Action for Mental Health

THE FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH

A PROGRAM FOR MEETING THE NATIONAL EMERGENCY

$6.75

Action for Mental Health is the long-awaited final report of the Joint Commission on Mental Illness and Health, empowered by the U. S. Congress to conduct the first study in history of the mental health of our nation—and to make recommendations for strengthening it.

Incorporating the principal findings of the five-year Joint Commission study, the book sets forth concrete steps to be undertaken by both federal and state governments as part of a broad mental health program. Among the major—and controversial—recommendations presented are:

Federal, state and local governments' spending for public mental health services should be doubled in the next five years, and tripled in the next ten;

Government loans, scholarships, and, especially, income tax relief should be granted immediately to encourage the pursuit of higher education by young people, particularly in the health professions;

The present system of state mental hospitals should be abandoned and replaced by a totally new concept of mental health care—based upon community clinics for out-patient treatment, psychiatric units in *general* hospitals for short-term in-patient treatment, "open communities" for those who are acutely mentally ill but who can be rehabilitated, and chronic disease centers for long-term illnesses of all kinds.

Forthright, fully documented, and immensely readable, *Action for Mental Health* may well do for the mental health movement what the historic Flexner Report of fifty years ago did for the cause of enlightened medicine. In the words of mental health specialist Albert Deutsch, "it affords a rallying-point around which the concerned professions and the interested citizenry can mobilize in a fresh drive to narrow the yawning gap between mental health needs and resources."

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ACTION FOR MENTAL HEALTH

Joint Commission
on Mental Illness and Health

Action for Mental Health

Final Report
of the
Joint Commission on Mental Illness
and Health
1961

Basic Books, Inc., Publishers, New York

Official distribution of this book has been made possible through a grant from the American Legion.

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MANUFACTURED IN THE UNITED STATES OF AMERICA

Letter of Transmittal

JOINT COMMISSION ON
MENTAL ILLNESS AND HEALTH

Headquarters, Boston, Massachusetts
December 31, 1960

To the Senate and House of Representatives of the United States of America in Congress Assembled:

Pursuant to the provisions of section 304(b) of Public Law No. 182, approved July 28, 1955, we have the honor to submit *Action for Mental Health,* the Final Report of the Joint Commission on Mental Illness and Health.

The Joint Commission received a mandate from Congress to survey the resources and to make recommendations for combating mental illness in the United States. An extensive study has been made by experts under the sponsorship of the thirty-six organizations making up the Commission. This study, while comprehensive, is not exhaustive because of the nature of the problems involved. This final volume contains a resumé of the findings and the recommendations.

Mental illness involves so many complexities—biological, chemical, psychological, and social—that we do not presume to present wholly definitive conclusions or universally approved recommendations. But the study has been thorough and conscientious. Its proposals are bold

and challenging. It remains for legislators and leaders in the mental health field to select for implementation those recommendations that seem immediately practicable and to press for the realization of others so far as they appear urgent and attainable.

Kenneth E. Appel, m.d., *President*
(Former President, American Psychiatric Association)

and

Leo H. Bartemeier, m.d., *Chairman, Board of Trustees*
(Chairman, Council on Mental Health, American Medical Association)

Recommendations for a National Mental Health Program: Summary

The Mental Health Study Act of 1955 directed the Joint Commission on Mental Illness and Health, as chosen by the National Institute of Mental Health, to analyze and evaluate the needs and resources of the mentally ill in the United States and make recommendations for a national mental health program. Our examination of the factors operating at the action level and the supporting level has shown that progress depends on the solution of the same three problems. They are (1) manpower, (2) facilities, and (3) costs. Our recommendations have been so ordered in the following three sections. We present them under the self-explanatory titles of Pursuit of New Knowledge, Better Use of Present Knowledge and Experience, and The Cost:

PURSUIT OF NEW KNOWLEDGE

The philosophy that the Federal government needs to develop and crystallize is that science and education are resources—like natural resources—and that they deserve conservation through intelligent use and protection and adequate support—period. They can meet an ends test, but not a means test and not a timetable or appeal for a specified result. Science and education operate not for profit but profit everybody; hence, they need adequate support from human society, whether this support comes from wise public philanthropy or private.

What is needed in mental health research is a balanced portfolio. Toward this end we recommend the following:

1. *A much larger proportion of total funds for mental health research should be invested in basic research as contrasted with applied research. Only through a large investment in basic research can we hope ultimately to specify the causes and characteristics sufficiently so that we can predict and therefore prevent various forms of mental illness or disordered behavior through specific knowledge of the defects and their remedies.*

2. *Congress and the State legislatures increasingly should favor long-term research in mental health and mental illness as contrasted with short-term projects.*

3. *Increased emphasis should be placed on, and greater allocations of money be made for, venture, or risk, capital in the support both of persons and of ideas in the mental health research area.*

4. *The National Institute of Mental Health should make new efforts to invest in, provide for, and hold the young scientist in his career choice. The Federal government must provide, on a stable base, more salary support for mental health career investigators, more full-time positions must be established for ten-year periods as well as some on the basis of lifetime appointments, and, in the case of medical schools and universities, these latter positions must be awarded on condition that the scientist receive a faculty appointment with tenure.*

5. *Support of program research in established scientific and educational institutions, as initiated by the National Institutes of Health, should be continued and considerably expanded in the field of mental health.*

6. *The Federal government should support the establishment of mental health research centers, or research institutes. These centers or institutes may operate in collaboration with educational institutions and training centers, or may be established independently.*

7. *Some reasonable portion of total mental health research support should be designated as capital investment in building up facilities for research in States or regions where scientific institutions are lacking or less well developed.*

8. *Diversification should be recognized as the guiding principle in the distribution of Federal research project, program, or institute*

grants from the standpoint of categories of interest, subject matter of research, and the branches of science involved.

In general, what we propose is an extension and expansion, combined with certain shifts of emphasis, in the research grant program ably administered at present by the National Institute of Mental Health through the wisdom of Congress. No specific sums will be recommended here, as it is felt that the needs, advances, and areas of interest will alter the sums required from year to year. We endorse and support *Federal Support of Medical Research* (Report of the Committee of Consultants on Medical Research to the Subcommittee on Departments of Labor and Health, Education, and Welfare of the Committee on Appropriations, United States Senate, May 1960). This committee, chaired by Boisfeuillet Jones, recommended total Federal expenditures for medical research which appeared to us currently adequate and reasonable. While substantially supported in the 1960 summer session of the Congress, the recommendations of the Jones Report unfortunately were not fully carried out, particularly as they applied to more realistic support of the indirect costs of research to the institutions which make the research possible. We would memorialize the Congress on the urgent need of reviewing this now notoriously sore point. Too many business-minded governing boards of deficit-ridden universities and teaching hospitals now conceive research as being operated at a direct loss to the institution and therefore are reluctant to approve of further expansion of research efforts.

BETTER USE OF PRESENT KNOWLEDGE AND EXPERIENCE

Manpower, Its Training and Utilization.

1. *Policy.*

In the absence of more specific and definitive scientific evidence of the causes of mental illnesses, psychiatry and the allied mental health professions should adopt and practice a broad, liberal philosophy of what constitutes and who can do treatment within the framework of their hospitals, clinics, or other professional service

agencies, particularly in relation to persons with psychoses or severe personality or character disorders that incapacitate them for work, family life, and everyday activity. All mental health professions should recognize:

A. *That certain kinds of medical, psychiatric, and neurological examinations and treatments must be carried out by or under the immediate direction of psychiatrists, neurologists, or other physicians specially trained for these procedures.*

B. *That psychoanalysis and allied forms of deeply searching and probing "depth psychotherapy" must be practiced only by those with special training, experience, and competence in handling these techniques without harm to the patient—namely, by physicians trained in psychoanalysis or intensive psychotherapy, plus those psychologists or other professional persons who lack a medical education but have an aptitude for, training in, and demonstrable competence in such techniques of psychotherapy.*

C. *That nonmedical mental health workers with aptitude, sound training, practical experience, and demonstrable competence should be permitted to do general, short-term psychotherapy—namely, treating persons by objective, permissive, nondirective techniques of listening to their troubles and helping them resolve these troubles in an individually insightful and socially useful way. Such therapy, combining some elements of psychiatric treatment, client counseling, "someone to tell one's troubles to," and love for one's fellow man, obviously can be carried out in a variety of settings by institutions, groups, and individuals, but in all cases should be undertaken under the auspices of recognized mental health agencies.*

2. *Recruitment and Training.*

The mental health professions need to launch a national manpower recruitment and training program, expanding on and extending present efforts and seeking to stimulate the interest of American youth in mental health work as a career. This program should include all categories of mental health personnel. The program should emphasize not only professional training but also short courses and

on-the-job training in the subprofessions and upgrading for partially trained persons.

3. *Image-Making.*

Steps should be taken to create the President's Prizes in the Humane Sciences, large awards to be made each year by the President of the United States to a young scientist and to a science teacher or professor for outstanding scientific or educational contributions in the life sciences, social sciences, or physical sciences of importance to mental health.

4. *Volunteers.*

The volunteer work with mental hospital patients done by college students and many others should be encouraged and extended.

5. *Support of Education.*

Leaders of the mental health professions should actively and aggressively participate in support of constructive legislation in the field of education, general as well as medical and scientific education.

The Federal government not only should support a student scholarship and loan program but also should foster financial responsibility for education of one's own children wherever possible. The time has come for the Federal government to adopt, and affirm through income tax law amendments permitting deductions from taxable income of direct expenses for higher education, the policy that education is an essential resource of modern life, the same as industrial investment capital, farm products, natural resources, housing, and, of course, medical care. In all these categories, income tax allowances are made, but the demonstrable fact that higher education is a resource and that investment in it increases the future taxable income of the Nation's children has been ignored.

The problems of medical education, the need for expansion of present medical schools, and the need for new medical schools have been impressively set forth in two studies by Federally appointed groups conducted independently of the Mental Health Study. These

are the Final Report of the Secretary's Consultant on Medical Research and Education (U.S. Department of Health, Education, and Welfare, 1958 [Bayne-Jones Report]), and the Report of the Surgeon General's Consultant Group on Medical Education (U.S. Department of Health, Education, and Welfare, 1959 [Bane Report]). The Joint Commission endorses these reports and favors the recommendations summarized in Chapter VI of the Bane Report.

Services to Mentally Troubled People.

Persons who are emotionally disturbed—that is to say, under psychological stress that they cannot tolerate—should have skilled attention and helpful counseling available to them in their community if the development of more serious mental breakdowns is to be prevented. This is known as secondary prevention, and is concerned with the detection of beginning signs and symptoms of mental illness and their relief; in other words, the earliest possible treatment. In the absence of fully trained psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses, such counseling should be done by persons with some psychological orientation and mental health training and access to expert consultation as needed.

1. *Mental Health Counselors.*

A host of persons untrained or partially trained in mental health principles and practices—clergymen, family physicians, teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, county farm agents, and others—are already trying to help and to treat the mentally ill in the absence of professional resources. With a moderate amount of training through short courses and consultation on the job, such persons can be fully equipped with an additional skill as mental health counselors.

2. *Mental Health Consultants.*

Persons fully trained in a mental health profession—psychologists, social workers, nurses, family physicians, pediatricians, or psychia-

trists with particular interest in community services—should be available for systematic consultation with mental health counselors. The basic functions of these consultants would be to provide on-the-job training, general professional supervision of subprofessional activities, and the moral support and reassurance found to be essential for most persons working with the emotionally disturbed or mentally ill.

3. *Pediatricians.*

Child specialists offer a considerable potential for helping emotionally disturbed children, but in many cases lack sufficient psychiatric orientation to capitalize on this potential. The National Institute of Mental Health should provide support for resident training programs in pediatrics that make well-designed efforts to incorporate adequate psychiatric information as a part of the pediatrician's graduate training. It also should provide stipends for pediatricians who wish to take postgraduate courses in psychiatry. The aim is not to convert pediatricians into psychiatrists but to increase the mental patient care resources of the community in which the pediatrician practices.

4. *Resident Schools.*

Pilot studies should be undertaken in the development of centers for the re-education of emotionally disturbed children, using different types of personnel than are customary. The schools would be operated by carefully selected teachers working with consultants from the mental health disciplines.

Immediate Care of Acutely Disturbed Mental Patients.

Immediate professional attention should be provided in the community for persons at the onset of acutely disturbed, socially disruptive, and sometimes personally catastrophic behavior—that is, for persons suffering a major breakdown. The few pilot programs for immediate, or emergency, psychiatric care presently in existence should be expanded and extended as rapidly as personnel becomes available.

Intensive Treatment of Acutely Ill Mental Patients.

A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement, and that the intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully trained members of the mental health professions. There is a need for expanding treatment of the acutely ill mental patient in all directions, via community mental health clinics, general hospitals, and mental hospitals, as rapidly as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, and occupational, physical, and other nonmedical therapists become available in the community. There is a related need for revision of commitment laws to ease the movement of patients through the various treatment facilities.

1. *Community Mental Health Clinics.*

Community mental health clinics serving both children and adults, operated as out-patient departments of general or mental hospitals, as part of State or regional systems for mental patient care, or as independent agencies, are a main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization. Therefore, a national mental health program should set as an objective one fully staffed, full-time mental health clinic available to each 50,000 of population. Greater efforts should be made to induce more psychiatrists in private practice to devote a substantial part of their working hours to community clinic services, both as consultants and as therapists.

For children:

Psychiatric clinics providing intensive psychotherapy for children, plus appropriate medical or social treatment procedures, should be fostered and, where they exist, expanded. Of all categories of psychiatrists, child psychiatrists are in shortest supply—children being especially trying to work with and requiring the close cooperation of the parents and infinite patience on the part of therapists. The pres-

ent State aid program is insufficient to provide for the needs in this area. It should be expanded.

