[58] Johnson, *Bedlam*, 52.
[59] "Mental Health Services for the Inner City," 1967, box 1, folder 2, EBD.
[60] "A Plan for the Control of Mental Disorders in NYS," July 1, 1965, box 2, folder 3, CMHBM.

services."[61] She employed forty paraprofessionals at a time, recruiting formerly-incarcerated people and high school dropouts. Her aim was to "restore purpose to the community" by reducing the unemployment that she believed could trigger mental illness.

To that end, Christmas planned from the beginning to relinquish control over the center to its employees, patients, and neighbors.[62] She established a Citizens' Board of Mental Health, open to anyone who lived in Harlem, to advise on treatment options and programming. Arguing that care would be most effective when it was responsive to the "social fabric of that community," she developed a "Core Curriculum" for HRC employees about the racial, educational, and vocational demographics of the so-called "catchment area," which encompassed most of Central Harlem.[63] Christmas believed community engagement would make CMHCs more effective than state hospitals. "It's about providing something where people are, and in small enough service units so that people get a feeling of personal involvement," she said in a WNBC feature on the center.[64]

After two years of planning, Christmas opened the HRC in May 1964. Discharged patients were arriving in Harlem at higher rates than anywhere else in the state.[65] At first, the HRC couldn't afford to rent its own space, but Christmas was firmly opposed to housing her program at Harlem Hospital because she wanted to integrate the program into the community.[66] The group of paraprofessionals and patients convened at a rotating list of community centers and churches until the HRC got an office on Lennox and 128th Street in 1967.

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[61] "Philosophical Orientation of HRC," May 22, 1967, box 2, folder 1, JJC.
[62] Christmas, Unpublished Memoir.
[63] "Core Curriculum," JJC.
[64] "New York Report" WNBC-tv Channel 4, September 10, 1972, box 2, folder 3, JJC.
[65] Christmas, interview.
[66] Christmas, interview.

**Figure 1:** At the Harlem Rehabilitation Center, Christmas discusses mental health policy with Elinor Wolfert, director of an advocacy organization called the New York Urban Coalition's Health Task Force. (Source: "Mental Health Task Force," July 3, 1971, New York Amsterdam News.)

The HRC quickly became a success. Its rates of rehabilitation, even for the chronically ill, were far above the averages at other CMHCs. In 1968, the center treated more than 500 chronic patients, half of whom showed "markedly improved psychosocial functioning" and another 10% of whom became gainfully employed.[67] The paraprofessionals went on to careers in social work, and some attended college. As Christmas later recalled, the center "proved that, if you use social and educational and vocational approaches along with medication and social work, you can keep people out of psychiatric hospitals longer, you can return them to homes."[68] A further mark of its success came in 1971, when the federal grant expired. Christmas asked Davis for Harlem Hospital to contribute part of its psychiatry budget, but Davis refused, leaving the center with no way to fund itself. People came from around the neighborhood to protest the impending closure, marching outside the building for weeks and sending over 1,000 letters to the mayor in support of the HRC.[69] Eventually, the city agreed to fund the center. Christmas had

[67] "Fact Sheet #3: The Critical Situation at the Harlem Rehab Center," 1970, box 2, folder 5, JJC.
[68] Christmas, interview.
[69] Lyles, "Service Center Saved," *New York Amsterdam News.*

created a CMHC that was so integrated into its community that even those who received neither treatment nor paycheck from the center came out to support it.

This episode becomes even more remarkable when compared to how poorly many other CMHCs, which did not involve or employ their neighbors, fared.[70] A decade later, Christmas would note that deinstitutionalization's biggest failure was its creation of a strong "backlash against the concept of community care."[71] CMHCs in other parts of the city often faced strong backlash from those who did not want mentally ill people in their neighborhoods.[72] Meanwhile, at the HRC, the community lobbied in favor of the center. The deinstitutionalization movement aspired to integrate the mentally ill into their communities rather than hide them away. Through its neighborhood governance and emphasis on social services, Christmas's center did just that.

[70] "Level of Care," SLK.
[71] "Deinstitutionalization or Rehabilitation: the need for an integrated mental health system," 1978, box 10, folder 12, JJC.
[72] "Deinstitutionalization or Rehabilitation," JJC.

## Chapter 2: Halfway Housed

In May 1976, Christmas, who was four years into her tenure as commissioner of the DMH, delivered the keynote address at the Public Health Association of New York City's annual conference.[73] She used the speech to draw attention to a phenomenon that other New Yorkers were only beginning to notice: a dramatic rise in homelessness.[74] As deinstitutionalization had progressed, she told the audience, "too many former patients have become the bag women on our library steps, the old men wasting their days in SROs, the human beings discarded by policies which were not implemented or funded adequately."[75] The patients discharged in the later stages of deinstitutionalization were the most severely ill and the least likely to have an alternative place to stay. At the time of Christmas's speech, the New Homeless were just beginning to appear on street corners and at shelters.[76]

Christmas blamed their homelessness on the health care system's failure to place deinstitutionalized patients safely into communities in the city. As they were discharged, she believed it was still the responsibility of mental health workers to arrange housing, disability checks, and health services. And, as she explained in her speech, the funding should be allocated accordingly: "Deinstitutionalization became 'dumping' because the discharge was not matched by an increase in local funding."[77] Christmas believed the movement had gone astray when it granted negative rights to patients rather than highly-structured aftercare.

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[73] Christmas was appointed by Mayor Lindsay in October 1972. "Christmas Swearing-In," box 57, folder 728, JVL.
[74] The growth of the homeless population would go unacknowledged for a few more years; the novelty is apparent in the tone of articles like this one from June 28, 1981: Carmody, "New York Is Facing 'Crisis' on Vagrants," *New York Times*.
[75] "Future of Mental Hygiene Services," JJC. "SROs" refer to Single Room Occupancy hotels, which were run-down tenement apartments where tenants could rent a room with a shared bathroom and kitchen for a cheap weekly rate, as explained later in this chapter.
[76] Jencks, *Homeless*, 28.
[77] "Deinstitutionalization or Rehabilitation," JJC.


**Figure 2**: Dr. Christmas and Mayor Abraham Beame (center right) issue a proclamation on the 20th anniversary of New York State's Community Mental Health Services Act affirming the city's commitment to deinstitutionalization. The legislation came with no city funds. Instead, the statement petitioned the state for increased financial support. (Source: April 1974, box 2, JJC Photograph and Print Division.)

The lack of structured care was in part a result of city-wide housing trends. When Christmas began to look for patient housing for the HRC in 1971, she was unable to find a suitable building. New York City's housing stock was more limited and more expensive than what had been available when deinstitutionalization was first imagined. The abandonment of buildings by landlords, a result of white flight and changes to federal housing subsidies, had risen from 21,000 units per year to as many as 40,000 units between 1970 and 1978.[78] Harlem was especially hard-hit.[79] The shortage meant that remaining housing was also more expensive: between 1980 and 1989 the city's housing prices rose at faster than they ever have since.[80]

[78] Goldstein, *Roots of Urban Renaissance*, 157.
[79] Heller, "City's Shrinking Households."
[80] Furman Center, "Trends in New York City Housing."

HRC workers tried to find alternatives for their patients, like rooms with friends or space at the YMCA, but they failed to house every patient. Meanwhile, the CMHCs in other neighborhoods had secured "halfway houses" for their patients. As Christmas recalled, "in marginal or lower middle class white neighborhoods, people could get housing … that really rubbed me the wrong way because I realized that as I went to meetings at other [CMHC] programs that had started after ours, they had the funds and the property to buy property for the chronically mentally ill."[81]

Treatment rarely proved effective when patients lacked a reliable place to stay. As Christmas put it two decades later,

> The chief victims were the patients themselves. Most were discharged without assured residential placement: many ended up in dilapidated substandard SRO hotels or poorly-operated residences. Without services, without monitoring of medication, without opportunities for self-help and assistance in mastering the unfamiliar tasks of independent living, many simply cannot cope.[82]

Without housing, deinstitutionalization's promise to effectively treat the patient in the community was broken.

By the end of the 1970s, deinstitutionalization was seen as a failed movement. Ignoring outliers such as the HRC, politicians and psychiatrists began to denounce deinstitutionalization as a "sham" and to criticize CMHCs for "paying little attention" to "seriously-disturbed patients."[83] Two forces were to blame for the homelessness of discharged patients. The first was an attack on psychiatry's authority by intellectuals like Thomas Szasz, whose comparisons of mental treatment to totalitarian state control prompted the attribution of new civil rights to mental patients. The ability of patients to refuse hospitalization and treatment allowed facilities

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[81] Christmas, interview.
[82] "Deinstitutionalization or Rehabilitation," JJC.
[83] Torrey, *American Psychosis,* 85.

to discharge patients more easily, often without any coordination of housing or social services. The second force was the mounting opposition to mental patients from their new neighbors, who lobbied against welfare hotels and treatment services and for pro-development housing policies.