For adults:

The principal functions of a mental health clinic serving adults (the majority serve both adults and children) should be (1) to provide treatment by a basic mental health team (usually psychiatrist, psychologist, and social worker) for persons with acute mental illness, (2) to care for incompletely recovered mental patients either short of admission to a hospital or following discharge from the hospital, and (3) to provide a headquarters base for mental health consultants working with mental health counselors. The function of such a clinic as a center of mental health education for the public is of incidental importance, and should preferably be left to other agencies.

2. *General Hospital Psychiatric Units.*

No community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short-term hospitalization and therefore provides a psychiatric unit or psychiatric beds. Every community general hospital of 100 or more beds should make this provision. A hospital with such facilities should be regarded as an integral part of a total system of mental patient services in its region.

It is the consensus of the Mental Health Study that definitive care for patients with major mental illness should be given if possible, or for as long as possible, in a psychiatric unit of a general hospital and then, on a longer-term basis, in a specialized mental hospital organized as an intensive psychiatric treatment center.

3. *Intensive Psychiatric Treatment Centers.*

Smaller State hospitals, of 1000 beds or less and suitably located for regional service, should be converted as rapidly as possible into intensive treatment centers for patients with major mental illness in the acute stages or, in the case of a more prolonged illness, those with a good prospect for improvement or recovery. All new State

hospital construction should be devoted to these smaller intensive treatment centers.

The most important requirement for an intensive treatment center is a well-trained and competent staff at least as large in number as the patients served. This staff should have a good-sized complement of skilled psychiatrists who know how to work comfortably with a clinical team including a variety of professional and subprofessional persons who can assist them in the treatment of patients. Such workers would include occupational, recreational, and physical therapists as well as psychologists, social workers, nurses, and attendants. The medical superintendent of such a mental hospital should be a competent psychiatrist, thoroughly aware of and prepared to use modern psychological and social concepts of treatment as well as physical techniques of treatment, and should be trained in hospital administration.

Care of Chronic Mental Patients.

No further State hospitals of more than 1000 beds should be built, and not one patient should be added to any existing mental hospital already housing 1000 or more patients. It is further recommended that all existing State hospitals of more than 1000 beds be gradually and progressively converted into centers for the long-term and combined care of chronic diseases, including mental illness. This conversion should be undertaken in the next ten years.

Special techniques are available for the care of the chronically ill and these techniques of socialization, relearning, group living, and gradual rehabilitation or social improvement should be expanded and extended to more people, including the aged who are sick and in need of care, through conversion of State mental hospitals into combined chronic disease centers.

A chronic disease center could be operated by a trained hospital administrator (layman or physician) with the psychiatrists and other physicians coming in as a visiting staff or functioning as a full-time medical staff. The layman professionally trained in hospital administration could effect a saving in scarce manpower.

It would be necessary to provide the intensive treatment services

for the acutely ill, outlined in the preceding section, before large State hospitals could be converted to treat chronic diseases. It also would be necessary to make certain changes in Federal and State laws.

Many of the facilities needed for the prolonged care of mental patients are identical with those necessary for the prolonged care of any type of chronic physical illness. Therefore, communities should find it practical to care for patients with all types of chronic physical and mental disorders in the came chronic disease hospital.

Aftercare, Intermediate Care, and Rehabilitation Services.

The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all service to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them day hospitals, night hospitals, aftercare clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and ex-patient groups. We recommend that demonstration programs for day and night hospitals and the more flexible use of mental hospital facilities, in the treatment of both the acute and the chronic patient, be encouraged and augmented through institutional, program, and project grants.

Aftercare services for the mentally ill are in a primitive stage of development almost everywhere. Where they do exist, services and agencies caring for the former patient tend to split off from mental patient services as a whole and further to approach the patient's problems piecemeal. Rehabilitation agencies should work closely with treatment agencies and preferably have representatives in the latters' institutional settings. It is important that rehabilitation be regarded as a part of a comprehensive program of patient services in which each and every member of the mental health team has a part to play.

PUBLIC INFORMATION ON MENTAL ILLNESS

A national mental health program should avoid the risk of false promise in "public education for better mental health" and focus on the more modest goal of disseminating such information about mental illness as the public needs and wants in order to recognize psychological forms of sickness and to arrive at an informed opinion in its responsibility toward the mentally ill.

It is possible to make certain general recommendations about dissemination of information concerning mental illness aimed at (1) greater public understanding of the mentally ill person and those who care for him, (2) the avoiding of *mis*understanding in the relations of one professional group with another and, (3) the importance of making sure, in the relations of the mental health professions with the lay public, that others understand what we are driving at.

An important point has been missed in overinsistence that the public recognize that mentally ill persons are sick, the same as if they were physically sick, and should be treated no differently from other sick persons. *Mental illness* is *different from physical illness in the one fundamental aspect that it tends to disturb and repel others rather than evoke their sympathy and desire to help.*

A sharper focus in a national program against mental illness might be achieved if the information publicly disseminated capitalized on the aspect in which mental differs *from physical illness. Such information should have at least four general objectives:*

1. To overcome the general difficulty in thinking about recognizing mental illness as such—that is, a disorder with psychological as well as physiological, emotional as well as organic, social as well as individual causes and effects.

2. To overcome society's many-sided pattern of rejecting the mentally ill, by making it clear that the major mentally ill are singularly lacking in appeal, why this is so, and the need consciously to solve the rejection problem.

3. To make clear what mental illness is like as it occurs in its various forms and is seen in daily life and what the average person's reactions to it are like, as well as to elucidate means of coping with

it in casual or in close contact. As an example, the popular stereotype of the "raving maniac" or "berserk madman" as the only kind of person who goes to mental hospitals needs to be dispelled. We have not made it clear to date that such persons (who are wild and out of control) exist, but in a somewhat similar proportion as airplanes that crash in relation to airplanes that land safely.

4. To overcome the pervasive defeatism that stands in the way of effective treatment. While no attempt should be made to gloss over gaps in knowledge of diagnosis and treatment, the fallacies of "total insanity," "hopelessness," and "incurability" should be attacked, and the prospects of recovery or improvement through modern concepts of treatment and rehabilitation emphasized. One aspect of the problem is that hospitalization taking the form of ostracization, incarceration, or punishment increases rather than decreases disability.

Attention is also needed to the manner in which professional persons and groups approach the public, since winning friends and support for care of the mentally ill depends first and foremost on not giving cause for offense. *We recommend that the American Psychiatric Association make special efforts to explore, understand, and transmit to its members an accurate perception of the public's image of the psychiatrist.* Such efforts could pay a great dividend in "education of the public" if the profession were to be educated, perhaps as a part of its formal training, against overvaluing, overreaching, and overselling itself.

The primary responsibility for preparation of mental health information for dissemination to laymen should rest with "laymen" who are experts in public education and mass communications and who will work in consultation with mental health experts. But the mental health expert and the educator or mass communications expert have the primary problem of fully communicating with one another before communicating with the public. Too often the basis for discussions among mental health professionals and laymen is the easy assumption on both sides that the other fellow doesn't "understand the problem" or "know what he is talking about."

As a matter of policy, *the mental health professions can now assume that the public knows the magnitude if not the nature of the*

mental illness problem and psychiatry's primary responsibility for care of mental patients. Henceforth the psychiatrist and his teammates should seek ways of sharing this responsibility with others and correcting deficiencies and inadequacies without feeling the need to be overbearing, defensive, seclusive, or evasive. A first principle of honest public relations bears repeating: To win public confidence, first confide in the public.

THE COST

Expenditures for public mental patient services should be doubled in the next five years—and tripled in the next ten.

Only by this magnitude of expenditure can typical State hospitals be made in fact what they are now in name only—hospitals for mental patients. Only by this magnitude of expenditure can outpatient and ex-patient programs be sufficiently extended outside of the mental hospital, into the community. It is self-evident that the States, for the most part, have defaulted on adequate care for the mentally ill, and have consistently done so for a century. It is likewise evident that the States cannot afford the kind of money needed to catch up with modern standards of care without revolutionary changes in their tax structure.

Therefore, *we recommend that the States and the Federal government work toward a time when a share of the cost of State and local mental patient services will be borne by the Federal government, over and above the present and future program of Federal grants in aid for research and training.* The simple and sufficient reason for this recommendation is that under present tax structure only the Federal government has the financial resources needed to overcome the lag and to achieve a minimum standard of adequacy. The Federal government should be prepared to assume a major part of the responsibility for the mentally ill insofar as the States are agreeable to surrendering it.

For convenience, the Veterans Adminstration mental hospitals can be taken as financial models of what can be done in the operation

of public mental hospitals. *Congress and the National Institute of Mental Health, with the assistance of the intervening administrative branches of government, should develop a Federal subsidy program that will encourage States and local governments to emulate the example set by VA mental hospitals.*

Certain principles should be followed in a Federal program of matching grants to States for the care of the mentally ill:

The *first principle* is that the Federal government on the one side and State and local governments on the other should *share in the costs* of services to the mentally ill.

The *second principle* is that the total Federal share should be arrived at in a *series of graduated steps* over a period of years, the share being determined each year on the basis of State funds spent in a previous year.

The *third principle* is that the grants should be awarded according to *criteria of merit and incentive* to be formulated by an expert advisory committee appointed by the National Institute of Mental Health.

In arriving at a formula, such an expert committee would establish conditions affecting various portions of the available grant, including the following:

1. *Bring about any necessary changes in the laws of the State to make professionally acceptable treatment as well as custody a requirement in mental hospitalization, to differentiate between need of treatment and need of institutionalization, and to provide treatment without hospitalization.*

2. *Bring about any necessary changes in laws of the State to make voluntary admission the preferred method and court commitment the exceptional method of placing patients in a mental hospital or other treatment facilities, and to emphasize ease of patient movement into and out of such facilities.*

3. *Accept any and all persons requiring treatment and/or hospitalization on the same basis as persons holding legal residence within the State.*

4. *Revise laws of the State governing medical responsibility for*

the patient to distinguish between administrative responsibility for his welfare and safekeeping and responsibility for his professional care.

5. *Institute suitable differentiation between administrative structure and professional personnel requirements for (1) State mental institutions intended primarily as intensive treatment centers (i.e., true hospitals) and (2) facilities for humane and progressive care of various classes of the chronically ill or disabled, among them the aged.*

6. *Establish State mental health agencies with well-defined powers and sufficient authority to assume overall responsibility for the State's services to the mentally ill, and to coordinate State and local community health services.*

7. *Make reasonable efforts to operate open mental hospitals as mental health centers, i.e., as part of an integrated community service with emphasis on outpatient and aftercare facilities as well as inpatient services.*

8. *Establish in selected State mental hospitals and community mental health programs training for mental health workers, ranging in scope, as appropriate, from professional training in psychiatry through all professional and subprofessional levels, including on-the-job training of attendants and volunteers. Since each mental health center cannot undertake all forms of teaching activity, consideration here must be given to a variety of programs and total effort. States should be required ultimately to spend 2½ per cent of State mental patient service funds for training.*

9. *Establish in selected State mental hospitals and community mental health programs scientific research programs appropriate to the facility, the opportunities for well-designed research, and the research talent and experience of staff members. States should be required ultimately to spend 2½ per cent of State mental patient service funds for research.*

10. *Encourage county, town, and municipal tax participation in the public mental health services of the State as a means of obtaining Federal funds matched against local mental health appropriations.*

11. *Agree that no money will be spent to build mental hospitals*

of more than 1000 beds, or to add a single patient to mental hospitals presently having 1000 or more patients.

Our proposal would encourage local responsibility of a degree that has not existed since the State hospital system was founded, while at the same time recognizing that the combined State-local responsibility cannot be fulfilled by the means at hand.

Our proposal is the first one in American history that attempts to encompass the total problem of public support of mental health services and to make minimum standards of adequate care financially possible.

The outstanding characteristics of mental illness as a public health problem are its staggering size, the present limitations in our methods of treatment, and the peculiar nature of mental illness that differentiates its victims from those with other diseases or disabilities. It would follow that *any national program against mental illness adopted by Congress and the States must be scaled to the size of the problem, imaginative in the course it pursues, and energetic in overcoming both psychological and economic resistances to progress in this direction.* We have sought to acquit our assignment in full recognition of these facts and judgments.

NOTE ON IMPLEMENTATION

Perhaps it would be well at this point to stress the function of the Joint Commission. It is that of a study group. Its mission is complete with the transmission of this report. We have made a study and from it drawn recommendations for a national mental health program.

It is easy, however, to visualize the next two steps and even a third. The first is the formation of public opinion for or against the program we propose. The second is the formation of legislative opinion pro or con. The third, and *one which we urge the Congress to take immediately, is the formation of a Committee of Consultants who would concern themselves with standards and requirements for implementation of our program and with the kinds of enabling legislation that will be needed.* We can see that a comparable expert committee, forming an effective channel of communication between the

legislature and the mental health professions, eventually will be needed in every State.

In the matter of establishing priorities as they relate to the broad areas of patient care, recruitment, professional education, and research in mental health, we would sound a note of caution. In the final analysis, we actually have no choice, as humanitarians as well as educators and scientists, but to move as rapidly as possible on all fronts at once. In medicine, professional services, education, and research move together insofar as they center on or relate to patients.

JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH

Affirm	42*
Abstain	3
Deny	0
Total Members	45

* For three dissents: See Appendix VII.

Introduction

THE REPORT: AN EXPLANATION OF ITS PURPOSE, SOURCE, AND UNDERLYING PHILOSOPHY

THE PURPOSE of this final report of the Joint Commission on Mental Illness and Health is to arrive at a national program that would approach adequacy in meeting the individual needs of the mentally ill people of America—to develop a plan of action that would satisfy us that we are doing the best we can.

The latter is not presently the case. We who work in the mental health professions have not been able to do our best for the mentally ill to date, nor have we been able to make it wholly clear what keeps us from doing so.

Therefore, it will be necessary first to determine why progress in helping and healing mentally ill persons, progress of which we recently have seen definite signs, has been and still remains arduous, slow, and uneven.

The mental health professions have engaged in a long series of small efforts—some scientific and based on reasonably good evidence; some simply practical applications of wisdom derived from the experience of living; some coming from flashes of insight or good intuition about human motivation; and many simply acts of sheer will power—all directed toward the relief, recovery, and rehabilitation of the mentally ill. To date, however, it would appear that hope has constituted the most constant force in our efforts to move these people toward greater health—hope and a tender compassion for persons who are overwhelmingly in trouble through no conscious intent and yet are often treated as if the fault were all theirs—hope and a scientific conviction that within the disordered mind talented therapists can help its owner find the seed of good mental health, if

only a way can be provided to cultivate this seed in the soil available.

This principle of the healthy, salvageable component of human personality bears some analogy to the fundamentals of religious faith focusing on man's redemption, but encompasses the hopeful prospect, as it were, in a humanitarian science of what is possible here and now. This is as yet among the most difficult of sciences, but fresh acceptance of the above principle in the mental health sciences marks the end of society's long-pursued tenet of "hopeless insanity." To be sure, this more constructive approach to the whole man is not new. The eighteenth-century biographer, James Boswell, appears to have perceived its value and thus provided an early definition of good mental health: "We are so formed that almost every man is superior, or thinks himself superior, to any other man in something; and, fixing his view upon that, he is in good temper with himself" (William K. Wimsatt, 1959, p. 211).

But even if we can find the road to a substantial reduction in the human and economic problems of mental illness, as our marching orders would require us to do, we are obliged to keep in full view certain intervening observations that provide little cause for hope except as we can dispose of them. We must note, for instance, the curious blindness of the public as a whole and of psychiatry itself to what in reality would be required to fulfill our well-publicized demand that millions of the mentally ill have sufficient help in overcoming the disturbances that tend to immobilize their self-respect and social usefulness. To state the case truthfully and place the reality of *what is* side by side with our pretensions as a preponderantly Christian, democratic, humanitarian, scientific, productive society can serve only to embarrass us. But how else can we reap the profit of history's lessons?

This report can succeed in its purpose only if its readers can keep in mind that its primary object is to bring a help to the mentally ill that hitherto has been generally denied them. If we are to accelerate the mental health movement, reduce mental illness, and improve mental health, we must rise above our self-preservative functions as members of different professions and different social classes and adherents of different economic philosophies and illuminate the means

of working together out of mutual respect for our fellow man. We each have our roles and our sense of duties and obligations, but also we each have one kind of responsibility that is common to all and transcends all others. This is our responsibility as citizens of a democratic nation founded out of faith in the uniqueness, integrity, and dignity of human life.

A united effort to help each other achieve, in Boswell's words, a sense of superiority or achievement or effectiveness "in something" and a feeling of "good temper," perhaps implying capacity to overcome obstacles and withstand frustration—in short, good mental health—is consistent with this higher responsibility and with our professional and political ideals. It is also consistent with what the American people should want—not simply peace of mind but strength of mind.

Beyond this opening statement, containing certain topographical hints of the terrain to be traversed in our main presentation, we need only account here for the genesis of the Mental Health Study and briefly mention a few of the events and attitudes that have shaped this report in its final form.

The United States Congress, in the last ten years, has given the American public a working demonstration of a new willingness to accept leadership and responsibility in active efforts to help citizens who are threatened by mental illness. The Federal government's chief implementations of this demonstration may be found in the programs of the National Institute of Mental Health and the Veterans Administration. The good example has been followed in the efforts of State legislatures, Governors, and their public health, mental health, and public welfare agencies in many States.

One evidence of the intent of Congress was the passage of the Mental Health Study Act of 1955 (see Appendix I). In this act, adopted by joint resolution without a dissenting vote, the senators and representatives recognized a critical need for an objective, thorough, nationwide analysis of the human and economic problems of mental illness and the methods of solving these problems. The object was to arrive at comprehensive and realistic recommendations for better utilization and improvement of our resources for reducing

mental illness and improving mental health. This, in essence, was the language of the Act. It specified that the analysis should be done by a nongovernmental, multidisciplinary group or groups. It authorized the National Institute of Mental Health, with the aid of the National Mental Health Advisory Council, to select the investigatory organization.

The responsibility of meeting the wish of Congress fell to the Joint Commission on Mental Illness and Health, a study group originated earlier in 1955 by the American Psychiatric Association and the American Medical Association under the stimulus of Dr. Kenneth E. Appel, Dr. Leo H. Bartemeier, and other psychiatrists who shared a dismay at the stopgap, piecemeal, and generally planless and unsystematic way in which mental health services were being organized and operated, even in States where an attitude of urgent need and desire for progress had clearly emerged.

Psychologists, biologists, sociologists, nurses, occupational therapists, welfare experts, mental health educators, pediatricians, clergymen, other members of the mental health professions, and leaders from other groups with a professional or a public interest in the mental health movement joined with the psychiatrists. This affirmation of partnership was a fulfillment of the spirit of teamwork and mutual good will characterizing the specific therapeutic undertaking in the most advanced mental hospitals and mental health clinics. In its ultimate form, the Joint Commission encompassed forty-five individual members coming from thirty-six participating agencies (see Appendix II).

From the outset, the organizers of the Joint Commission foresaw and voiced certain hopes and fears, certain limitations, and certain obstacles, all inherent in a study of such ambitious scope and diversified interests, dealing as it would with a somewhat vague and confusing mixture of useful knowledge, some practical results, much unproved theory, some good ideas, many eloquent verbalizations, and some plain wishful thoughts. These concerns—some correctly anticipated, some never fully resolved—have remained in the minds of some of us throughout the study life of the Commission. Since they are ultimately of great pertinence, we should be less than

candid if we did not touch upon these matters. They may be summarized as follows:

1. Americans, it has been observed, appear to be alarm-minded and action-oriented. When confronted with a deplorable condition of man or of society, we want to "do something about it," through voluntary pressure groups or by passing a law. Our first inclination, in practice, appears to be expose in muckraking fashion the alarming condition, enumerate the victims, name the "villain." But such an attack begs the question of what can be done; consequently, our second inclination is to appoint a commission to study the problem. In some instances, if the condition is of a tangible character and manageable size and the remedy is within our grasp, the study leads to effective action. More complicated social problems, however, are apt to elicit solutions requiring depth and breadth of understanding and rather drastic changes in prevailing attitudes and systems; they often cut across social, moral, political, and economic biases which are not easily modified. In such instances the expert survey and the publicity attending it may become a substitute for remedial action. It is some satisfaction to the participants, of course, to see their efforts memorialized in the glossy pages of an attractively designed and illustrated brochure, or couched with sobriety and dignity between the hard covers of a heavy book, perhaps in many volumes. But as the late Abraham Flexner, author of the "Flexner Report" that keynoted an early reform of American medical schools, reportedly commented in later years: "Who reads them?" We are as concerned now as in the beginning with this realistic question and, more precisely, with the larger and equally realistic question of what we can possibly say that *will make a difference* in the future of the mentally ill. In answer, this report will have to speak for itself.

2. Attempts to provide more humane care for the mentally ill and to transform mental institutions into hospitals and clinics true to the healing purpose of medicine have occurred periodically during the last two centuries. While each reform appears to have gained sufficient ground to give its supporters some sense of progress, each has been rather quickly followed by backsliding, loss of professional momentum, and public indifference. The Joint Commission and the

Mental Health Study came into being as an expression of the new wave of interest, movement, and progress in mental health that followed World War II. The Commission's leaders held the opportunity presented by Congress to take stock and evaluate new directions to be "a chance of a lifetime."

Yet by 1956, when the study was still in its first year, it was apparent that, as bold as Congress had been in its appropriations for this purpose, the project would suffer from the same sort of financial inadequacy that has plagued mental hospitals, except that in this case the inadequacy was wholly in funds that we hoped to raise from *private* sources. Our efforts to match Federal funds proved ineffective, except for the gifts of a certain few among the smaller foundations and the friendly gestures of other groups. (See Appendix III for a complete listing of sources of financial support.)

A number of study projects that were part of the staff's original study design were deferred inasmuch as they would have required twice as much money as was available. These are listed in Appendix V, Footnote 6-3. (For complete list of titles in the Joint Commission monograph series see Appendix IV.) Nonetheless, the ten projects we were able to finance, plus information from competent studies made available by other agencies during the Joint Commission's study life, have provided sufficient authoritative data to enable us to come to definite conclusions regarding public care of persons with major mental illness—the core problem of mental health.

3. We recognized in the beginning that to cut through to the core, expose the true nature of the problem, and bring it into a true perspective, we would have to set aside partisan interests which would endanger the integrity of the report. During the period of organization, the Joint Commission appointed a Committee on Objectives and Methods, later renamed the Committee on the Studies (see Appendix II), and subsequently adopted the Committee's plan of study. The committee proposed:

> The Commission should act on a conviction that the solution of the problem of mental illness in America is far more important than the preservation of any tradition, institution, procedure, alignment of professional responsibility, or

set of theoretical assumptions. . . . The Commission should be ready to recommend radical reconstruction of the present system, if such is indicated. . . .

In entertaining the possibility of a radical approach, we of course used *radical* in its pure meaning, "proceeding from the root," rather than in any political sense of extremism or fanaticism. To make the above statement *in toto* required, some of us felt, not only a good deal of insight but also some daring, if not downright rashness, inasmuch as the profession of psychiatry, like any burgeoning art or science has had its share of conflict, contention, controversy, criticism, and disagreement.

The reading public is not unaware of this state of affairs, for the modern American press tends to keep its readership informed on both the background and foreground of issues affecting the health of people; so much so that it is well known that various segments of the educated population, including many persons in other professions, are divided *for* and *against* psychiatry, as these factions understand or misunderstand this medical specialty. In fact, because of a predominance of psychiatrists among the founders of the Joint Commission, some members of the press and some nonmedical members of the Commission shared the fear that our final report would simply endorse the status quo. This fear may now be dispelled.

4. At the same time, complete objectivity regarding diversity of opinion posed a problem that one legislative adviser suggested we would do well to avoid. He pointed out that differences of opinion lead to inaction at the legislative level, whereas unanimity would readily form the basis for action. From the outset, the organizers of the Joint Commission were concerned about finding the common grounds of complete agreement in so large and varied a group; unanimity might mean the reduction of areas of agreement to a few meaningless platitudes "for mental health" and "against mental illness." Complete agreement appeared so unlikely that the Joint Commission recognized only one possible course of action. That was to recognize, in its charter, the propriety of expressed and recorded dissent on the part of any member who could not bring himself to agree with the majority. Thus we were officially bound to provide

in the present report, which is centered on majority findings and recommendations, space for the recording of minority opinions, if any.

Each of the Joint Commission's ten monographs deals with a major facet of mental illness and mental health, and each reflects the state of current knowledge and opinion in the given field. These monographs are distributed at the time of publication to the members of Congress, the Governors of the States, the Surgeon General of the Public Health Service, and the official mental health audience in Federal and State governments, as well as made available to the general public through Basic Books, Inc.

These monographs, together with other independent studies and information from the National Institute of Mental Health and organizations represented by Joint Commission members, form the working documents of the final report. The sources of much, though not all, of the material that has helped form our analysis, findings, and recommendations are cited in the text and listed in the references (Appendix VI).

Each book in the Joint Commission monograph series was prepared by persons with research training and experience in economics, psychology, sociology, medicine, or psychiatry, and with special interest and competence in the assigned subject. These authors took their mental health colleagues as their primary audience and hence approached their materials in a technical manner.

The Joint Commission, on the other hand, has the responsibility of addressing the people of the United States through their elected representatives and appointed officials in Federal and State governments. *Action for Mental Health* is especially written to them and for them, the decision makers, out of our primary concern for persons who are or will become mentally sick.

The final report is a distillation of the ideas and efforts of many persons as well as of the lessons of history. It is impossible to give appropriate credit to all who have made contributions to this document, and we will not attempt it. We ourselves claim no originality of proposition or proof, having freely borrowed from the thinking and knowledge of the members of the Joint Commission, of the

Committee on the Studies, of our advisory committees, our monograph authors, our headquarters staff, and our friends in and outside of the field of mental health. This has been a joint, cooperative, multidisciplinary piece of work; we hope that in it all those who labor to better the lot of the mentally ill can find common cause.

It is impossible, of course, for a commission of forty-five persons to write a report, in this instance the work of a professional staff (see Appendix II). But it is possible for such a commission and the interested public to identify with and support a report that seeks to capture the sense of their own mission. In this hoped-for embracement lie the seeds of renewed energy, new impetus, and new success.

JACK R. EWALT, M.D., *Director*

Contents

ACTION FOR MENTAL HEALTH

I

The First Question: Why Has Care of the Mentally Ill Lagged?

We are tempted simply to take the position that there is a crying public demand and great unmet needs for mental health services of all kinds. The demand and needs are easily observable in the difficulty many persons experience in seeing a psychiatrist when they feel the need of one, in the long waiting lists of mental health clinics, the small amount of treatment many clinic patients receive, the total absence of mental health workers and clinics in many communities, the overcrowding of public mental hospitals, and their professional staff shortages. Despite the new drugs and increases in hospital personnel, many thousands of patients diagnosed as seriously ill receive little or no care of a kind designed to bring about their improvement or recovery.

Commonly, the clearly defined, well-established public demand and need for a particular health program is sufficient to stimulate aggressive public action toward its support and progressive steps to organize whatever preventive, treatment, research, and educational facilities may be needed. This we can see has been the general course of action in our time against such diseases as tuberculosis, the water- and milk-borne infections, and the insect-borne infections; against the dietary diseases such as rickets, scurvy, and pellagra; against syphilis, poliomyelitis, and the great killers, such as heart disease and cancer.