In 1978, an advocate for the homeless named Robert Hayes sued the city over its failure to shelter the New Homeless, citing La Guardia's constitutional amendment that pledged to provide "aid and care to the needy."[84] The case culminated in the *Callahan Consent Decree*, which established a right to shelter for all homeless men and was heralded as a victory of the city's progressive legacy, both contemporaneously and in the existing historiography. I will take a different view by arguing that the implementation of the right to shelter aligned with the interests of two forces that minimized the city government's role in caring for the mentally ill: pro-development community sentiment and wariness of government-controlled psychiatry.

### *Thomas Szasz and Patient Rights*

In 1961, psychiatrist and intellectual Thomas Szasz published a book titled *The Myth of Mental Illness* that would change the course of deinstitutionalization. Szasz was born in Budapest, Hungary in 1920. His family, who was Jewish, fled the Holocaust in 1938 and emigrated to the United States, where Szasz trained in psychiatry at the University of Cincinnati and the Chicago Institute for Psychoanalysis. No doubt influenced by the totalitarianism that took over his homeland, first by Nazism in 1944 and later Stalinism in 1956, he believed the powers of the state should be minimized.[85] He became an outspoken libertarian who contributed frequently to *Reason* magazine. Szasz advocated for a free market for drugs, the right to refuse mental treatment, and most notably the right to die, a right that he supported by invoking the

[84] Stout, "Unusual Amendment to State Constitution."
[85] Haldipur, *Thomas Szasz*, 101.

histories of Nazis' efforts to prevent Jews in concentration camps from committing suicide.[86] Szasz died of suicide in 2012, as his friends said he had long planned to do, after suffering a back injury.[87]

Szasz's beliefs surrounding both psychiatry and social services stemmed from his wariness of the moralistic tendencies of the state. Throughout history, he argued, states used religious and social pressure to control the behavior of their citizens. As long as psychiatric care was administered by the government, it would be used as a coercive force. He believed that "psychiatric interventions are directed at moral, not medical, problems." Individuals should pursue psychiatric treatment of their own volition, but state-controlled treatment was as inappropriate as state-mandated religion. For the same reasons, he believed that social services should not be provided by the government. The welfare state, he warned, was a secular analogue to Christian morality—both fostered disability and weakness. "Disability is used as a coercive tactic to force others to provide for one's needs," he wrote, following a chapter that ridiculed the Beatitudes for similar reasons. "It may then be discovered that religion, society, and parents have conspired, as it were, to inculcate this code of conduct."[88] Szasz believed that by diagnosing mental illness, psychiatrists encouraged it. The tendency to institutionalize the mentally ill, then, was simply a product of society's intolerance for deviancy.[89]

Though there is no record of a meeting or correspondence between Christmas and Szasz, they were perfect foils for one another. Szasz argued that the notion of mental "illness" was a product of metaphor choice, not real pathology, while Christmas took mental illness literally.

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[86] Szasz, "Psychiatric Self-Defense," *Reason*, May 1983; Szasz, *Suicide Prohibition*, 60.
[87] Schaler, "Kaddish for Thomas Szasz."
[88] Szasz, *Myth of Mental Illness,* 171.
[89] This led Szasz to dispute the use of psychiatry to "cure" homosexuality earlier than the rest of his field. He claimed it was a "colossal and costly mistake" to classify addiction, delinquency, homosexuality, suicide, and other behaviors as psychiatric illnesses. Szasz, *Myth*, 34.

Where Szasz claimed that psychiatric diagnoses were too subjective to attribute causality, Christmas was a devout determinist.[90] Whereas Christmas believed deinstitutionalization would only succeed if the government took on an expansive role in both mental treatment and welfare, Szasz supported deinstitutionalization because of its potential to diminish government power.

Among other psychiatrists, Szasz's views were not only unpopular but seen as heretical. After *The Myth of Mental Illness* was published, the New York State Commissioner of Mental Hygiene called for Szasz to be dismissed from his teaching position at SUNY Upstate Medical College and banned from Syracuse Psychiatric Hospital.[91] The President of the American Psychiatric Association conceded that mental illness was partly a result of society's intolerance of deviance, but argued that psychiatry must treat the patient to shelter him or her from stigma and rejection. He denounced Szasz for attempting to "delegitimize the field."[92]

Over the next decade, however, Szasz's views on patient rights began to gain traction as sensational articles were published in America about the Soviet government's practice of declaring political dissidents mentally ill. Psychiatrists at the Soviet Serbsky Institute of Forensic Psychiatry developed a new variant of schizophrenia which they labeled 'slow progressive.' The symptoms of this strain were allegedly latent and imperceptible, allowing psychiatrists to diagnose anyone they liked. Between 1960 and 1991, 674 individuals were involuntarily committed to psychiatric hospitals after committing anti-Soviet acts. Citizens were typically committed in closed-door trials in absentia, and Soviet psychiatrists would have jeopardized their careers if they disputed the verdict.[93]

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[90] Szasz, *Myth*, 39, 67.
[91] Oliver, "The Myth of Thomas Szasz," 68–84.
[92] Parsons, *Prison to Asylum*, 77.
[93] Nathans, *Hopeless Cause,* 412-415.

In his 1961 polemic *The Myth of Mental Illness*, Szasz had briefly mentioned the Soviet practice of declaring a patient insane without due process as part of his larger argument about the dangers of state-controlled treatment.[94] However, Soviet psychiatric internment of dissidents had not yet become known. That changed seven years later, when sensational reports spread throughout the American media. Concerns about the Soviet weaponization of mental hospitalization became intertwined with the Western perception of the Cold War as a struggle against totalitarianism, with Soviet dissidents "subjected to straitjackets and mind-numbing drugs as the ultimate expression of 'total' power over individual human beings."[95] Szasz's argument appeared prophetic, and the reception to his ideas became more positive.

Szasz's book was quickly followed by a wave of scholarship that criticized psychiatry for its moralistic and abusive tendencies. Philosopher Michael Foucault's *Madness and Civilization* and Erving Goffman's *Asylums* based their criticisms of mental treatment on warnings of authoritarianism, which became especially convincing as Americans became more aware of Soviet abuse of psychiatric authority.[96] Szasz's previously-defamed work took on a new life in America just after these reports gained prominence.[97] Lawyers cited Szasz to argue for the rights of patients to refuse involuntary institutionalization in *Lessard v Schmidt* (1972), when a federal court ordered states to narrow their commitment statutes.[98] In 1975, the Supreme Court ruled in *O'Connor v. Donaldson* that mental illness did not itself justify involuntary commitment. The case did not cite Szasz by name but was premised on an argument made in *Lessard* that was based on Szasz's work. In *O'Connor* the court ruled that one could be committed coercively only

[94] Szasz, *Myth*, 101-102, 175.
[95] Nathans, *Hopeless Cause,* 414.
[96] Foucault, *Madness and Civilization*, 263-265. Goffman, *Asylums*, 16-25.
[97] Haldipur, *Szasz*, 2.
[98] Johnson, *Bedlam*, 58.

if "proven to be a danger to oneself or others." And in *Rennie v. Klein* (1978), district court judges cited Szasz in their conclusions to establish the right of patients who were already hospitalized to refuse medication and therapy.[99]

In the wake of *O'Connor*, mental hospitals in New York State changed their admission criteria. It was specifically "because the courts said these patients had a legal right to leave" that they began to discharge even the patients who had no place to go.[100] No longer would patients be held until proper housing and care were arranged, and no longer would the police bring a patient back to the hospital, unless that patient posed an imminent danger. As the severely mentally ill were discharged from hospitals in the late 1970s, the right to refuse treatment would allow the state and city governments to treat them not as mental patients in need of services but as transients who could simply be ignored and eventually removed. As Cold War America came to see paternalistic treatment as incompatible with freedom, services were substituted for rights.

### *Home Rule*

Just as the rights of mental patients were being revised, another element of deinstitutionalized treatment was called into question: community control. As Commissioner, Christmas had applied the so-called "principle of home rule" to the city's mental treatment system.[101] Her "Master Plan," drafted for Mayor John Lindsay and continued under the next two mayors, recreated the HRC's paraprofessionals program by employing New Yorkers to work as "guides" for discharged patients.[102] The guides picked up patients from state institutions and traveled with them to their local communities to find housing and set up their disability checks.

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[99] Scull, "Thomas Szasz," 1463.
[100] Jencks, *Homeless*, 33.
[101] "Address to the New York Public Health Association," March 7, 1974, box 12, folder 16, JJC.
[102] "New York Report," JJC.

Christmas also created "Mental Retardation Councils" for each of the city's 50 catchment areas. The councils included representatives from agencies, voluntary service providers, vocational programs, and lay community members who advised the DMH on neighborhood needs. And by 1977, Christmas had developed what she called the "Boroughs Federations," which brought the councils together annually to review the city's services.[103]

[103] "New York City Mental Hygiene Planning Body Established," 1977, box 5, folder 3, JJC.