Quick responsiveness in meeting the demand is not characteristic in the mental illness field, however. Every responsible person in

public life must now be familiar with the statistical clichés as well as the snakepit exposés—the shocking facts that no longer shock—that nearly half of all hospital beds in the United States are occupied by mental patients; that there are approximately 700,000 patients of all types at any given time; that an estimated 17,000,000 persons in the United States suffer from some form of psychological disturbance or mental illness (National Health Education Committee, 1959); that mental illness costs nearly $1 billion a year in direct costs, and an estimated $3 billion in direct and indirect costs (Rashi Fein, 1958).

We, in this report, will have little to add to these bleak statistics. Mental health workers in their appeals roll such figures on their tongues, like pebbles used as a means of assuaging thirst. But these pebbles of fact have not moved us far in meeting mental health needs, even if we pass over such broader social problems as unstable family life, care of the aged, juvenile delinquency and crimes, and merely take humane and healing treatment for all, or most, persons with major mental illness as the measure of progress. *Merely* in this context covers *much.* Viewed either historically or currently, the care of persons voluntarily admitted or legally committed to public mental hospitals constitutes the great unfinished business of the mental health movement.

It would seem futile to content ourselves with restating the problem of the unmet needs of the untreated or poorly treated mentally ill. Such a statement of *what,* as an aftermath of the millions and millions of words which have been written and spoken on the subject in the last fifteen years, would seem useless without at the same time seeking the more important explanation of *why* the words have not moved us. We are prone to boast of progress in mental health, and some has been made, but measured against the over-all dimensions of mental illness, our gains are pitifully small.

Therefore, the first and pivotal question in appraising where we in the mental health professions now stand and should go next is this: *Why have our efforts to provide effective treatment for the mentally ill lagged (1) behind our own professional objectives, (2) behind the public demand for mental health services, and (3) behind programs staged against other major health problems?*

If we cannot at this point in the long history of efforts in behalf of mental patients answer this basic question with greater conviction and persuasiveness than heretofore has prevailed, then we can hardly expect to make recommendations for actions that will be more successful than those presently being pursued. Rather, we may be forced to conclude that greater progress is not possible at this time.

In fact, without an answer to the pivotal question, we may be destined to go on living with our seemingly well-defended but deep-seated sense of having failed these people who need our help. We who attend the mentally ill have learned that we can help them, as we subsequently will show. The problem, then, is not one of having failed to learn what aids their recovery in a great many cases, but of having failed to apply what we do know. We have not had a maximum opportunity (or anything close to it) to demonstrate how much more could be done with present knowledge. Nor have we had, at least until recently, an opportunity to discover new knowledge through intensified, uninterrupted research. Rather, we have been prevented from a frontal and mass attack on mental illness by a combination of forces thus far beyond our power to overcome.

Some persons who are conscious of recent gains might challenge the present existence of lag and the alleged impediments to greater and more lasting progress. It is necessary to review these recent gains and also to demonstrate the lag before pursuing the question we have raised.

RECENT GAINS

During the study life of the Joint Commission (1956–1960) we have witnessed a number of encouraging advances in the fight against mental illness.

One handy index of the measure of public support or lack of it is dollars spent.

Dollars raised and spent are an index of interest and effort in solving a problem. They do not necessarily equate with better results—especially within a given time—if such results depend on scientific

discovery of new knowledge or on a change in public attitudes and practices, but they can be taken as one index of the quality of humanitarian and scientific care rendered public mental hospitals in the light of present knowledge. The quality of patient care depends both on the number of hospital personnel available and on the level of competence attained by these personnel, and personnel comprise the largest item in any hospital budget, usually about two-thirds. It is impossible to increase the number of personnel and, most of all, the quality of personnel without substantial increases in dollars spent. Therefore, we feel wholly justified in using dollars as an index of gain or lag, even though members of the mental health profession are wont to point out that money discussions constitute vast oversimplifications. Money is a key factor in progress, and few social or health problems are solved without large expenditures of it. It is true, of course, that the expenditure often comes only when the state of scientific knowledge presents an especially good opportunity for progress. Notwithstanding, social reform and humanitarian progress do not necessarily depend on acquisition of scientific knowledge, as we shall see in Chapter III. Rather, they may depend on public conviction that a class of people is being wronged.

For fiscal 1956, Congress appropriated $18,000,000 for the activities of the National Institute of Mental Health. By 1959, this sum rose to $53,400,000 and in fiscal 1960 increased to $68,000,000, as we can see from Table 1, showing the total appropriations of Congress for major activities of the National Institutes of Health, 1950–1961. The appropriation of $100,900,000 for fiscal 1961 is twelve times the $8,700,000 appropriated for fiscal 1950, the first year after the Public Health Service established a separate institute for mental health.

Total appropriations for State, county, and psychopathic (teaching and research) hospital care of the mentally ill rose from $663,000,000 in 1956 to $854,000,000 in 1959. Actually, the gain is more impressive if dated from 1954, when the figure was $568,000,000—an increase of more than $250,000,000 in four years' time. As a consequence, the average amount of money spent daily for the care of each patient increased by almost a dollar from 1956 to 1958—from $3.18 to $4.06. The variation from state to state, however, was large, from a 1958

low of $2.11 in Mississippi to highs of $6.15 and $6.17 in Kansas and the District of Columbia (Joint Information Service, 1960a). For 1959, the national average rose to $4.44 (*Hospitals Guide Issue,* August 1960).

The total number of patients living in 277 public mental hospitals (State, county, and psychopathic) may be construed as another measure of progress. This total showed a decrease for four consecutive years, as first reported in 1956 and continuing in 1957, 1958, and 1959. The figure was 559,342 at the beginning of 1956 and by the end of 1959 had dropped to 542,721—a decrease of nearly 17,000.

The most important thing about this conversion of an expected increase of inpatients into a decrease, as pointed out by the National Institute of Mental Health, is that it reverses an upward trend that had previously persisted throughout the twentieth century. In fact, the public mental hospital population had quadrupled during the previous half century, whereas the general population only doubled (U.S. Department of Health, Education, and Welfare, 1960b).

Table 1—Total Appropriations of Congress for Major Activities of the National Institutes of Health, 1950–1961 (in Millions of Dollars)

Fiscal Year	Cancer	Mental Health	Heart	General	(Arthritis, Allergy and Infectious Diseases, Neurology and Blindness became separate categories in 1954.)		
					Arthritis	Allergy	Neurology
1950	$18.9	$8.7	$10.7	$12.0			
1951	20.0	9.5	14.2	14.3			
1952	19.6	10.5	10.0	15.7			
1953	17.9	10.9	12.0	16.6			
1954	20.2	12.1	15.2	4.7	$7.0	$5.7	$4.5
1955	21.7	14.1	16.7	4.7	8.2	6.1	7.6
1956	25.0	18.0	18.9	5.9	10.8	7.8	9.9
1957	48.4	35.1	33.4	12.1	15.9	13.2	18.7
1958	56.4	39.2	35.9	14.0	20.3	17.4	21.3
1959	75.3	52.4	45.6	29.0	31.2	24.0	29.4
1960	91.2	68.1	62.2	46.0	46.9	34.0	41.4
1961	111.0	100.9	86.9	83.9	61.2	44.0	56.6
Totals	$555.6	$379.5	$361.7	$258.9	$201.5	$152.2	$189.4

Source: National Institutes of Health operating appropriations by activity, 1950 through 1961. From Office of the Director, N.I.M.H.

This reversal of a long-time upward trend began immediately following introduction of the tranquilizing drugs. It is logical to believe the drugs were primarily responsible. However, the continued

reduction of the resident patient load coincides with increases in mental hospital personnel, improved social treatment of patients, and more liberal parole and discharge policies, as well as other factors that complicate the simple explanation: patients plus drugs equal more discharges.

Increased use of psychiatric beds and other beds in general hospitals, outpatient psychiatric clinics, nursing homes, halfway houses, and sheltered workshops may also have been factors in the shift of population out of, rather than into, State hospitals.

We are fortunate in having available *Fifteen Indices* (Joint Information Service, 1960a) prepared by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health. To select some favorable indices for the moment, we find the following:

1. A decrease, as already indicated, in the rate of patients residing each day in public mental hospitals from 336 to 319 per 100,000 population between 1956 and 1959. (These statistics also show a rather incredible variation in the use of public mental hospitals from one State to the next, the low being 116 mental hospital residents per 100,000 population in New Mexico and the high being 589 per 100,000 in New York State, excluding the District of Columbia which has 866 per 100,000.)

2. Between 1956 and 1958, the number of physicians working in public mental hospitals increased from 45 to 57 per cent adequacy, based on the A.P.A. *Standards for Hospitals and Clinics* (1958). But only two states, Kansas and Iowa, had the number of physicians called for, and only half of the states were at least 50 per cent adequate.

3. An even more significant index is total professional patient-care personnel in public mental hospitals (including physicians, registered nurses, social workers, psychologists, psychometrists, occupational therapists, and other therapists). Such personnel increased from 2.8 to 3.4 per 100 patients between 1956 and 1958; the numbers of psychologists increasing from 65 per cent adequacy to 75 per cent; of registered nurses, from 20 to 23 per cent; and of social workers, from 36 to 40 per cent.

4. Total public mental hospital employees also showed an upward trend, from about 27 per 100 patients in 1956 to 31 per 100 in 1958. The employees who spend the most time with patients, the attendants, increased in adequacy of numbers from 76 to 91 per cent.

5. The total number of recognized psychiatrists in the United States (in private as well as public practice) showed a 57 per cent increase from 1950 (5534) to 1956 (8713), and a further increase of 35 per cent by 1960 (11,787). While the total has doubled in ten years, again there is maldistribution—varying in 1959 from 1.4 per 100,000 population in North Dakota and Alabama to 15.6 per 100,000 in New York State and 27.8 per 100,000 in the District of Columbia.

6. The professional man-hours spent in mental health clinics by psychiatrists, psychologists, and social workers rose from 116 to 147 per 100,000 population between 1955 and 1959. Again, the spread was rather fantastic—in 1959 from 10 per 100,000 in Wyoming to 387 per 100,00 in Massachusetts and 584 per 100,000 in the District of Columbia.

DEMONSTRATION OF LAG

The National Cancer Institute was established in 1937, and the National Heart Institute, the National Institute of Dental Research and the National Microbiological Institute (now the National Institute of Allergy and Infectious Diseases) in 1948. The National Institute of Mental Health did not come into being until 1949. Still, we in mental health can find little to complain about here; after a tardy start N.I.M.H. expenditures now have risen to second place, behind cancer but ahead of heart disease (Table 1).

Heart disease and cancer are our two greatest killers and, as in the case of major mental illness, the causes, means of prevention, and specific methods of cure are largely unknown or only imperfectly understood and the certain means of control are not yet in sight.

Mental disease is not commonly thought of as a great killer, but rather a wrecker and waster of useful, satisfying human life. However, it is commonly overlooked that more than 50,000 persons die in mental hospitals every year. Also, there are each year approxi-

mately 8000 homicides and 16,000 suicides, many of which are due to mental diseases or mental disturbances. Undoubtedly, mental stress plays an important precipitating role in many of the nearly 100,000 accidental deaths occurring each year, but we have no data to substantiate its contribution to this toll of life or to the much greater numbers of crippling accidents.

Mainly, however, mental illness is a disabler of individual life and a disrupter of family and social life, enough so that it is commonly classed as the No. 1 health problem, although neither the public nor the medical profession generally has treated it so.

Public interest in mental health became high during and following World War II. There appear to be two basic causes for this:

1. At the beginning of World War II, psychiatry was given the assignment of screening out all those young men who appeared psychologically unfit for military service. Huge numbers were rejected on the reasonable assumption that those with obvious neurotic symptoms or personality defects would break under the stress of adjustment to military life and to combat or become troublemakers and hence impose a tremendous drain on effective troop strength and morale. Some who were accepted later broke down in service, and a few who concealed rather serious defects, or were rejected and later accepted when standards were loosened, did well. Not simply absence of neurosis or psychosis, but the presence of motivation, appeared to be a key factor. As the war progressed, the problem of neuropsychiatric casualties, their handling, and discharge loomed large. It came to public attention as these men returned home, some to be hospitalized and others to make their own adjustment to civilian life. Compounding the problem was the fact that returnees who had successfully survived combat often displayed symptoms of anxiety neurosis during the letdown period.

The general state of mind, military and civilian, was well expressed in the official Army Air Forces policy of 1945:

> The need exists for creating a public understanding of the psychological behavior of returning combat veterans as an aid to their rehabilitation as confident, productive members of the AAF or of their civilian communities. . . .
>
> Individuals requiring psychiatric care are sick in the same sense that a person

may become ill as a result of any other type of disease or injury. . . . Fear is a natural response to danger and insecurity, and is so recognized in the AAF (Williams, 1946).

But it was easier to talk about public understanding than to get it. Postwar conversations between the new Group for Advancement of Psychiatry and the National Advertising Council regarding a proposed national campaign aimed at understanding of human behavior, sick and well, broke down in the discussion of details of how to do it. It is difficult, if not impossible, to reduce information about psychological mechanisms to publicity slogans and "radio spots." Psychiatrists, eager to impart their knowlege, were aware that focusing attention on a threat to life or health—such as the fear of losing one's mind—increases anxiety. Anxiety is a symptom of mental illness. At the same time, they could offer no assurance that the recipient of the information could relieve his anxiety through insight or action. A sometimes neglected principle of public health education dictates that it is unfair to raise people's fear of disease without, at the same time, giving them the opportunity to determine whether or not they have the disease and the chance to obtain proper treatment for it if they do.

Psychiatrists, numbering 4000 at the end of the war, did not feel that they could meet the demand such a campaign would create, and thus turned cautious backs on a friendly critic, the late Dr. Alan Gregg (1944), who not long before had lectured them:

In a country equipped with radio and moving pictures, with syndicated features in newspapers, with science writers and magazines counting their readers in millions, already permeated with the commercial rhetoric of the advertiser, must you psychiatrists be inarticulate? Must you forever rely on outsiders to tell the laity your overwhelming truths? Are you relying on another Clifford Beers, another Dorothea Dix to tell the public you are hopelessly overburdened and starved for adequate support and understanding? I do not urge you to oversell what mental hygiene can do. I know that experts prefer the *status quo,* and if there is to be progress themselves to set its tempo. Good! I urge you to tell society the present, the actual burdens psychiatrists are trying in vain to carry. For until you insist, until you are heard to state with your authority that your present resources are unequal to the demand, you are derelict in your duty to yourselves, to your nurses and attendants, and to your patients.

2. There was a second factor in the rise of public, and particularly official, interest in mental illness following World War II. The mental hospitals, it seems, are the first public health institutions to suffer in bad times and the last to benefit in good times. Our State hospitals began to deteriorate during the Great Depression of the early 1930's. They had not recovered from financial setbacks during this period when struck by another severe blow. World War II bled them of their never-plentiful professional and other personnel, their financial resources, and their institutional morale; it brought them to their lowest state, as houses of horror, in the last fifty years. War, of course, demands the sacrifice of nonessentials. The incarcerated mentally ill were nonessential, and they were sacrificed. New hospitals could not be built; few old ones could be repaired. This fact of wartime damage to care of the mentally ill was related by muckraking successors of Mr. Beers and Miss Dix. Most prominent among the mental health writers have been Albert Deutsch, Lucy Freeman, Mike Gorman, Edith Stern, and, more recently, John Bartlow Martin. Newspapers, magazines, and books—both fiction and nonfiction—paraded *The Shame of the States,* as Mr. Deutsch called one of his two excellent books. He and others showed a sharp reportorial eye for morbid detail; for example, in his account (1949, pp. 448–449) of visits to more than two dozen institutions during 1946 and 1947, he wrote:

Most of them were located in or near great centers of culture in our wealthier states such as New York, Michigan, Ohio, California, and Pennsylvania. In some of the wards there were scenes that rivaled the horrors of the Nazi concentration camps—hundreds of naked mental patients herded into huge, barnlike, filth-infested wards, in all degrees of deterioration, untended and untreated, stripped of every vestige of human decency, many in stages of semi-starvation.

The writer heard state hospital doctors frankly admit that the animals of near-by piggeries were better fed, housed and treated than many of the patients in their wards. He saw hundreds of sick people shackled, strapped, straitjacketed and bound to their beds; he saw mental patients . . . crawl into beds jammed close together, in dormitories filled to twice or three times their normal capacity.

He saw black eyes and bruises. . . . He saw court records and hospital accident lists indicating that brutality against patients, while not as common as occasional newspaper exposés might suggest, was of shocking frequency.

Occasional accounts of fatal beatings of mental patients attested to the end-results of some of this treatment. . . .

There were signs of medical neglect, of possibly curable cases sinking into chronicity. . . .

Words such as these were written and were to some extent heeded by some public officials as the nation returned to peacetime pursuits. As already indicated, there have been many signs of improvement in the care of the mentally ill, but these to a large extent have concerned physical care of patients and, as Morris Schwartz and his associates have noted in the forthcoming Joint Commission monograph, *New Perspectives on Mental Patient Care,* have involved only comparatively few State hospitals in innovations designed to improve them as therapeutic, in contrast to custodial, institutions. Emphasizing still-existing deficiencies, Deutsch recently commented to us: ". . . the mental hospital picture . . . has developed an over-rosy hue due to the recent reports of progress. Lots of people tend to forget the abysmally low point at which things started (to improve) a bare decade or so ago."

To return to the handy index of the dollar, all this good work on the part of the press and the psychiatrists and public officials who accepted the responsibility of treating psychotic patients—the core problem—seemed to evoke little public response, either spontaneous or organized, of the kind seen in the better-known voluntary health campaigns. Certainly it was not for lack of publicity.

Whereas public officials have demonstrated themselves to be increasingly alert to the human costs of mental illness and persuaded of the desirability of finding means of meeting the financial costs of this great State and national burden, public interest of the kind that mobilizes itself in doorbell-ringing campaigns, mothers' marches, employee pledge cards, and other forms of voluntary fund-raising activities has been notably weak until the last five years.

Most of the voluntary health movements are old. The National Committee on Mental Hygiene, which through merger and reorganization became the National Association for Mental Health in 1950, was founded in 1909. The National Tuberculosis Association (Christmas seals) was founded in 1904. The American Cancer Society orig-

inated in 1913. The National Society for Crippled Children and Adults (Easter seals) began in 1921. Few achieved a dynamic form prior to World War II, however. The National Foundation, then "for Infantile Paralysis," founded in 1938, was one of the few exceptions. Cancer, heart disease, and arthritis did not become the subjects of major drives until after the war. The cerebral palsy, muscular dystrophy, and multiple sclerosis organizations were not born until this new era of systematic combination of specific health problems with fund-raising talents.

Table 2 tells the fund-raising story of the ten largest national voluntary health campaigns of the last ten years. Mental health ranks eighth among the ten leading drives; behind poliomyelitis, cancer, tuberculosis, heart disease, crippled children and adults, cerebral palsy, and muscular dystrophy in the order of financial success. Since 1954, the National Association for Mental Health's campaign appears to have begun to move. In 1958, it surpassed the United Cerebral Palsy Association's campaign fund for 1952 and in 1959 arrived at the point where the American Heart Association was in 1951. In the last ten years, the N.A.M.H. raised some $22,500,000—about one-twentieth as much as the National Foundation raised during the same period and about one-tenth as much as either the American Cancer Society or the National Tuberculosis Association.

The programs of most, if not all, voluntary health organizations are some blend of education (public and professional), service (to victims and their families), and research (basic and developmental). Most use public education as a fund-raising device (or, as some say, use fund-raising as an educational device), in any case creating both the desire and the means for more service and more research. Inevitably, each organization bids against all of the others for the public's attention, as is becoming in a society that stresses private initiative and free enterprise; all therefore are competitive. In such attention-attracting competition, we again find that the mental health movement lags.

George Gerbner (1959) of the Institute of Communications Research, University of Illinois, surveyed the amount of space given to psychological and mental illness topics in the mass media of this

Table 2—Total Funds Raised Nationally in Ten Leading Voluntary Health Campaigns, 1950–1959 (in Millions of Dollars)

	1	2	3	4	5	6	7	8	9	10
Year	*Polio*	*TB*	*Cancer*	*Heart*	*Crippled Children*	*Cerebral Palsy*	*Muscular Dystrophy*	*Mental Health* [b]	*Arthritis*	*Multiple Sclerosis*
1950	30.8	21.0	13.9	4.1	5.8	1.0	——[a]	——[c]	0.7	0.18
1951	33.5	21.7	14.6	5.5	6.1	2.1	——[a]	0.7	1.0	0.19
1952	41.4	23.2	16.4	6.7	6.7	4.0	0.26	0.6	1.0	0.25
1953	51.4	23.8	19.8	8.5	7.7	6.4	0.6	0.7A	1.4	0.45
1954	65.0	24.0	21.7	11.3	8.1	8.2	4.0	1.7A	1.5	0.8
1955	52.5	24.6	24.4	13.6	8.5	7.5	3.9	2.4	1.8	1.3
1956	51.9	25.8	27.2	17.5	9.8	8.1	3.0	2.6	2.2	2.0
1957	44.0	26.3	29.6	20.5	10.3	8.4	3.7	3.8	2.4	2.3
1958	35.4	26.0	29.7	22.3	10.4	9.2	4.9	4.5	3.0	2.5
1959	31.3E	26.0	31.0E	24.0	10.3	9.5	4.6	5.5E	3.6	——[d]
Totals:	437.2	242.4	228.3	134.0	83.7	64.4	24.96	22.5	18.6	9.97

Source: Rough figures supplied by National Information Bureau for (1) National Foundation, (2) National Tuberculosis Association, (3) American Cancer Society, (4) American Heart Association, (5) National Association for Crippled Children and Adults, (6) United Cerebral Palsy Association, (7) Muscular Dystrophy Association of America, (8) National Association for Mental Health, (9) Arthritis and Rheumatism Foundation, (10) National Multiple Sclerosis Society.

[a] No campaign.

[b] Figures for 1951 and 1952 from National Information Bureau, for 1953–1959 from National Association for Mental Health.

[c] Not available, due to merger.

[d] Not available.

E: Estimate

A: Approximate

country from 1900 to 1959, and came to some conclusions of interest here. In general, he found "Popular interest in (or exposure to) articles on mental illness, psychiatry, and psychology appears to rise in war and prosperity, and fall during depression or recession." While there has been a general upward trend in the amount of such information available, he found the number of articles "did *not* increase in relation to articles on all other subjects."

For confirmation of the low pulling power of the mental health movement, we need only turn to a nationwide survey, *The Public Impact of Science in the Mass Media,* conducted by the University of Michigan Survey Research Center (1958, p. 52) for the National Association of Science Writers. A cross section of people were asked to recall the types of medical news that they had read in various media. The results were as follows:

Recall	*Newspapers (per cent)*	*Magazines (per cent)*	*Radio (per cent)*	*Television (per cent)*
Heart	32	10	2	11
Cancer	31	6	2	3
Polio	20	6	4	1
Mental illness	5	3	—	4
Other psychological items	2	3	—	2
Other diseases	22	6	1	7
Other medical information	22	10	2	13

It is easy to see that mental illness rates a poor fourth except on television, where it is second.

"Tranquilizers, recently a topic of considerable discussion, were mentioned by only 2 per cent of the newspaper audience but largely ignored by users of other media" (Hillier Krieghbaum, 1958, p. 19).

Some mental health workers doubtless will construe it as unfair to them to examine the lag of interest in and support for mental health in this comparative frame of reference, particularly without consideration of any extenuating circumstances or special problems that they face. We shall seek an explanation later; for the present, we need only state that the lag is a fact. To avoid unnecessary mystery, we may say here that for mental health organizations to raise only $5,500,000 in voluntary funds in a year (1959) in which cancer drives raised $31,000,000 and heart disease drives raised $24,000,000 suggests not only a much later fund-raising start, but, because of this late

start, raises questions about leadership, organization, motivation, goals, methods of appeal, and—most important—public receptivity.

Examining the figures cited, we find no reason to object to the amount spent on any other health problem, or even to the fact that the amounts spent are, by comparison, not necessarily in proportion to the size of the problem. It is only right that persons concerned with polio, heart disease, cancer, or other killing or crippling diseases do the best they can to solve the problem of their choice.

We are interested in reducing mental illness and in improving mental health. Our concern is not so much that our field gets such a *small share* of the citizen's voluntarily given health dollar but simply that we in mental health have not yet done as well in enlisting this form of public support as have other health agencies. The need for more money is certainly an important element in our disappointment, but it is equally important that we have had less success in arousing citizens to give more frequently and generously. Voluntary crusades are public education as well as money-raising devices. Most of the money now spent for mental health programs comes from the State legislatures or Congress, out of official recognition of the needs rather than out of any insistent, persuasive popular demand.

There are other financial indications of lag. *Fifteen Indices* (pp. 3–4), previously cited, indicates that the "big push" of the 1950's to improve care of the mentally ill may have reached a leveling off point (still far short of general adequacy). "Expenditures for mental health and hospital programs, when measured against total state and local budgets, indicated that, despite increases in dollar expenditures, these programs received a smaller slice of the tax dollar." These are the facts:

In 1956, the proportion of general State expenditures spent for the maintenance of patients in mental hospitals averaged 3.31 per cent; in 1958, the percentage was 3.25. These percentages varied, incidentally, from 0.80 for New Mexico to 6.88 for New York State. "More than half of the states spend less than 3 per cent of their total general budget to maintain the State hospital system."

In 1958, the States and their local governments spent an average of 22.8 cents of every dollar budgeted for health purposes on mental

health services. This was a decrease from 24.2 in 1957, the first year in which the Department of Commerce recorded total State and local expenditures for health. The percentage was 50.7 for the District of Columbia in 1958. Ten States spent more than 30 per cent, and nineteen States, less than 20 per cent, of their health budgets for mental health services.

The same slight general decline was observable when per capita expenditures for mental hospital and community mental health programs were figured against per capita State and local expenditures. From 1957 to 1958, the proportion of total expenditures devoted to mental health services decreased from 1.89 to 1.81 per cent.

In the absence of more recent information at this writing and without the opportunity to weigh legislative intentions and expectations, it is impossible to say whether the States have come to the end of a cycle in their recent interest and efforts to improve the lot of the hospitalized mentally ill—80 per cent of whom are to be found in State hospitals. We have reason to be apprehensive.

The lag is nowhere more evident than when we compare State hospitals with other types of hospitals. The most common image of an American hospital is the community general hospital, operated mainly for short-term medical and surgical cases on a voluntary, nonprofit basis. The 1960 *Guide Issue* of the American Hospital Association journal, *Hospitals,* shows that two of every three of these hospitals are accredited according to the minimum standards of the Joint Commission on Accreditation of Hospitals, and that patient care costs them $31.16 per patient per day, a sum that helps support 2.3 employees per patient, but does not, of course, cover private doctor bills. As classified by the A.H.A., here are some other types of hospitals, together with their daily patient costs (usually including medical treatment) and ratio of employees to patients:

State and local general	$27.65	2.1
Federal general	25.42	1.5
Proprietary psychiatric	17.33	1.1
Voluntary psychiatric	16.72	1.2
Tuberculosis	12.80	0.93
VA psychiatric	12.01	0.71
Nonfederal long-term general	12.50	0.91
State, county, city psychiatric	4.44	0.32

It does not require further analysis to conclude that patients in State and local governmental mental hospitals fare the worst of any type of hospitalized patient in the country, as judged by the significant indices of available money and available personnel. This always has been so, and "recent progress" has not changed the fact. This viewpoint is further confirmed by the fact that only 29 per cent were approved by the Joint Commission on Accreditation of Hospitals.