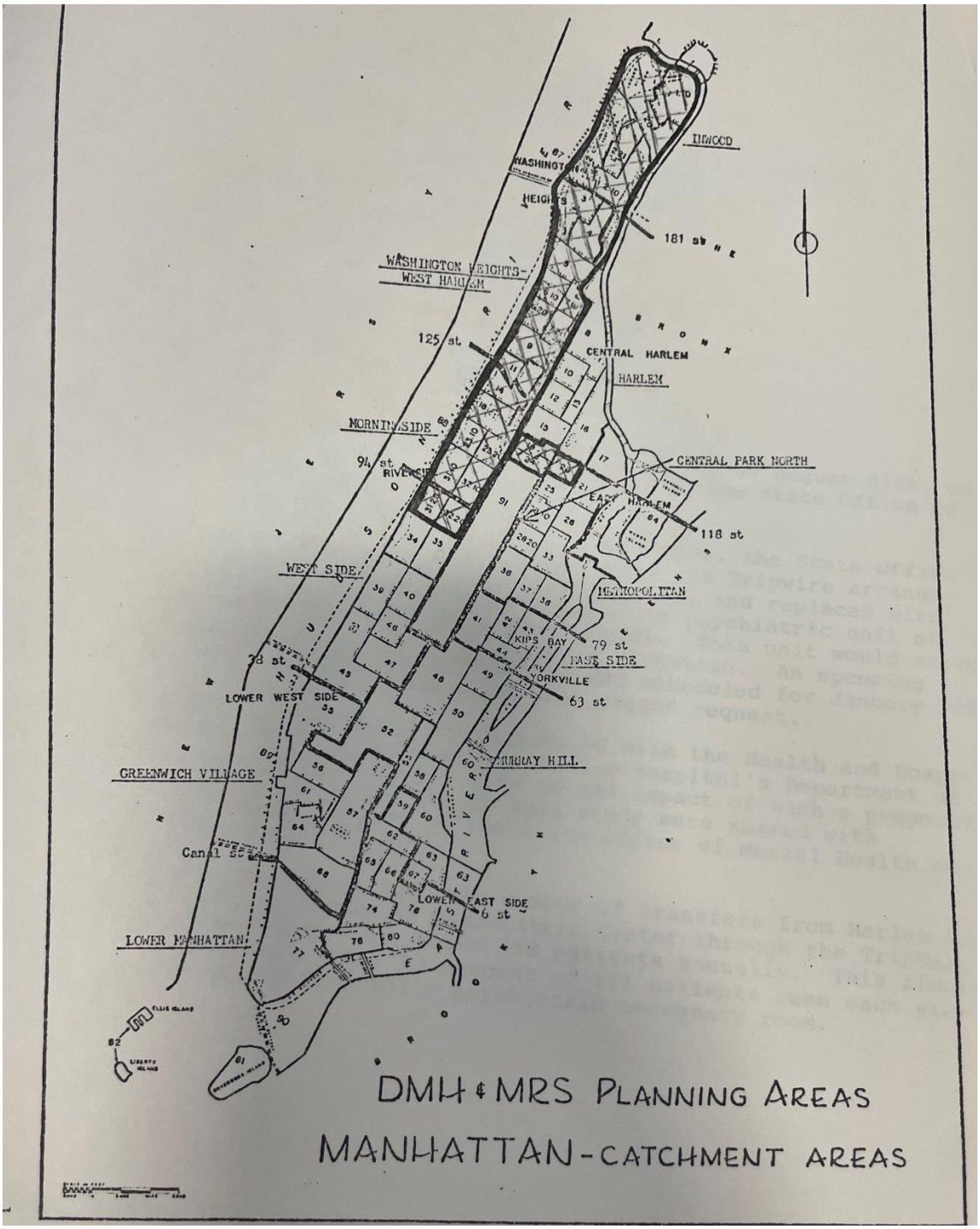


**Figure 3:** Manhattan treatment map developed by Christmas at the DMH, where she tracked health and socioeconomic statistics in each area and intended to open a CMHC in every zone. (Source: "DMH&MRS Services Survey," October 1973, box 1, folder 2, DMH).

What Christmas failed to anticipate was the ambivalence of the community. During her first year as Commissioner, the "furor" over conditions inside of state hospitals began to die down.[104] In a speech honoring the 25th anniversary of the 1954 CMHSA, Christmas warned of a "whittling away of the attention paid to mental health," and in an interview the following year she lamented the lack of participation from citizens with the department's community control mechanisms.[105]

As the decade went on, communities began to oppose the presence of the mentally ill in their neighborhoods altogether, mobilizing against the arrivals of discharged patients on two fronts. First, communities lobbied for the redevelopment of the Single Room Occupancy hotels (SROs). The hotels, in which individual rooms with communal bathrooms and kitchens were rented for a low weekly rate, had become home to many deinstitutionalized patients. Because communities complained about the presence of mental patients in their neighborhoods and city officials offered tax incentives to developers to convert the SROs into apartments, the hotels began to disappear.[106] Second, the city built neither the housing that was promised to deinstitutionalized mental patients nor homeless shelters as communities mobilized to defeat any proposed facilities. While political leaders encouraged both of these trends, they were driven primarily by neighborhood sentiment, newly empowered by the 1975 city charter revision that strengthened community control over land use.[107] In the first years of New Homelessness, active community boards and neighborhood councils pushed for the conversion of SROs to luxury apartments and fought against the citing of new shelters in the area, revealing the way in which

[104] "New York Report," JJC.
[105] "Address to the New York Public Health Association," JJC.
[106] Hietpas, *Islands of the Poor.*
[107] "Uniform Land Use Review Procedure," NYCDCP, 1–2.

the growing sense of "community rights" clashed with the right to treatment and shelter attributed to the homeless mentally ill of the 1980s.

In the wake of deinstitutionalization, patients who did not have families to take them in landed in SROs. In 1981, Laurence Klein, whom Koch appointed to head up the newly-created "SRO Office," described the connection to deinstitutionalization this way:

> In the absence of a network of community-based care, these vulnerable patients …were herded into substandard lower-income hotel rooms in this neighborhood with absolutely no provision for aftercare services and often-times with only a single non-refillable prescription for a psychotropic drug like Thorazine, which they had become habituated to over years of hospital care.[108]

The city blamed the state for breaking its promise by failing to fund housing for discharged patients, and called for the state to readjust its admission criteria to take back some of its more seriously ill patients.[109]

However, as long as the state continued to neglect its responsibility for the former patients, the Koch administration saw SROs as a sufficient way to house chronic patients. Teams of social workers and psychiatrists made the rounds to the hotels, providing prescriptions, therapy, and welfare support. The Woodstock Hotel on West 43rd Street, for example, was leased by a city-funded organization called Project Find, which ran the building as a nonprofit SRO for a mixed population with on-site social services.[110] The set-up was close to what original supporters of deinstitutionalization like Christmas had imagined for their patients: independent living in communities where they received psychiatric care.

Former mental patients had been integrated into New York City, but the success didn't last long. In 1975, Mayor Abraham Beame expanded the existing J-51 tax abatement to

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[108] "Memo from Laurence Klein to Ed Koch, 'Re: SRO Issues at West Side Town Hall on Feb 22nd,'" 1979, box 63, folder 11, EIK.
[109] Edward I. Koch to Hugh L. Carey, October 30, 1981, box 5, folder 3, DHMH.
[110] "Recommendations to Improve City's Attack on SRO Problems," Eleane Berlin, 1979, box 53, folder 20, EIK.

encourage private developers to convert SROs into apartment buildings. The incentive worked: from 1975 to 1983, the city's stock of SRO units fell from 51,000 to 14,000. By selling off SROs be redeveloped, landlords could reap "windfall profits," and by 1979 nearly five thousand SRO units were being lost per year.[111] Tenants, the majority of whom were former mental patients, were pushed to move out by their landlords, who often using tactics of harassment and even violence to speed up evictions.[112] Meanwhile, neighborhood residents who resented the SROs reported safety violations that would trigger a fine for the landlord, making SRO ownership less profitable and increasing the pressure to sell the building to a developer.[113]

The city's SRO Office tried to assist those evicted in finding a new home, but officials reported that "it is painfully obvious from these relocation attempts that there is no empty low-income housing anywhere." A decade of arson, landlord abandonment, and gentrification had made cheap housing harder to come by than ever before. Klein wrote to Koch on July 3, 1979 that the elimination of SROs induced by the J-51 incentive was creating a "class of homeless people who should rival the Vietnamese boat people for our attention and sympathy."[114] Despite the warning, Koch delegated the decision to pause the conversions to his Deputy Mayor Nat Leventhal, who chose not to implement a moratorium on the J-51 abatement until after Koch's re-election in 1981.[115]

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[111] "Bi-Weekly Summary June 15- July 1," July 3,1979, box 63, folder 11, EIK.
[112] One SRO landlord on West 113th attacked two of his tenants, both of whom were chronically mentally ill, with a metal pipe. The landlord was under pressure by Columbia University to sell the building so that Columbia could take advantage of the J-51 abatement before it expired. The building is now a university dormitory. "Columbia Speeds Up Take-Over of SRO on 113th," *The Westsider*.
[113] Hietpas, *Islands of the Poor*, 38.
[114]"Bi-Weekly Summary June 15- July 1," July 3,1979, box 63, folder 11, EIK.
[115] Memo from Ed Koch to Nat Leventhal, August 30, 1979, box 63, folder 11, EIK.