On the other hand, it is equally apparent that the 41 psychiatric hospitals operated by the Veterans Administration are comparatively well off as the result of Federal expenditures almost triple, and staffing more than double, that found in State mental institutions. Still, the VA mental hospital sum per patient per day is only half of that available in Federal general hospitals.

As a final point in demonstration of lag—or at least the danger of complacence over small gains—we must re-examine the four-year decline in the number of patients living in public mental hospitals and reiterate that it represents a shift of patients out of the hospital rather than a reduction in total patient load. Inspection of the tabulations in the *Census of Mental Patients,* as compiled by the Biometrics Branch, N.I.M.H., discloses that patients resident in hospitals is the only category in which a decline has occurred, and that this decline occurred only in State hospitals (Joint Information Service, 1959a).

We may take, for an example, 1957 experience. In that year, there were 1,240,897 patients on active records of *all* mental hospitals in the United States—State, psychopathic, Veterans', Federal, private, and psychiatric units of general hospitals (this total excludes institutions for mental defectives and epileptics, which have not been studied). The distribution of this million and a quarter patients—the core problem of which we previously have spoken—was as follows:

State hospitals	839,644	
Psychopathic (teaching and research) hospitals	5,622	
Veterans' hospitals	119,403	
Federal hospitals	6,549	
Private hospitals	80,807	
General hospitals	188,852	
Total		1,240,897

Of this 1.24 million total, 743,392 were carried on the hospital books (in the hospital and on parole) at the beginning of the year, and 746,208 at the end of the year—a slight increase. For State hospitals alone, the figures were 651,204 and 652,105, also a slight increase. Similar small increases also characterized the patients-on-books experience of all other types of mental hospitals, including those of the Veterans Administration. Likewise, these small increases also apply to inpatient figures for all types of mental hospitals *except* the State hospitals.

Furthermore, as we can see from Table 3, reflecting 1956–1959 experience, admission of patients for the first time and readmission of former patients both steadily increased during those years. The upward trend in admissions cannot be said to reflect increased incidence of mental illness, but can be accounted for in terms of increased population or increased utilization, it would appear. Indeed, all experience would indicate that as the treatment facilities of public mental hospitals improve, utilization will continue to increase unless alternative services come into use.

In general, then, we have witnessed some concurrent shift in the flow and whereabouts of mental patients, possibly reflecting in part the widely accepted conviction that, if at all possible, it is better for the patient and his prospects to keep him out of State hospitals, as well as definitely reflecting increased discharge rates for State hospitals. The desirability of this policy is reinforced, of course, by the fact that every patient not added to the State hospital population represents some savings in maintenance costs.

It would be fallacious, however, to assume that this represents an average savings of about $4 per patient per day, or a total of $1460 a year. Daily patient cost is obtained by dividing total maintenance costs by the number of patients in residence. The removal of one patient does not reduce by $1460 the budget of a superintendent responsible for operating a collection of buildings containing thousands of beds and requiring hundreds of maintenance employees as well as a professional staff.

Mental health clinics, operated as outpatient extensions of mental hospitals or as independent service agencies in the community, have

Table 3—Movement of Patient Population in Public Mental Hospitals in the United States, 1956–1959

Item	*1956*	*1957*	*1958*	*1959*	*Per Cent Change* 1956–1957	1957–1958	1958–1959
All admissions	185,597	194,497	209,503	223,225	4.8	7.7	6.5
First admissions	125,539	129,278	137,061	142,881	3.0	6.0	4.2
Readmissions	60,058	65,219	72,442	80,344	8.6	11.1	10.9
Discharges	133,208	145,116	161,972	175,727	8.9	11.6	8.4
Deaths in hospital	48,236	46,848	51,294	49,640	—2.9	9.5	—3.2
Resident patients at end of year	551,390	548,626	544,863	542,721	—0.5	—0.7	—0.4
Personnel employed full time at end of year	153,715	162,753	169,438	174,218	5.9	4.1	2.8
Maintenance expenditures:							
Total	$663,280,934.	$731,875,462.	$805,861,786.	$854,354,503.	10.3	10.1	6.0
Per patient	$1,194.88	$1,332.31	$1,475.26	$1,577.54	11.5	10.7	6.9

Source: Data supplied by Biometrics Branch, National Institute of Mental Health.

been advocated as both a supplementary and alternative approach to the hospital care of the mentally ill. While we noted, among recent gains, the increase in the professional man-hours of work in these clinics and the possibility that some patients who previously would have been part of the hospital population now are under treatment in these clinics while living at home or in foster homes, the outlook here promises no quick solution to the more effective operation of public mental hospitals. The clinics suffer from the same deficiencies that so long have plagued the hospitals—understaffing and overcrowding—except that in this case clinics do not come into being or continue to operate if professional personnel cannot be found for them, and the overcrowding is confined to their waiting lists rather than to hospital wards. The bottleneck is the same in either hospital or clinic—the professional manpower shortage. We shall return to this problem in Chapter IV.

The foregoing statement should be sufficient to bring recent signs of progress into better perspective. The result leaves us torn between the desire and need to be optimistic and real cause for pessimism. There are two ways to measure progress: *from the standpoint of how far we have come, or from the standpoint of how far we yet have to go.*

By the first measure, we have made considerable progress. By the second measure, we have little cause for self-congratulation and no cause for relaxation of efforts.

It is natural, of course, that we should wish to emphasize gains as a buttress to an attitude of constructive hope and as a source of renewed energy. One thing recent progress has done is to show that tangible changes can be produced through increased governmental initiative, public attention, pressure, and support, thus putting to rout the attitude of cynicism and futility that has been connected with custodial care of the mentally ill for so long.

But if we are to be wholly honest with ourselves and with the public, then we must view the mental health problem in terms of the unmet need—those who are untreated and inadequately cared for. We have no definitive analysis of how many such patients there are, but the information we have leads us to believe that more than

half of the patients in most State hospitals receive no active treatment of any kind designed to improve their mental condition. This applies to most of the patients on continued treatment wards—a term actually meaning "discontinued treatment," the supposition being that the patient's illness has progressed from an acute to a chronic stage.

We still have a long, long way to go to provide healing care for the mentally ill of America. In their behalf, we must guard against succumbing to the easy virtue of putting on a good show. Only from a bedrock of cold, hard facts can we hope to build them a future.

We have documented the lag, but so far have left the critical question unanswered: What is it that holds back mental health progress? To it we have only succeeded thus far in adding a second question: Can we really hope for greater progress in the future?

II

Treatment and Its Results

UP TO THIS POINT, we have spoken with the assumption in mind that many patients—known in other times as madmen, maniacs, and lunatics and still known to laymen as insane, but diagnosed by doctors as "psychotic"—can be helped to lead useful, satisfying lives if treated in a humane and rational manner. Palpably, if this assumption is untrue then we have no immediate incentive for efforts to reduce lag and accelerate progress. Even if true, it requires documentation in this text. As we ponder the inadequacy of financial support, we suspect the assumption likewise remains to be proved to the general public. Moreover, many mental health workers themselves require reassurance that there is a sound basis for an optimistic attitude toward psychotics.

Actually, though desirable, it is not crucially important in demonstrating need of greater support to show good results in the psychiatric treatment of psychotics. It would be possible to emphasize the need for more knowledge and to wage a large and well-rounded public campaign for support of scientific research and professional education as well as the associated patient-care services while taking substantially negative results as a point of departure. For example, surgeons commonly have reported the curative outlook for persons with lung and stomach cancers at the time the disease comes to surgical attention as in the range of 5 to 15 per cent. Our colleagues in surgery make no bones about such statistics, but record them, publish percentages of "five-year cures," and find professional satisfaction in each percentage point of gain.

The typical patient with a functional psychosis (so called because

no organic cause is known) has a much better outlook than do patients with the types of cancer cited, however. Depending on the type and classification of the patients' psychoses, psychiatrists commonly have reported *spontaneous* remission rates of 15 per cent or more. How much more depends in part, as we know from the studies of Stanton and Schwartz (1954) and others, on what is done in the routine management of the patient to aggravate his condition, "set him back," and thereafter fix his disorder in a treatment-resistant form. In short, it is as important to guard a patient against the *wrong* treatment as it is to institute active therapy likely to produce favorable results. By "remission" we mean that symptoms of illness subside. The patient feels and appears "well" or "much better." This is the object of most medical treatment and what laymen often mean by "cured." Absolute cure is of great scientific interest in psychiatry and is as unusual here as in internal medicine and the more major surgical operations.

PUNISHMENT AS TREATMENT

Since the beginning of history, for reasons to be explored in Chapter III, society has pursued what we now regard as a superstitious and retaliatory approach in the care of the mentally ill. The instrument of this approach is punishment, pursuant to the theory that the patient is either possessed by one of the devil's legion of demons or, if not, is willfully and morally responsible for his antisocial acts. Either sinful or criminal behavior calls for punishment.

For our purposes, we need trace the origins and development of social and medical treatment of the mentally ill back no further than Colonial America of the late seventeenth century, a New World then still in the grip of Old World attitudes. Albert Deutsch (1949, pp. 39–40) has summed up the early American attitude:

> In accordance with the dominant ideology at home and abroad, the sufferings of the handicapped members of the community were looked upon as the natural consequence of a stern unbending Providence, meting out judgment to the wicked and the innately inferior. Contempt, cold and narrow, rather than sympathy and understanding, characterized the attitudes toward the

destitute and dependent classes. . . . The individual in need of assistance was apt to receive public attention only when his condition was looked upon as a social danger or a public nuisance—and he was then "disposed of" rather than helped. These general attitudes and conditions were reflected and accentuated in provisions for the insane. . . .

The mentally ill fell into two general social classes, private and public cases, and two general types, the dangerously and harmlessly insane. Persons of wealth or family commonly were kept at home and, if they became troublesome, were chained and locked in strong rooms, cellars, attics, or outhouses. Being a disgrace to the families, they were kept out of sight. They were of legal concern only regarding the protection and disposition of their property.

The poor and homeless insane were, if violent, treated as felons or, if adjudged harmless, simply as paupers "falling on the town." Legally, a community was responsible for feeding and housing its own poor, but they were sometimes treated so badly that they became vagrants. One town wanted no part of another town's public charges. A common procedure was to cause the poor stranger to be warned out of town with the promise of a public whipping if he returned. Thus, while the violently insane went to the whipping post and into prison dungeons or, as sometimes happened, were burned at the stake or hanged, the pauper insane often roamed the countryside as wild men and from time to time were pilloried, whipped, and jailed. Custom required the towns to board out their resident paupers, sane or insane. If capable of work, a man might be auctioned off as free labor to the farmer who would accept the smallest payment from the town. This was a form of slavery. Eventually, houses of correction, workhouses, and almshouses assumed custody of the insane.

The first American hospital to admit the mentally ill offered them little better treatment than they had known previously. This was Pennsylvania Hospital, founded in 1751, and intended by its Philadelphia founders (including Benjamin Franklin) for the sick poor plus "the Reception and Cure of Lunaticks." Franklin's justification for this inclusion was "the experience of many Years, that above Two Thirds of the Mad People received into Bethlehem Hospital, and there treated properly, have been cured" (Deutsch, p. 59). This

claim for an infamous London insane asylum better known as Bedlam seems overly generous; it possibly referred to discharges of all kinds rather than cures. However, it reflected an enlightened belief that the mentally ill *could* and often *did* recover their senses.

Insane patients were assigned to the Pennsylvania Hospital's cellar and there placed in bolted prison cells. Deutsch (pp. 60–61) quotes Thomas G. Morton's *History of the Pennsylvania Hospital* as follows: "Their scalps were shaved and blistered; they were bled to the point of syncope; purged until the alimentary canal failed to yield anything but mucus, and in the intervals, they were chained by the waist or the ankle to the cell wall. . . ."

The cell keeper saw it as his duty to prevent escape and subdue violence, as a man might watch over a cage of wild animals. For this purpose, cell keepers carried a whip and used it freely on their chained captives. Curiously enough, Deutsch describes these early days at the Pennsylvania Hospital as the beginning of a therapeutic, rather than a custodial, a medical, rather than a penal, approach to the care of the mentally ill. When we contemplate the scene as depicted and then add to it the fact that these patients were at times exhibited through their cell windows to Sunday afternoon sight-seers who paid an admission fee and perhaps teased and goaded them, we can see how far "rational humanitarianism" as a new philosophy for the treatment of the mentally ill had come at that time. That treatment then was still neither rational nor humanitarian but simply represented a conversion of punishment into a more fashionable form may be judged from the statement of the director, Dr. Benjamin Rush, sometimes called "the father of American psychiatry": "Terror acts powerfully on the body through the medium of the mind, and should be employed in the cure of madness" (Deutsch, p. 80).

Rush did not stand alone in this viewpoint. Rather, the idea of basing treatment for disease on purgatorial acts and ordeals is an ancient one in medicine. It may trace back to the Old Testament belief that disease of any kind, whether mental or physical, represented punishment for sin; and thus relief could take the form of a final heroic act of atonement. This superstition appears to have given

support to fallacious medical rationales for such procedures as purging, bleeding, induced vomiting, and blistering, as well as an entire chamber of horrors constituting the early treatment of mental illness. The latter included a wide assortment of shock techniques, such as the "water cures" (dousing, ducking, and near-drowning), spinning in a chair, centrifugal swinging, and an early form of electric shock. All, it would appear, were planned as means of driving from the body some evil spirit or toxic vapor.