Why didn't the city halt the conversions sooner? Koch was warned of the tax incentive's consequences for the New Homeless,[116] but he was responding to something outside of his control: community sentiment. On Manhattan's Upper West Side, home to the highest concentration of SROs, neighbors complained about the proximity of the mentally ill and pushed the city to inspect, shut down, and convert the hotels.[117] State Senator Carl McCall wrote to Koch that the hotels in his Upper West Side district were "having a debilitating effect on our community. The single room occupancy hotels and their accompanying problems continue to plague and disrupt the unique fabric of community life."[118] And after a Town Hall at which Upper West Side residents demanded the SROs be closed down, Klein wrote to Koch that neighborhood rejection would leave the city with the "tragic sight of hopeless institutional immigrants to this community, unserviced, misunderstood and poorly housed."[119] Clearly, the experiment of reintegrating mental patients would not be so easy after all. Community sentiment was eradicating the city's affordable housing stock and forcing patients out of their new neighborhoods.

### *The Callahan Consent Decree*

As the SROs closed, the mentally ill were left with no other option but the city's shelter system. In 1980, the system held 900 beds, mostly in Bowery hotels. Hotel vouchers were issued at the Men's Shelter at 8 East Third Street, which served as the city's intake point rather than an overnight shelter. Both the Men's Shelter and the hotels were so dangerous, unclean, and high-

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[116] Holtzman and Soffer blame Koch's policies for the SRO conversions. Holtzman, *The Long Crisis*, 83; Soffer, *Rebuilding of New York City*, 278.
[117] "Issues and Functions for the Mayor's Office for SRO Housing," Sept 14, 1978, box 53, folder 20, EIK.
[118] Letter from Carl McCall to Ed Koch, July 17, 1978, box 245, folder 4, EIK.
[119] "Memo from Laurence Klein to Ed Koch, 'Re: SRO Issues at West Side Town Hall on Feb 22nd,'" 1979, box 63, folder 11, EIK.

security that many found the streets and subways to be less "degrading." When the unhoused did seek city shelter, they were often turned away due to capacity restrictions.[120] According to city records, the Men's Shelter was turning away "literally hundreds of homeless men each day in spite of the fact that over a hundred are accommodated by sleeping in chairs in a room licensed by the State to provide only 16 crisis beds."[121] Counter to the ethos of the movement that had deinstitutionalized them a decade prior, the closing of the SROs removed the mentally ill from local communities and recentralized them around the city's only public shelter.

The Bowery did not welcome the influx of former mental patients. During the 1979 legislative session, State Senator Manfred Ohrenstein, whose district included the Men's Shelter, blocked a bill that aimed to bring financial relief and expansion provisions to the shelter "on the grounds that the facility must be decentralized," though no such option was passed in its place. Meanwhile, the "flop houses," which were the hotels that the Men's Shelter referred clients to, were "closing at a fast clip, bowing to pressure on the Lower East Side to join the gentrification tide."[122] Quickly, community opposition began to constrain even the city's existing shelter by moving to block its funding and close the buildings that held its remaining overnight beds. No community in Manhattan seemed eager to provide space for the New Homeless.

It was against this backdrop of community-led cuts to housing for chronic mental patients that the city signed the *Callahan Consent Decree* in August 1981. The decree, which legally obligated the city to provide shelter to any unhoused man who requested it, was the culmination of a three-year long court battle brought by Robert Hayes, a lawyer for Sullivan & Cromwell and shelter volunteer. Hayes had noticed the recent rise in people sleeping outdoors and set out to

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[120] Main, *Homelessness*, 23.
[121] Letter from Laurence Klein to Ed Koch, July 3, 1979, box 53, folder 11, EIK.
[122] "Bi-Weekly Summary June 15- July 1," July 3,1979, box 63, folder 11, EIK.

establish a legal right to "housing." After combing through the municipal and state legal codes he saw that such a right would be difficult to claim, but found grounds for a legal right to "shelter" in Article 17 of the New York State Constitution, which granted that the "aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions." It was the very same article that had been proposed by Mayor La Guardia in 1937, when the Great Depression had plunged the city into a bout of homelessness even worse than the one Hayes observed.[123]

The court case began in the fall of 1979, when Hayes brought a class action suit against the city and state before the New York State Supreme Court. The lead plaintiff, Bob Callahan, was a former line cook who had been homeless for years as he dealt with chronic alcoholism. He and two other plaintiffs alleged that homeless men were turned away from the Men's Shelter on cold winter nights, risking frostbite and even death, and that the city's shortage of beds was a violation of their constitutional right to shelter.[124]

The court first issued an injunction requiring the city to provide an "adequate supply of shelter," including an order to immediately add 750 and to keep the Men's Shelter on East Third Street open despite qualms about its condition. This injunction also prompted the city to open a shelter in the Keener building on Ward's Island, which had been a mental hospital before deinstitutionalization.[125] According to officials, the city chose the location because of the resistance they received when they attempted to open a shelter anywhere else.[126] Only a remote island could avoid opposition from neighbors. The extension of rights under *Callahan* was constrained by other New Yorkers' disdain for the homeless from the beginning.

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[123] Soffer, *Ed Koch*, 281.
[124] Chang, "Lawyer Who Turned New York into a 'Right to Shelter' City," *Curbed*.
[125] Yanos, *Exiles*, 66-68.
[126] Letter from Ed Koch to Carol Bellamy, June 18, 1981, box 65, folder 18, EIK.

In August 1981, the city agreed to sign a consent decree.[127] The *Callahan Consent Decree* granted a "recognition with the force of law to a right to shelter" for homeless men. Though Hayes had sued both the city and state, the court compelled only the city to provide shelter, citing the state constitution's clause that care for the needy should be provided by both the state and by "such of its subdivisions."[128] Housing was the responsibility of the city. Over the next five years the ruling provided a foundation for further expansions of this right at the local level, including *Eldredge v. Koch,* which granted a right to a certain quality of shelter for women, and *McCain v. Koch,* which applied to homeless families with young children.

*Callahan* was hailed as a victory of the city's welfare state legacy.[129] Even when the city fell short of its shelter mandate, the decree represented a more progressive conception of government than that of the laissez faire policies of gentrification and deinstitutionalization which had created New Homelessness. After all, the decree was a product of the La Guardia-style welfare state. I argue, however, that the *Callahan* right to shelter, because it did not include a broader right to housing or social services for the New Homeless, should be recharacterized. In its implementation, *Callahan* became the concluding episode of communities' efforts to resist the integration of former mental patients into their neighborhoods.

The first reason for this recharacterization is that the shelter system became one of large warehouses in non-residential neighborhoods because of the same community opposition that closed the SROs in the previous decade. After Ohrenstein successfully deprived the Men's Shelter of additional funding, the Koch administration tried to establish new shelters in other

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[127] Main, *Homelessness*, 26.
[128] *Callahan v. Carey*, consent decree.
[129] Holtzman and Johnson argue that homelessness was a consequence of city-level housing and health policies, framing *Callahan* as the proper enforcement of that duty. Soffer and Main blame the state's deinstitutionalization policies but still cast *Callahan* as the beginning of a new progressive effort to minimize homelessness. Holtzman, *The Long Crisis*, 24; Johnson, *Bedlam*, 148; Soffer, *Rebuilding of New York City*, 279; Main, *Homelessness*, 12.

neighborhoods to comply with the initial *Callahan* requirements. However, the recent city charter revision required officials to present development proposals to community boards, where the city faced enormous resistance to the construction of new shelters.[130] When Koch defended a proposed homeless outreach center at an Upper West Side community board meeting, he was shouted down by residents who later hired a lawyer to halt the project.[131] A shelter set up in an old Brooklyn school building was dismantled after "angry residents, clergymen and politicians" threatened to sue the city for endangerment.[132] The final blow came when every community board in the city voted against siting Koch's proposed 300-bed shelter in their neighborhood in 1981.[133] Because of his reluctance to oppose the community board votes, which were advisory and non-binding, Koch was left with few options besides the temporary Keener shelter—the same building that had served as a state mental hospital until it was emptied by deinstitutionalization.[134] Community opposition had pushed the mentally ill back to the warehouses they had been discharged from just a decade earlier.

The second reason to cast the city's new right to shelter as the culmination of a laissez faire movement rather than a provision of welfare is that the shelters were designed to deter permanent use. Unhoused people congregated around shelters for services and meals but only slept inside them when the weather forced them to. City Council President Carol Bellamy wrote to Deputy Mayor Leventhal in July 1981 requesting that the city implement a plan to "discourage long-term residence at the Keener Building" by assigning worse rooms to repeated residents. Later that year, the city changed the shelter guidelines to prescribe less comfortable bedding,

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[130] Department of City Planning, Land Use Review, 1–2; Letter from Ed Koch to Carol Bellamy, June 18, 1981, box 65, folder 18, EIK.
[131] Carmody, "New York Is Facing 'Crisis' on Vagrants," *New York Times*.
[132] "Shelter for Derelicts Gets Bums Rush," November 2, 1981, box 5, folder 2, DHMH.
[133] Letter from Carol Bellamy to Ed Koch, May 28, 1981, box 65, folder 18, EIK.
[134] Yanos, *Exiles in New York City.*

mattresses, and lighting. The aim of these policy changes was to "prepare shelter clients for independent living in the community" by discouraging long-term use of city facilities, though such an agenda ignores the fact that the "community" had neither the cheap housing nor the mental services that such independent living would require.[135]

### *"Doing Better"*

In a speech at a psychiatry conference in 1979, Christmas reflected on the course of the deinstitutionalization movement. In the three years since her address to the Public Health Association, her warnings about mass homelessness of former mental patients had come true. Christmas's support for deinstitutionalization had always been founded on a belief that "people do better in the community" than in a mental hospital.[136] But that day, she qualified that belief. "We have to raise the question, 'Are people who are sitting on the library steps in NYC and sleeping underneath the stairs in the stands at Grand Central Station and lying in the park at Farragut Square really doing better in the community?'"