MORAL TREATMENT

It fell to a French physician and an English layman to revolutionize care of the insane, and so pave the way for modern treatment as we now pursue it. Therapeutics of mental illness stand on two rational pedestals, one social and one medical: humanitarianism and science. The eighteenth-century French and English reforms sprang from the same philosophy of liberalism, human understanding, and respect for personal freedom that sustained the Bill of Rights in England and supplied the intellectual inspiration for the American and French Revolutions.

In 1792, Dr. Philippe Pinel, placed by the Revolution in charge of two Paris insane asylums, systematically went about striking off the chains shackling his charges, who resembled unkempt wild animals. His revolutionary colleagues thought him mad to release such dangerous "beasts," but most of the patients ceased their violent behavior when they felt free to move about. (The psychology of nonrestraint is sound, of course, and has been proved a thousand times over, experimentally and clinically. The *normal* reactions of man and many animals to being tied or caged are panic, rage, and a restless drive to escape. But it requires some wisdom and personal courage to act on this still-neglected knowledge.)

Pinel was aware that a few earlier physicians had advocated mild and kindly treatment of the insane, and himself resolved to apply "moral treatment," as differentiated from medical and surgical treatment. The term did not refer exclusively to the morality of the therapist, although it encompassed all that is implied in humanitari-

anism, including what we would now call "tender loving care" or "brotherly love." Rather, his moral treatment proceeded from the teaching principle of setting the patient an example of how he is expected to behave, and thus appealing to his moral sense and arousing his will to give as good as he receives. The approach clearly contained the precursors of the tolerating and accepting attitudes that characterize modern psychological and social treatment techniques.

Pinel's method of treatment sprang from the fact that, as a physician, he could find no physical defects or injuries (organic lesions) to explain insanity (Bockoven, 1956). In his original account of his discoveries, Pinel (1806) credited a lay superintendent with teaching him the curability of insanity:

> Forgetting the empty honours of my titular distinction as a physician, I viewed the scene that was opened to me with the eyes of common sense and unprejudiced observation. I saw a great number of maniacs assembled together, and submitted to a regular system of discipline. Their disorders presented an endless variety of character; but their discordant movements were regulated on the part of the governor (lay superintendent) by the greatest possible skill, and even extravagance and disorders were marshalled into order and harmony. I then discovered that insanity was curable in many instances, by mildness of treatment and attention to the mind exclusively, and when coercion was indispensable, that it might be very effectively applied without corporal indignity. . . . I saw, with wonder, the resources of nature when left to herself, or skillfully assisted in her efforts. . . .
>
> Attention to these principles of moral treatment alone will, frequently, not only lay the foundation of, but complete a cure; while neglect of them may exasperate each succeeding paroxysm, till, at length, the disease becomes established, continued in its form and incurable. The successful application of moral regimen exclusively gives great weight to the supposition, that, in the majority of instances, there is no organic lesion of the brain. . . .

To Pinel's principles for the treatment of psychotics twentieth-century psychiatry can add little, except to convert them into modern terminological dress, contribute more systematic thought on the significance of various symptoms, intensify the doctor-patient relationship through scientific knowledge of psychological mechanisms, treat the patient as a member of a social group which expects him to be-

have in accepted ways, and specify that moral treatment has been subject to an incredible amount of distortion and misinterpretation, depending on the personality, motivations, and vicissitudes of its administrators.

Also in 1792, William Tuke, a Quaker of York, became appalled at England's lunatic asylums, one of which had refused members of the Society of Friends the opportunity to visit a Quaker woman patient not long before she died. Tuke determined to build a retreat for Friends "deranged in mind," and succeeded, despite some opposition. He planned the York Retreat, so called to avoid the stigma of *madhouse* or *asylum,* as "a quiet haven in which the shattered bark might find the means of reparation and safety."

The Retreat emphasized a family environment, employment, exercise, and treatment of patients as guests. Its atmosphere of kindness and consideration, characteristic of the gentle permissiveness and practical idealism of the Quaker faith, was well captured in its maxim taken from Solomon: "A soft answer turneth away wrath." Binding of the patients' arms with broad leather belts or strait jackets, and solitary confinement, were used only when absolutely necessary. Like Pinel, who had turned against use of drugs, the Quakers showed an aversion to orthodox medical approaches of the times; they completely abolished bloodletting.

The Quakers brought moral treatment to America with the opening near Philadelphia in 1817 of the Friends' Asylum "for such of our members as may be deprived of their reason." It was closely modeled after the York Retreat. Forty years later, Friends' Asylum could boast it had never chained a fellow man, but had succeeded in its object: "To fetter strong madness in a silken thread."

The moral movement, after Pinel and Tuke, spread to a score of American mental hospitals, both private and State, during the first third of the nineteenth century. Although town officials still considered it cheaper to keep the bulk of the pauper insane in almshouse and jails or board them out at 60 or 90 cents a week, there was much cause for optimism as to the future of the care of the mentally ill in America. Charles Dickens (1842, pp. 105–111) re-

flected this cheerful outlook, in his account of a visit to the Institution of South Boston, now the Boston State Hospital:

The State Hospital for the insane [is] admirably conducted on those enlightened principles of conciliation and kindness which twenty years ago would have been worse than heretical. . . .

Each ward in this institution is shaped like a long gallery or hall, with the dormitories of the patients opening from it on either hand. Here they work, read, play at skittles, and other games; and when the weather does not admit of their taking exercises out of doors, pass the day together. . . .

Every patient in this asylum sits down to dinner every day with a knife and fork; and in the midst of them sits the gentleman (the superintendent). . . . At every meal, moral influence alone restrains the more violent among them from cutting the throats of the rest; but the effect of that influence is reduced to an absolute certainty, and is found, even as a means of restraint, to say nothing of it as a means of cure, a hundred times more efficacious than all the strait-waistcoats, fetters, and hand-cuffs, that ignorance, prejudice, and cruelty have manufactured since the creation of the world.

In the labour department, every patient is as freely trusted with the tools of his trade as if he were a sane man. In the garden, and on the farm, they work with spades, rakes, and hoes. For amusement, they walk, run, fish, paint, read, and ride out to take the air in carriages provided for the purpose. They have among themselves a sewing society to make clothes for the poor, which holds meetings, passes resolutions, never comes to fisticuffs or bowie-knives as sane assemblies have been known to do elsewhere; and conducts all its proceedings with the greatest decorum. The irritability, which would otherwise be expended on their own flesh, clothes, and furniture, is dissipated in these pursuits. They are cheerful, tranquil, and healthy.

Once a week they have a ball, in which the Doctor and his family, with all the nurses and attendants, take an active part. Dances and marches are performed alternately, to the enlivening strains of a piano; and now and then some gentleman or lady (whose proficiency has been previously ascertained) obliges the company with a song: nor does it ever degenerate, at a tender crisis, into a screech or a howl; wherein, I must confess, I should have thought the danger lay. At an early hour they all meet together for these festive purposes; at eight o'clock refreshments are served; and at nine they separate.

Immense politeness and good-breeding are observed throughout. They all take their tone from the Doctor; and he moves a very Chesterfield among the company. Like other assemblies, these entertainments afford a fruitful topic of conversation among the ladies for some days; and the gentlemen are so anxious to shine on these occasions, that they have been sometimes found

"practising their steps" in private, to cut a more distinguished figure in the dance.

It is obvious that one great feature of this system is the inculcation and encouragement, even among such unhappy persons, of a decent self-respect.

This wholesome scene did not long survive either in Boston or elsewhere on the American institutional scene, for reasons that will be made clear in the next chapter. A modern counterpart has begun to emerge with a renewal of interest in social treatment variously described as "therapeutic milieu," "therapeutic community," and the "open hospital." First, however, let us examine the early results of moral treatment.

EARLY AND MORE RECENT RESULTS

One of the earliest studies on record summed up as follows the case histories of 244 persons treated at the York Retreat in England prior to 1845: "In round numbers, of ten persons attacked by insanity, five recover and five die, sooner or later, during the attack. Of the five who recover, not more than two remain well during the rest of their lives; the other three sustain subsequent attacks, during which at least two of them will die" (Deutsch, 1949, p. 154). The death rate, we may surmise, was mainly due to the complicating hazards of diseases other than mental illness per se. But we can see that the hospital discharge rate was around 50 per cent and the permanent recovery rate 20 per cent.

J. Sanbourne Bockoven (1956) has reviewed the reported outcome among patients admitted to Worcester State Hospital ill less than one year prior to admission for the period 1833–1852. His study of Worcester's annual reports showed: "During the entire 20 years there were 2,267 such admissions, of whom 1,618 were discharged as recovered or improved, or 71% (66% recovered, 5% improved). During this same period the total of all admissions (including those whose illnesses had lasted longer than one year prior to admission) was 4,119, of whom 2,439 or 59% were discharged recovered or improved (45% recovered, 14% improved)." This record, taken at face value, is equal to that of first-class mental hospitals of today.

In the Worcester Hospital's annual reports, Bockoven also uncovered a hitherto unnoticed follow-up study of what became of discharged patients, perhaps the first such study of its scope ever made. Between 1882 and 1893, Dr. John G. Park prepared a questionnaire and succeeded in getting information about 1157 of 1173 former patients who had been hospitalized between 1833 and 1846. In other words, his follow-up observations covered a minimum of 36 and a maximum of 60 years per case. Some 26 per cent were still alive and well, and an additional 22 per cent had died of other causes but without a mental relapse; an additional 6 per cent had suffered a relapse, but had been again discharged—making 54 per cent who remained well or apparently died in good mental health. The remaining 46 per cent had relapsed and died or were still alive but mentally ill.

Do these studies have an antique flavor? Certainly they leave many now-unanswerable questions. How good were the records? What was the definition of "insanity"? What were the criteria of "improvement" and "recovery"? What was the composition of the York Retreat's and Worcester State's case loads? We have some reason to suppose that they were dealing with psychotics, as we know them, but we do not know to what extent those hospitalized were types with good or poor prognoses. Certainly Worcester State may have had its share of a poor-prognosis group now much less frequently found in State hospitals—syphilis of the brain.

We can turn for more up-to-date information to Boston Psychopathic Hospital. This State-operated, Harvard-affiliated, teaching hospital is a leader in reviving nonpunitive, open ward treatment. This treatment is combined with psychotherapy, group therapy, and, where indicated, somatic treatments such as electroshock, in an intensive and more systematic approach to the "therapeutic community"—in this case, the use of the resources of a hospital for a total push toward social recovery of the patient.

This new rendition of a therapeutic theme originally composed by Pinel and Tuke was conducted under the inspired and imaginative leadership of Dr. Harry C. Solomon, who, following his appointment as Superintendent in 1943, substantially recaptured the moral treatment scene described by Charles Dickens in 1842 and to it added

the refinements of modern science. This therapeutic revolution and its extensions have been well and warmly described by Drs. Milton Greenblatt, Richard H. York, and Esther Lucile Brown (1955) in *From Custodial to Therapeutic Patient Care in Mental Hospitals,* as well as in John Bartlow Martin's *The Pane of Glass* (1959).

Bockoven and Solomon (1954) reported a five-year follow-up of the first 100 acute psychotic patients committed to Boston Psychopathic (now the Massachusetts Mental Health Center) after June 30, 1946.

Each patient received intensive, individualized treatment along the lines described. The average hospital stay was seventy-five days, after which time 70 patients had been discharged into the community, one had died, and 29 had been transferred to mental hospitals for continued care. One year after discharge, 72 were in the community and 20 in other Massachusetts hospitals, 4 had left the State and hence were not studied further, and 4 had died. At the end of five years, 76 were living in the community, 12 were in mental hospitals, 4 had left the State, and 8 were dead.

The Boston study provided some interesting information on relapses. Of the original 100, there were 45 who remained out of the hospital for the entire five years. The remaining 31 of the 76 living in the community after five years had been readmitted and again discharged. All told, the 100 patients spent 18 per cent of their time during the five years in a mental hospital, but most of this time was accumulated by 10 or 12, a small, hard core of "irrecoverable" or "malignant" cases.

These figures, a fair sample of what can be achieved by the best mental hospitals, do not deal with cure, meaning a complete disappearance of the disease. They deal with the former patient's capacity to get along in the community. (Hospitalization usually occurs when the patient's behavior reaches a point where his family, associates, the public, or sometimes he himself no longer can stand it.)

There is no need, however, to apologize for social recovery as the test of success in psychiatric treatment (although there is a frequent, somewhat nihilistic inclination in the mental health movement to protest: "But these are not cures"). The same general measure of

recovery is used in relation to many physically disabling diseases manifesting an underlying chronic defect and some tendency toward relapse, among them: certain heart diseases, cancer, cerebral hemorrhage, anemia, arthritis, diabetes, nephritis, asthma, stomach ulcers. To what extent can the person lead a normal life? How many useful years of life can we offer him? In brief, how is he getting along? These are the practical man's questions.

Previously we touched on the five-year cure in cancer, meaning that the patient is regarded as "cured" if he does not have a recurrence of the treated cancer within five years, an event usually meaning further hospitalization and treatment. In the Boston Psychopathic follow-up study, the test of "five-year cure" was simply this need of further hospitalization. In surgery for cancer, a fifty-fifty chance of five years of freedom from further need of hospitalization for the treated disease is considered remarkably good for many types of malignancy. We can say the same for major mental illnesses.

When we narrow the question of treatment results to schizophrenia, the most refractory of the functional psychoses, we can find some answers in the study reported by Dr. Earl D. Bond (1954) on 393 consecutive schizophrenic patients treated at the Institute of the Pennsylvania Hospital in the period 1925–1934 as compared with 440 in the period 1940–1946. In the early group, with an average hospital stay of one year, only 9 per cent recovered and remained well for five years or more. In the later group, treated either with insulin or electric shock and with an average stay of two months, the sustained recoveries were 22 per cent. No effort was made to appraise the amount of psychotherapy or occupational therapy received by the patients in these studies.