Without structured care or housing, Christmas saw that former mental patients were not receiving the kind of care that had been promised. She criticized the right to refuse treatment that deinstitutionalization had become associated with, arguing that such an emphasis was incompatible with the care regimens some patients needed.[137] Patients had either fallen through the cracks or been re-exiled to the Keener Building on Ward's Island.[138] Without permanent housing, those former patients had no community to take responsibility for them—mostly due to local neighborhoods' rejection of the integration of mental patients and heightened skepticism of

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[135] Soffer, *Ed Koch*, 282.
[136] "Future of Mental Hygiene Services in NYC," JJC.
[137] "Current Concepts and Challenges," JJC.
[138] Johnson, *Bedlam*, 131.

government-controlled mental treatment. It is against this backdrop that New York City's landmark right to shelter appeared: not as a true civil liberty or a progressive victory, but as a force which excluded the mentally ill from the social contract of a rapidly-gentrifying city.

## Chapter 3: Re-institutionalization

Mental Hygiene Commissioner Sarah Kellermann's monthly report to the mayor usually consisted of hospital censuses and budget updates. But on October 1, 1982, it began quite differently: "Central Park Incident: Polar Bear Killing of Homeless Man," the first item read.[139] A 29-year-old man named Conrado Mones had experienced a mental break four days earlier, attempting to enter multiple animal enclosures at the Central Park Zoo before zoo guards escorted him from the premises. Finally, he reentered and scaled a twelve-foot wall into the bear pen, where the polar bear killed him.[140] Kellermann wrote that she was working with the DMH and the Parks Department to "discuss ways of handling similar situations in the future" and to "provide access to services for mentally-disturbed homeless persons frequenting the park." Parks Department personnel would be trained to identify visitors in distress, and a mobile crisis team would patrol the area in the evenings.[141]

The death of Conrado Mones was reported in multiple papers, all of which described him as "homeless" or a "derelict."[142] But according to a *New York Times* op-ed from a week later, Mones was not homeless at all. Mones had come from Cuba two years before on the Mariel Boatlift.[143] In Cuba he had taught biology and he hoped to continue teaching in America, so he worked at a gas station in Queens while attending English night school. Mones had been living with his common-law wife in a Brooklyn apartment, but the two had had a fight a month earlier and Mones was staying temporarily with his friend. According to the article, his wife was raising

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[139] Sara Kellermann to Ed Koch, "Monthly Summary," September 30, 1982, box 125, folder 2, SLK.
[140] "Man Killed by Polar Bear Identified as a Cuban," *New York Times*.
[141] Kellermann to Koch, "Monthly Summary," SLK.
[142] Sutton, "Zoo Bear Kills Derelict," *New York Daily News*; "1,000-pound polar bear slashed and bit intruder," *United Press International.*
[143] The Mariel Boatlift included former mental patients, though the number of patients was likely exaggerated by the American media and the Cuban government. Hawk, *Mariel Boatlift*, 40.

money to reclaim his body from the morgue so that he would not be buried in the Hart Island potter's field. The op-ed concluded emphatically that Mones was "not a bum" and had simply become "mentally disoriented." He had been working a difficult schedule and had fought with his spouse—both feasible contributors to a mental break.[144] The attack was during broad daylight, meaning that it wasn't directly related to whether he had a place to sleep. Regardless of these facts, Mones was labeled by officials and the media as homeless—an assumption that would become routine for the city.

I argue in this chapter that the conflation of homelessness with acute mental illness was partly a product of financial incentives from the state. I will then seek to show that this association changed the place of the mentally ill in New York's social contract. Whereas, in the early years of deinstitutionalization, mental illness was believed to be exacerbated by city-level factors and thus an indictment of poor municipal governance, the classification of mental illness was used by the city in the 1980s to shirk responsibility for the New Homeless.

### *The City Against the State*

On Monday, July 28, 1979, at City Hall's Board of Estimate Chamber, Mayor Koch swore Kellermann in as Commissioner of the DMH. Christmas, the former commissioner, stepped down a few months earlier after voting against Koch's polarizing closure of Sydenham Hospital in Harlem.[145] Kellermann had filled in for Christmas since then, and she and the mayor planned to use her ceremony as an opportunity to publicly denounce the state's deinstitutionalization policies.

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[144] Schanberg, "New York; Death of a Biology Teacher," *New York Times*.

[145] After Christmas voted against Koch's budget proposal to close Sydenham, relations between the two of them were "not cordial." Christmas said serving in Koch's administration made her "tired of not being able to talk about what concerns me the most, which is to make life better for black people." The city closed Sydenham one year later. Christmas, interview.

After praising her record as Commissioner in his speech, Koch accused the state of "dumping" mental patients onto city streets, whom he alleged were "submerging our parks, subways and public places in an atmosphere of anxiety." He warned that "the city can no longer afford to have its neighborhoods used as mental wards and its police officers as orderlies."[146] The New Homeless were dangerous, he claimed, and the communities that deinstitutionalization had enlisted as caretakers were not up to the task.

For that reason, just a month before Kellermann was officially appointed, Koch asked the DMH General Counsel, Peter Freed, to find grounds on which he could sue the state for discharging so many patients into his city. And, if no such lawsuit could be constructed, he directed Freed to find a method of involuntarily re-institutionalizing the "shopping bag women and similar people." Freed turned down both proposals, citing the landmark court ruling *O'Connor v Donaldson*, which granted patients both a right to quality treatment and the right to refuse it. In addition, New York State's hospitalization laws lacked the provision for committing a patient for 72 hours that most other states had on their books. The only circumstance under which an individual could be compelled into treatment was when they were an immediate danger to themselves or others. Freed added that involuntary hospitalization was not only inadvisable for legal reasons. The majority of the New Homeless were chronically, not acutely, ill, and therefore a remote and restrictive setting would do more harm than good.[147] Kellermann agreed, forwarding his memo to Koch and adding that "one can mitigate the program of non-consent" by "improving the quality" of mental illness outreach programs and shelters rather than forcing people to use them.[148]

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[146] "Remarks," SLK.
[147] "Memo from General Counsel Peter Freed to Kellermann," July 31, 1980, box 125, SLK.
[148] "Services to Disaffiliated Persons," August 1, 1980, box 125, SLK.

Disregarding their warnings, Koch continued to push for a route through which he could involuntarily hospitalize those on the street. He convened a group of lawyers on his own, circumventing the DMH's legal team, and asked them to find a loophole in the commitment laws. That December, Kevin Cahill, the Governor's health policy advisor, caught wind of Koch's strategy. In a letter to the mayor, Cahill reacted with disdain at Koch's idea of "seizing these people against their will, delousing them and holding them in some State facility." For three more pages, Cahill argued that something good could still be fashioned from deinstitutionalization. He believed that the biggest roadblock to its success was Koch's fearmongering about the New Homeless: "Many of the 'street people', and 'bag ladies' in particular, must be among the most vulnerable on God's earth. It should be noted that the majority of 'street people' would not be classified as mentally ill."[149] If Koch would stop fear mongering about the New Homeless, Cahill believed that they could be integrated into city life.

Cahill alleged that the Koch administration stoked fear of New Homelessness to distract from the city's housing policies, such as the J-51 tax abatement, the administration's "low prioritization" of low-income housing construction, and the city's failure to develop decentralized shelters, factors which he believed were the true causes of New Homelessness.[150] From the state's perspective, community-directed mental health care had failed because the City's housing stock did not have the capacity to place them into a community. Cahill claimed that the city's characterization of the unhoused as acutely mentally ill was strategic. By implying that New Homelessness was a product of individual pathology, the city shirked its responsibility to address the eradication of affordable housing.

[149] Kevin Cahill to Edward I. Koch, December 1, 1980, box 125, folder 7, SLK.
[150] Cahill to Koch, SLK.

Both the city and the state had their own financial interests in mind. While it was true that the city's housing stock and employment opportunities were changing, the state had broken a promise of its own: when deinstitutionalization had begun more than two decades earlier, New York State had pledged to reattribute 50% of its mental hygiene budget to the city to cover community-level mental treatment.[151] However, as Christmas, Kellermann, and other city officials pointed out, no such funding ever materialized.[152] 90% of the state's mental hygiene budget continued to go to half-empty asylums, while only 10% was directly sent to cities.[153] Some new initiatives like the Community Services Society of New York funneled state dollars into local mental health programs, but it was undeniable that the majority of the financial burden fell onto the city.

It is in the context of this funding debate that government officials at both levels began to operate in split realities, in which different statistics about mental illness in the population and different understandings of deinstitutionalization itself began to form. Cahill, writing with the state's interests in mind, claimed that "the best studies indicate that only 10-30% of those identified [as homeless] have a history of mental disease requiring previous hospitalization."[154] Meanwhile, Koch's own writing shows his assumption that the homeless were predominantly mentally ill patients in need of hospitalization.[155] Undergirding all of this is a misunderstanding of deinstitutionalization's origins as described in the previous chapters: a movement that

[151] Over the course of deindustrialization, the city lost 600,000 private manufacturing jobs (1950-1976). The city also cut roughly 60,000 public sector jobs during the fiscal crisis. FRBNY, "New York's Economy," 49-50. For more on the state's original funding promises, see Johnson, *Bedlam*, 89-96.
[152] Main, *Homelessness*, 67.
[153] "Deinstitutionalization or Rehabilitation," JJC.
[154] Cahill to Koch, SLK.
[155] Koch to Carey, DHMH.

intended to discharge the less-seriously ill patients into their communities, where housing is provided and care is highly structured.

### *The Tripwire Agreement*

Conflict between the city and state over the fallout of deinstitutionalization came to a head in the fall of 1981, when patients began to flood the psychiatric intake units of New York City's hospitals. City newspapers reported that the mental patients "jam corridors and emergency rooms" usually used for surgery, with some patients "under constant guard while tied to chairs or simply handcuffed."[156] Psychiatric intake facilities were legally obligated to help anyone who was in distress, but such rates of mental illness were far more than the hospitals could handle. The negotiations between city and state that ensued changed the place of the New Homeless in the city's social contract in two ways. First, they hinged on the city classifying its deinstitutionalized mental patients as acutely ill and dangerous, rather than chronically ill and in need of outpatient services. And second, they made the state's financial assistance contingent upon viewing the mental illness of the New Homeless as an "emergency," invoking temporary powers and restricting rights in a way that became quite permanent. The crisis would culminate in the Tripwire Agreement, under which state facilities would take in overflow patients from city psychiatric wards for the first time since deinstitutionalization had begun.

When news broke of the overcrowding, Koch wrote a letter to Governor Hugh Carey blaming the state. "Numerous persons clearly in need of psychiatric attention wander our streets, and represent both individual human tragedies and unanswerable dilemmas for their local communities," Koch wrote. "There needs to be a prompt and comprehensive reassessment of the

[156] "Who's in charge here," *New York Daily News*, October 28, 1981, box 216, folder 7, EIK; "Mental health tragedy," *Post*, November 6, 1981, box 216, folder 7, EIK.

policies of psychiatric deinstitutionalization."[157] In the meantime, Koch demanded that the state mental hospitals around New York City take back the patients who were flooding into the city's intake wards.[158] Ironically, SOMH inspectors had arrived at the city's hospitals unannounced in late September after hearing reports of horrific conditions.[159] The state threatened the city with legal action for alleged patient neglect, and SOMH's regional director, Sarah Connell, gave city hospitals fifteen days to construct a plan to alleviate the overcrowding.

The state's charges were received with incredulity by the Koch Administration, who saw the overcrowding as a product of the state's deinstitutionalization policies.[160] Dr. Luis Marcos, Director of Mental Health Services, waited the full fifteen days before responding with a public letter, cc'ing the *New York Times*. Marcos revealed that he had found a footnote in the state law that undermined Connell's blame of the city. The note granted that, "upon a determination that overcrowding exists in any facility because of the scarcity of space…the State Commissioner shall arrange for interim and emergency accommodation of patients." Marcos claimed that the overcrowding was now the state's responsibility by emphasizing that city hospital conditions were indeed an "emergency" and the patients "dangerous." Marcos ended his letter by attaching a list of patient names, noting sarcastically that he would "look forward to [SOMH's] prompt accommodation of the patients for whom we are providing treatment in violation of the New York State Mental Hygiene Law, as cited by you."[161]

Rather than conceding, Connell recanted her assessment of the city's psychiatric units. She told the *New York Times* on October 26 that there was in fact "no emergency" in the city

[157] Koch to Carey, DHMH.
[158] Koch to Carey, DHMH.
[159] Luis Marcos to Sarah Connell, October 20, 1981, box 4, folder 7, DHMH.
[160] Koch to Carey, DHMH.
[161] Marcos to Connell, DHMH.

hospitals after all, and thus no need for the state to take in surplus patients, despite the fact that state psychiatric hospitals around New York City were only half full and could have alleviated the burden.[162] Immediately, New York City Council President Carol Bellamy wrote to Governor Carey to criticize Connell's switch-up. Bellamy insisted that city hospitals were indeed in crisis, and that it should fall to the state to resolve it because many of the patients in city hospitals were the same patients who would have resided in state institutions twenty years ago.[163]

Unlike Koch, however, Bellamy still supported deinstitutionalization. "I do not disagree with the thrust of the State policy," she wrote. "I believe the State has failed these patients and ex-patients by not setting up a comprehensive system of housing, support and mental services."[164] Such a conception of holistic care was exactly what Christmas had imagined, but the difference lay in who was expected to provide that environment. Whereas Christmas believed the city was responsible, Bellamy conveniently blamed the state.

To support this blame while supporting deinstitutionalization, city officials Bellamy and Marcos characterized the hospital overcrowding as an "emergency," implying that the crisis was temporary. Their messaging was self-contradictory: both attributed the hospital overcrowding to the state's failure to readmit patients, but claimed to maintain their reform-minded opposition to state mental institutions. They insisted that the overcrowding of city wards was a brief aberration and not a permanent effect of the deinstitutionalization policies they endorsed. City officials refused to acknowledge that deinstitutionalization originally aimed to bring mental patients into the city's social contract, and that without support services, the mentally ill had nowhere to go but the hospital.

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[162] Berger, "Mental Cases Are Crowding City Hospitals," B7; Carol Bellamy to Hugh Carey, October 29, 1981, box 4, DMHM.
[163] Bellamy to Carey, DHMH.
[164] Bellamy to Carey, DHMH.

In November 1981, after a few more antagonistic letters between city and state officials, as well as newspaper op-eds criticizing them for their "unseemly haggling," the city's DMH and the SOMH signed the "Tripwire Agreement."[165] The terms granted that state institutions in the New York City area operate at full capacity and accept patients directly from city hospital psychiatric intake units as soon as city facilities reached capacity. The state added a requirement that any patient they admit must have either a history of state-level psychiatric treatment or exhibit symptoms worthy of involuntary treatment.[166] That amendment was meant to prevent the city from offloading too many people, but it created an even worse incentive: as the flooding of the shelters and psychiatric intake units continued, it was now in the city's best interest to cast the New Homeless as acutely ill. In the wake of the Tripwire Agreement, the populations of state mental hospitals began to rise for the first time since deinstitutionalization began.[167]

It was exactly what the city had asked for, and yet the agreement failed to relieve overcrowding. Two months into the agreement, the city reported that, "while it appears that the 'Tripwire' concept has the potential for a positive impact, the scope of the present plan precludes any system-wide relief." State facilities had filled up with transfer patients quickly, and rather than stymie the inflow of patients, city hospital administrators reported that the greater volume of patients accepted only seemed to generate more demand for care.[168] At Harlem and Elmhurst Hospitals, psychiatric wings remained above 100% capacity no matter how many patients were transferred.[169] City officials wrote that "no one seems to be able to explain why there is this

[165] Sarah Connell to Victor Botnick, November 5, 1981, Patrick Lochrane to Sarah Connell, November 9, 1981, box 5, folder 3, DHMH; "Who Cares for the Mentally Ill," *New York Times*, November 5, 1981, box 4, DHMH.
[166] "Proposed State Actions to Address Overcrowded Conditions in HHC Hospitals for Discussion," November 13, 1981, box 125, folder 9, SLK.
[167] "Proposed State Actions," SLK.
[168] Sarah Connell to Luis Marcos, April 21, 1982, box 4, DHMH.
[169] Robert Wagner to James Prevost, January 26, 1982, box 4, DHMH.

sudden increase in the numbers of patients that we are seeing in our emergency rooms." By February 6, 1982, the state announced that its beds were too full to continue accepting overflow patients, and the Tripwire Agreement was paused.[170]

Tripwire failed because it treated the flood of mental patients in New York City as an aberration rather than the result of a structural lack of housing or mental services. In April 1982 the *New York Times* reported that one fifth of state psychiatric beds within the city were occupied by "patients no longer needing them but requiring other and less expensive care," meaning chronic patients who had recovered from their acute episodes but had nowhere else to go.[171] That was partly a product of state law, which prohibited the mental hospitals from releasing mental patients without an address to discharge them to.[172] The crowding continued unabated for a year, until Kellermann delivered a briefing on October 22, 1982. She told city officials that the agreement's failure laid bare the need for affordable housing and employment in the city, factors that had resulted in both a "higher prevalence of mental illness as well as a higher hospital recidivism rate."[173] As Christmas could have predicted, the Tripwire Agreement proved ineffective because the city did not provide support services, claiming the rise in mental illness was a temporary "emergency" for which the state should take the blame.

### *Project HELP*

That same month, as the numbers of the New Homeless continued to rise and intake wards continued to overflow, the city turned to involuntary hospitalization. Kellermann announced that she would invoke State Law 9.37, which allowed the government to commit a

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[170] "Monitoring of the Tripwire Plan," February 24, 1982, box 4, folder 5, DHMH.
[171] Peter Khiss, "Lag by Hospitals Cited in Psychiatric Transfers," *New York Times*, April 19, 1982, box 4, DHMH.
[172] "Conditional Release of Patients to the Community," box 4, folder 1, DHMH.
[173] "Briefing Material Prepared for the Community Services Board Regarding Overcrowding in the Adult Psych Care Services," Oct 22, 1982, box 5, DHMH.

patient whose mental illness could cause "serious harm to himself or herself or others."[174] Whereas Tripwire had consensually moved patients between local hospitals and state facilities, this statue would allow the city to take qualifying individuals straight to state mental hospitals. In the first week alone, the city involuntarily transported ten patients to facilities outside of New York City. Kellermann justified the legality of the move to the State Commissioner by pointing out that the state had failed to sufficiently alleviate the city-level overcrowding. [175] Her invocation of Section 9.37, though sparing, would be the first wide-scale expansion of involuntary treatment since the deinstitutionalization movement began nearly thirty years before.[176]

One week later, the city formally applied these powers to the homeless. The city unveiled "Project HELP," which stood for the Homeless Emergency Liaison Project. The program, which was integrated into the Police Department's call system, would send outreach workers to examine homeless individuals who "appeared dangerous" or simply "displayed self-neglect."[177] Kellermann endowed Project HELP workers with the ability to commit individuals to go to a psychiatric ward or state hospital for twenty-four hours for a wellness assessment. The city faced multiple lawsuits over the next decade for the program's alleged violation of patient rights, but the hospitalization policy would ultimately triumph.[178] The Koch Administration had found their legal loophole.

By December 1, 1982, Project HELP had committed seventy-two people.[179] Meanwhile, the overcrowding crisis continued in the city's psych wards and spread into the state hospitals. In

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[174] Carol Bellamy to James Prevost, Oct 15, 1982, box 5, folder 1, DHMH.
[175] "Community Services Board," DHMH.
[176] "Community Services Board," DHMH.
[177] Helen Greer, "Project H.E.L.P. Application to Operate," box 5, folder 1, DHMH; Barbanel, "Tough Test for New Homeless Policy," *New York Times*.
[178] Mahler, *Gods of New York*, 187-189.
[179] Kellermann to Koch, "Summary, December 1, 1982," box 125, SLK.

January 1983, the city announced that the state-run Manhattan Psychiatric Center on Ward's Island, next door to the Keener homeless shelter, would resume its role as a provider of long-term care, reversing the downsizing of the previous two decades.[180] Through Project HELP and other involuntary hospitalization measures, the city had begun to remove the New Homeless from the streets.

[180] Kellermann to Koch, "Summary, February 1, 1983," box 125, SLK.

## Conclusion

In January 2026, a spell of below-freezing temperatures hit New York City just weeks after newly-inaugurated mayor Zohran Mamdani had announced his homelessness policy: no more involuntary hospitalizations, an end to encampment sweeps, and a replacement of police officers with Department of Homeless Services workers for outreach to the unhoused.[181] But when nineteen New Yorkers froze to death, thirteen of whom had recently interacted with the department, his policies came under fire from activists and city council members who alleged the deaths were preventable.[182] So, by the second week of the cold spell, Mamdani announced that his administration would reverse its policy. Twenty New Yorkers were involuntarily removed from the streets to hospitals using the same law, Section 9.37, that Koch had invoked decades earlier. A few days later, Mamdani announced his administration would institute a permanent program of encampment sweeps, reportedly in reaction to the cold snap's death toll.[183] The reversal revealed that few of the contradictions within New York's exceptional social contract had been resolved in the half century since New Homelessness first appeared.

Mamdani's reinstitution of sweeps was polarizing. The Legal Aid Society and the Coalition for the Homeless called it "insane" and "another broken promise."[184] Their statement did not address the fact that Mamdani's decision was supported by community sentiment; more than 3,000 New Yorkers had reported the encampments to the city that month in order to have them removed.[185] Meanwhile, the *National Review*, a conservative publication, reported sarcastically that "compassionate left-wing activists" were "outraged Mamdani is saving

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[181] Greenberg, "Homeless Camps, Crackdowns Will End."
[182] Rubenstein, "Storm Tests Mamdani as Dangerous Cold Grips New York."
[183] Goldberg, "Mamdani to Reinstitute Homeless Encampment Sweeps."
[184] Coalition for the Homeless, "City Revamping Homeless Sweeps."
[185] Offenhartz, "Mamdani Vows to Restart Sweeps."

homeless people from freezing to death."[186] The article gave no consideration to where the city's homeless, whose numbers are at their highest since the Great Depression, should go after being removed from public spaces.[187]

In the forty-five years since re-institutionalization began, the sense of government responsibility for its citizens' mental health has been replaced with a more punitive philosophy. Koch remained in office until 1990, during which time he further expanded the powers of Project HELP workers to commit patients.[188] Many of those who were hospitalized by Project HELP would remain institutionalized merely because "they had nowhere else to go."[189] Under Mayor David Dinkins, in office from 1990 to 1993, the city employed new community policing initiatives to remove homeless people from public spaces. Shelters, which the city began to contract out to private organizations, required clients to participate in treatment programs as a precondition for housing. It was only a short road from these amendments to those implemented by Mayor Rudolph Giuliani, elected in 1993, who conditioned the right to shelter with work requirements and imposed legal penalties for sleeping in some public spaces.[190] The positive rights established by Mayor La Guardia were replaced with negative rights and austerity.

Today, the mental health care system in New York City is a hodgepodge of nonprofit contractors, state-run facilities, and day clinics. Only 13 of the 50 CMHCs imagined for New York City were ever built, and the HRC closed in 1989.[191] In their place, the city provides outpatient mental services in schools, hospitals, and shelters. Patient populations in New York

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[186] *National Review*, "Compassionate Left-Wing Activists Outraged."
[187] Counts depend largely on how homelessness is defined. However, the Coalition of the Homeless estimated that 350,000 New Yorkers were without homes in January 2026. "Basic Facts About Homelessness: New York City," Coalition for the Homeless. For yearly counts and city expenditures, see Main, *Homelessness*, 223-225.
[188] Main, *Homelessness*, 53.
[189] Basler, "Policy Extended of Hospitalizing the Homeless."
[190] Holtzman, *The Long Crisis,* 231-240.
[191] "New York City Mental Hygiene Planning Body Established," 1977, box 5, folder 3, JJC.

State mental hospitals have fallen from 93,314 to 3,541 since 1954, but twenty-three of the original twenty-five hospitals remain open.[192] Perhaps for that reason, the funding has not followed the patients: 90% of the state's mental health funding still goes to state hospitals, where only 10% of patients are treated. Meanwhile, the mentally ill have become overrepresented in the carceral system, with one third of men and two thirds of women in New York City jails diagnosed with a psychiatric disorder.[193] As New York City Public Advocate Jumaane Williams has written, budget shortfalls have forced the city to rely "far too heavily on policing and incarceration to move people with mental illness out of public view."[194] Just as it did under Mayor Koch, the city's approach to mental treatment has become more coercive as it is starved for funds.

Despite this bleak outlook, the origins of the deinstitutionalization movement can also be a source of redirection. As I have argued in this thesis, deinstitutionalized patients became homeless because idealistic reforms accidentally created bad incentives. Hospitals discharged patients too liberally, warehouse-like shelters were constructed far from residential areas, and state law rewarded the city's conflation of homelessness with mental illness. Rather than discrediting deinstitutionalization completely, New York City's story shows that it was never quite implemented as intended. Perhaps there are still alternative ways to care for the needy—ways that remain untried.

On May 22, 1967, Christmas gave a speech at the opening of the Harlem Rehabilitation Center's new building. It would be a fraught year in New York City; a month before, hundreds of thousands had marched through Manhattan to protest the Vietnam War. That summer, the

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[192] New York State Comptroller, "Inpatient Service Capacity."
[193] Parsons, *Asylum to Prison*, 3. For today's statistics, see DCJ, "Mental Health Needs in New York City Jails."
[194] NYC Public Advocate, *Mental Health Updates 2025*.

killing of a Puerto Rican man by an off-duty police officer would spark weeks-long rioting. Suburbanization and deindustrialization were leaving the city neglected and divided.[195] But that day, Christmas proposed a less alienated urban life; one that enlisted the local community to check government power and to care for the needy. She envisioned a health center that trained the unemployed to care for the disabled, reunited families with those who had once been housed in distant asylums, and brought communities together at monthly meetings. In this sense, deinstitutionalization could provide more than just mental treatment. It could provide patients, staff, and neighbors with "human renewal."[196]

**Figure 4:** In 1987, the HRC commissioned artist Noa Bornstein to paint a mural on the side of the center next to a community garden. Titled "Striving Together," the work depicted real people involved with the center. The mural still exists but has been partially covered up by a new affordable housing development, and the HRC has been replaced with a preschool. (Source: Photograph courtesy of Bornstein, used with permission.)

[195] Goldstein, *Roots of Urban Renaissance*, 157; FRBNY, "New York's Economy," 49-50.
[196] "Core Curriculum," JJC.

# Bibliography

## *Archival Collections Consulted*

**Archives & Special Collections, Columbia University Health Sciences Library**

Elizabeth Bishop Davis Papers

**Columbia Center for Oral History, Columbia University Libraries**

Edward I. Koch Administration Interviews

**New York City Municipal Archives**

Commissioner Sara L. Kellermann Subject Files
Community Mental Health Board Minutes, 1965-1976
Department of Health and Mental Hygiene Senior Administrative Records
Mayor Edward I. Koch Papers,
Mayor John V Lindsay Department Files 1966-1973

**Private Collections of Rachel Christmas**

**Schomburg Center for Research in Black Culture**

June Jackson Christmas Papers

June Jackson Christmas Oral History Interview

Photographs and Prints Division

## *Published Primary Sources*

Basler, Barbara. "Policy Extended of Hospitalizing the Homeless," *New York Times*, March 12, 1986.

Berger, Joseph. "Mental Cases Are Crowding City Hospitals," *New York Times*, October 27, 1981.

Carmody, Deirdre. "New York Is Facing 'Crisis' on Vagrants," *New York Times*, June 28, 1981.

Chang, Clio. “The Lawyer Who Turned New York into a ‘Right to Shelter’ City Thinks Mayor Adams Is Wrong.” *Curbed*, September 19, 2022.

“City Revamping Homeless Sweeps.” Coalition for the Homeless, February 18, 2026. https://www.coalitionforthehomeless.org/press/city-revamping-homeless-sweeps/.

“Columbia Speeds Up Take-Over of SRO on 113th.” *The Westsider*, June 28, 1979.

Compassionate Left-Wing Activists Outraged Mamdani Is Saving Homeless People from Freezing to Death. *National Review*. https://www.nationalreview.com/news/compassionate-left-wing-activists-outraged-mamdani-is-saving-homeless-people-from-freezing-to-death/.

Coalition for the Homeless. *Callahan v. Carey* Consent Decree. New York: Supreme Court of the State of New York, August 26, 1981. https://www.coalitionforthehomeless.org/wpcontent/uploads/2014/06/CallahanConsentDecree.pdf.

"Flagging for Mental Health Needs in New York City Jails.” Data Collaborative for Justice, April 2025. https://datacollaborativeforjustice.org/wp-content/uploads/2025/04/MH_Brief-1.pdf.

“Effects of Desegregation of a State Hospital System on Rates of Treated Mental Illnesses.” *Center for Disease Control*. January 1971. https://stacks.cdc.gov/view/cdc/62723/cdc_62723_DS1.pdf.

Federal Reserve Bank of New York. "New York City’s Economy: A Perspective on its Problems." FRBNY Quarterly Review 2, no. 2 (Summer 1977).

Foucault, Michel. *Madness and Civilization: A History of Insanity in the Age of Reason*. Translated by Richard Howard. New York: Pantheon Books, 1965.

Furman Center for Real Estate and Urban Policy. "Trends in New York City Housing Price Appreciation." In *State of New York City's Housing and Neighborhoods 2008*. New York: Furman Center, 2008.

Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Garden City, NY: Anchor Books, 1961.

Greenberg, Zoe. "Mamdani Says Homeless Camps, Crackdowns Will End." *THE CITY*, December 4, 2025. https://www.thecity.nyc/2025/12/04/mamdani-says-homeless-camps-crackdowns-will-end/.

Heller, Susan. "The City's Shrinking Households," *New York Times*, July 10, 1983.

Hochul, Kathy. "Governor Hochul Announces $63 Million Awarded to Strengthen Supportive Housing across New York." February 19, 2026. https://www.governor.ny.gov/news/governor-hochul-announces-63-million-awarded-strengthen-supportive-housing-across-new-york.

Lyles, Carole. "Service Center Saved," *New York Amsterdam News*, June 20, 1970.

"Man, Polar Bear Killed, Identified as a Cuban." *New York Times*, September 28, 1982.

"Mental Health Task Force," *New York Amsterdam News,* July 3, 1971.

New York State Comptroller. *Mental Health: Inpatient Service Capacity*. https://www.osc.ny.gov/files/reports/pdf/mental-health-inpatient-service-capacity.pdf

New York City Department of City Planning. *Uniform Land Use Review Procedure*. New York: New York City Department of City Planning, 1976.

New York City Public Advocate. *Mental Health Updates 2025*. New York: Office of the New York City Public Advocate, 2025.

https://advocate.nyc.gov/reports/mental-health-updates-2025.

Offenhartz, Jake. "Mamdani Vows to Restart Homeless Encampment Sweeps." *amNewYork*, February 18, 2026.

https://www.amny.com/politics/mamdani-homeless-encampment-sweeps-restart/.

Purnick, Joyce. "On the Streets, Tough Test for New Homeless Policy." *New York Times,* November 15, 1985.

Rubenstein, Dana. "Storm Tests Mamdani as Dangerous Cold Grips New York." *New York Times*, January 27, 2026. https://www.nytimes.com/2026/01/27/nyregion/mamdani-storm-deaths-homeless.html.

Schanberg, Sydney. "New York; Death of a Biology Teacher," *New York Times*, October 5, 1982.

Stout, David. "Federal Welfare Shift Spotlights Unusual Amendment to State Constitution," *New York Times,* September 8, 1996.

Sutton, Larry. "Zoo Bear Kills Derelict in Cage at Central Park," *New York Daily News*, September 27, 1982.

Szasz, Thomas S. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Harper & Row, 1961.

———. "Psychiatric Self-Defense," *Reason*, May 1983.

———. *Suicide Prohibition: The Shame of Medicine.* Syracuse, NY: Syracuse University Press, 2011.

Tuberculosis in New York City. New York: New York City Department of Health, 1959. https://www.nyc.gov/assets/doh/downloads/pdf/tb/tb1959.pdf.

"1,000-pound polar bear slashed and bit intruder." United Press International, September 27, 1982.

*Secondary Sources*

Deutsch, Albert. *The Shame of the States*. New York: Harcourt, Brace and Company, 1948.

Fernández, Johanna. *The Young Lords: A Radical History*. Chapel Hill: University of North Carolina Press, 2020.

Goldstein, Brian D. *The Roots of Urban Renaissance: Gentrification and the Struggle over Harlem*. Cambridge, MA: Harvard University Press, 2017.

Hawk, Kathleen Dupes, Ron Villella, and Adolfo Leyva de Varona. *Florida and the Mariel Boatlift Of 1980: The First Twenty Days.* Tuscaloosa: University of Alabama Press, 2014.

Hietpas, Jack. *Islands of the Poor: Single-Room Occupancy Housing on the Upper West Side of Manhattan, 1930–1990*, 2023.

Holtzman, Benjamin. *The Long Crisis: New York City and the Path to Neoliberalism*. New York: Oxford University Press, 2021.

Jencks, Christopher. *The Homeless*. Cambridge, MA: Harvard University Press, 1994.

Johnson, Ann Braden. *Out of Bedlam: The Truth about Deinstitutionalization*. New York: Basic Books, 1990.

Mahler, Jonathan. *The Gods of New York: Egotists, Idealists, Opportunists, and the Birth of the Modern City: 1986-1990.* New York: Random House, 2025

Main, Thomas. *Homelessness in New York City*. New York: New York University Press, 2016.

Nathans, Benjamin. *To the Success of Our Hopeless Cause: The Many Lives of the Soviet Dissident Movement*. Princeton, NJ: Princeton University Press, 2024.

Oliver, Jeffrey. "The Myth of Thomas Szasz." *The New Atlantis*, no. 13 (2006).

Parsons, Anne E. *From Asylum to Prison: Deinstitutionalization and the Rise of Mass Incarceration after 1945*. Chapel Hill: University of North Carolina Press, 2018.

Scull, Andrew. "Thomas Szasz: Rebel with a Questionable Cause." *The Lancet* 380, no. 9853 (October 20, 2012).

Soffer, Jonathan. *Ed Koch and the Rebuilding of New York City*. New York: Columbia University Press, 2010.

Taylor, Clarence. “The Rise of Community Control.” *Jacobin*, September 18, 2018.

Wallace, Mike. *Greater Gotham: A History of New York City from 1898 to 1919*. Oxford University Press, 2017.

Williams, Mason B. *City of Ambition: FDR, La Guardia, and the Making of Modern New York*. New York: W. W. Norton & Company, 2013.

Yanos, Philip T. *Exiles in New York City: Warehousing the Marginalized on Ward’s Island*. New York: Columbia University Press, 2025.

Word Count, excluding frontmatter and bibliography: 16,930