SHARPENING THE DOCTOR-PATIENT RELATIONSHIP

In recent years, increasing efforts have been made to treat schizophrenics with the aid of psychotherapy; an attempt by a professionally trained therapist to gain cooperation and insight through verbal or nonverbal communication with the patient at regular intervals over some extended period of time. The object of psychotherapy is to find

psychologically and socially acceptable solutions for the patient's troubled or troublemaking ways of thinking and doing.

Dr. John C. Whitehorn (1959) refined the problem of treating schizophrenia in a fascinating way, to take one example of an individual-treatment approach. In a 1954 study at the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, Whitehorn and Barbara J. Betz studied results of individual psychotherapy in 100 schizophrenics treated by various psychiatrists and noted that some doctors consistently did better than others. When grouped on this basis, there was a 75 per cent improvement rate in 48 patients treated by seven doctors (Group A) and a 27 per cent improvement in 52 patients treated by another seven doctors (Group B).

Whereas patients treated by Group A and B doctors did not seem to be different at the beginning of treatment, judged by the usual clinical criteria, the A group's patients showed greater trust in their doctors and communicated their personal problems more freely than did the B patients.

The investigators turned their attention to other psychiatrists and their patients. Again, choice of therapist loomed as a significant factor in results obtained.

Following up five or more years later, Whitehorn and Betz found that whereas 80 per cent of Group A patients were improved at time of discharge, 77 per cent were improved five years later. Among Group B patients, 31 per cent were improved at discharge and 65 per cent were improved after five years. Some had been discharged unimproved but improved later with or without treatment elsewhere.

The investigators now scrutinized the A and B doctors intensively, not only as to the way they worked with patients but also as to their vocational interests. From the results of this scrutiny they found that they could predict which doctors would do well with schizophrenics and which would not. They noted that, in psychotherapy, Group A doctors expressed their personal attitudes toward the patients' problems rather freely, and set limits on the kind and degree of obnoxious behavior they would permit, but did not seek to interpret or instruct. The Group B doctors, in contrast, were either passively per-

missive or pointed out, in an instructional style, the patient's mistakes and misunderstandings.

Further, the Group A, or superior, therapists scored high in the Strong Vocational Interest inventory on the occupational categories of lawyer and certified public accountant and low for printer and mathematics or physical sciences teacher. The B doctors rated precisely the opposite in these four vocational interests. The statistical significance of the finding was validated when it was found that, using 16 items in the test, it could be predicted with 90 per cent accuracy whether or not a given psychiatrist could do well with schizophrenics.

Pondering these curious findings, Whitehorn (1959) speculated:

> Lawyers, in general, have the function of helping their clients find loopholes in the laws, or more politely expressed, they keep the restrictive regulations of society from binding human activity so tightly and rigidly as to thwart reasonable human activities and desires. I picture this as a problem-solving approach, not a purely regulative or coercive approach.
>
> Now schizophrenic patients, as I see them, have a special position in regard to the power and influence of other persons. They are sensitive, resentful, baffled, boxed-in or withdrawn from ordinary participation in life. They respond to prescriptive pressures by further withdrawal and resentment; they respond to mere permissiveness by inertia, that is, by not having any response.
>
> The doctor whose attitudes are like those of the printer—that is, black or white, right or wrong—is likely to view the schizophrenic as a person with a wayward mind needing correction and instruction, and thus he is likely to alienate the schizophrenic still more, rather than intrigue him into hopeful effort.
>
> But the doctors whose attitudes to social situations are like those of the lawyer, who assumes that there is leeway in solving individual problems and for achieving individually desired goals within reasonably broad interpretations of society's rules and family expectations—such a doctor has a better prospect of . . . discovering personal problems . . . and thereby soliciting from the patient more problem-solving efforts and participation in life.

We have not paused in this chapter to consider the characteristics of mental illness in any of their major forms or to examine techniques of treatment, but have pressed forward on the trail of "results." For purposes of illustration we thus far have concentrated, for the most

part, on the reported results of early *moral* and modern *social treatment* employed alone or in combination with individual *psychotherapy* and, in some cases, with insulin or electric *shock*.

Superficially inspected, the good results appear to range from as low as 9 to as high as 77 per cent when followed for five years, in the manner of the five-year cancer cure.

By avoiding the nature of illness and content of treatment we have signalized, in a negative way, the pitfalls in attempting precise statements of the effectiveness of treatment. It is difficult to make comparative statements about treatment of a mental illness as long as we do not have a clearly defined, generally accepted theory of the cause of the mental illness being treated. We do not. It is similarly difficult to measure results of treatment when the treatment itself is as loosely defined and applied as are social treatment and the psychotherapy of schizophrenia. The situation can be better understood through contrast with two forms of psychosis of known organic cause that once constituted major problems but now have been controlled.

One form is the result of pellagra, at one time a leading cause of admissions to mental hospitals in the South as well as a major cause of death in the United States. Joseph Goldberger in 1914 established the cause of pellagra to be a dietary deficiency in Vitamin B-2, the particular factor subsequently being identified as niacin. A diet containing foods with niacin and administration of the vitamin itself serve as a preventive as well as a specific treatment of pellagra. As a result of this discovery, pellagra patients virtually disappeared from mental hospitals.

Unfortunately, the discovery of a disease's cause is not always immediately linked with its cure. The spirochete protozoon causing syphilis was known for half a century before the advent of penicillin as an ideal treatment for syphilis. Thanks to the effectiveness of penicillin in the early treatment of this infection, paresis, or syphilis of the brain, now rarely develops in later years. At one time, this psychosis produced by neurosyphilis accounted for as much as 10 per cent of the average mental hospital's patient load; it is now less than one per cent.

THE TRANQUILIZED HOSPITAL

We inherit the same problems of evaluation with the tranquilizing drugs, experimentally tested in the treatment of the mentally ill in 1953 and by 1955 in general use in State hospitals that could afford them. Estimates from various States indicate that as many as one third of all public mental hospital patients now receive these drugs, the general rule being to tranquilize patients who are hyperactive, unmanageable, excited, highly disturbed, or highly disturbing.

These drugs have revolutionized the management of psychotic patients in American mental hospitals, and probably deserve primary credit for reversal of the upward spiral of the State hospital inpatient load in the last four years. They have largely replaced the various forms of shock, as well as surgery on the prefrontal lobes of the brain (lobotomy). Unquestionably, the drugs have delivered the greatest blow for patient freedom, in terms of nonrestraint, since Pinel struck off the chains of the lunatics in the Paris asylum 168 years ago. The most noticeable effect of the drugs is to reduce the hospital ward noise level. Bedlam has been laid to rest. The debate still continues as to what precisely the drugs accomplish, physiologically and socially. Some have predicted they would empty mental hospitals, and others have dubbed them chemical strait jackets. In the surprising, pleasant effects they produce on patient-staff relationships, the drugs might be described as moral treatment in pill form, as may be judged from the remarks of Robert H. Felix (1960), Director of the National Institute of Mental Health:

> In the whole of *materia medica,* I suspect that the tranquilizers are the only substances whose responses have been measured or observed not only on the persons who receive the drugs but also on those who live and work in the same surroundings. We have known for some time that if mental hospital patients can be made aware of the staff's sympathetic perception and high expectations, the patients will tend to fit the roles which are set for them. It has also been evident that every improvement in the patient's behavior tends to enhance the staff's attitudes toward him. In the tranquilizers we have found a valuable means by which both staff and patients have been able to help each other to perform at a higher and more constructive level.

In short, we have *new hope*. Medicine long has believed that the man who feels he can do something for a patient and can impart the feeling to the patient that something *is* being done for him may "pull a patient through" conditions that would overwhelm the bored, unenthusiastic, or uncertain person. In less scientific circles, this kind of mutual enthusiasm is known as faith healing. Conversely, when the persons attending the critically ill patient feel that they cannot help him, then surely there is little hope for him. This hopelessness is an old story in our large, overcrowded, understaffed State hospitals.

Understandably, the biases introduced by a long history of contention and doubt about the relative merits of one course of treatment or another and the question of whether we are measuring drug efficacy or enthusiasm make scientific evaluation of the effects of the tranquilizers a tricky problem.

For this final report, we have the benefit of a four-year study of the use of tranquilizers in the New York State mental hospitals (Henry Brill and Robert E. Patton, 1957, 1959). The study covers the period from March 31, 1955 to March 31, 1959. In 1955, the Department of Mental Hygiene, State of New York, under the direction of Dr. Paul Hoch, introduced chlorpromazine and reserpine for general use in the State's 18 mental hospitals, some 30,000 patients receiving drug treatment during the first year out of a total patient load of 93,300. The drug-treated portion rose to 40,000 by 1959.

Prior to 1956, the resident population of New York State mental hospitals had continually increased, having doubled itself since 1929, reflecting population growth, an increased proportion of aged persons, reduced mortality rates, and a greater use of mental hospitals. As in so many other States, the New York State mental hospital system was the victim of a population explosion following public indifference and neglect. As elsewhere, the public mental hospitals had no control over total admissions or over the suitability of patients for hospitalization; the law required that they admit all patients certified, or committed, to their care. The public and not the professional staffs thus determined the hospital's destiny.

The New York State mental patient population was 91,000 in 1954,

prior to the introduction of the drugs, and rose another 2300 by 1955. Then in 1955–1956, the first year of the tranquilizers, the trend abruptly reversed itself and a net fall of nearly 500 occurred in the resident hospital population. The mental hospital systems of about three-fifths of the States witnessed the same phenomenon in 1956. As indicated in Chapter I, the reversal of trend and continued decreases have occurred in the State mental hospital population of the entire United States. In four years' time, the New York State mental hospital population declined to 89,000 in 1959, a net drop of approximately 4000.

The immediate assumption in 1956 was that this dramatic event, coming as the first ray of spring sun to a snowbound and winter-worn family, was caused by the tranquilizers. Doubters had to be satisfied. They were of two general kinds: (1) those well trained in scientific method and interpretation of data who were simply aware of the common mistake of confusing coincidental events with cause and effect; (2) those whose own orientation and prejudices opposed them to the idea that a pill could make a big difference. The latter group, it would seem, were chiefly those who preferred analytic psychotherapy of the individual or who advocated a sociological approach, but of course included some organic-minded hospital psychiatrists trained in pessimism by years of disappointed hopes in one new treatment or another.

The New York State mental hospital system appeared well suited for a statewide analysis of the relationship between tranquilizers and the hospital population reduction. New York's public mental hospital patients constitute roughly one eighth of the total for the United States. The State was financially in a position to afford the use of drugs as needed on a wide range of patients. Importantly, the administrative and statistical controls were good, making it feasible to set up a study in all hospitals of the system and to collect and analyze large quantities of data. At the same time, the ratio of physicians and other professional staff members to patients was only a little above the national average (that is to say, rather low), minimizing the possibility of greatly increasing individual attention to patients.

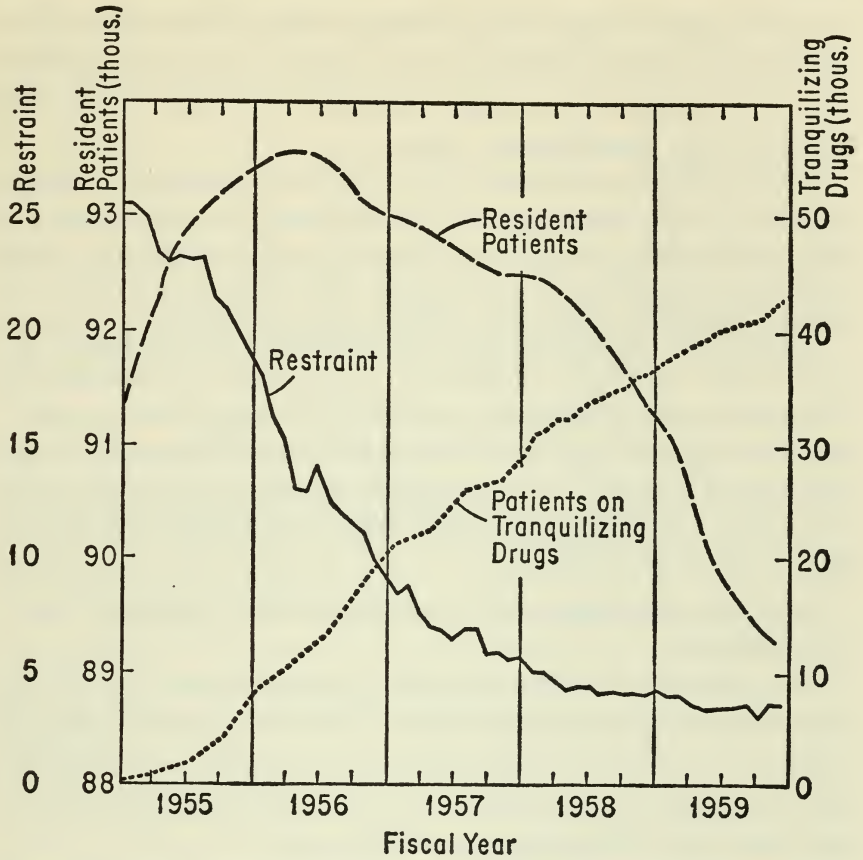
Most importantly, as Brill and Patton pointed out, there had been no change in methods or standards for admitting or discharging patients at the time drug treatment began. They state:

> The measure of therapeutic potential has been the capacity to return patients to society. It is recognized that return to the communiy does not represent an end in itself and can be easily subject to changes of administrative policy. We can only say that such policy changes have not taken place. Moreover, anyone who has attempted to change the operating conditions of a large organization . . . will recognize that sweeping administrative changes are virtually impossible to achieve quickly, but require a period of years. The fact is that no effort was made to produce any administrative changes during the first year of large-scale drug therapy; during the last three, a very active program of change and liberalization has been under way.

Thus, Brill and Patton have been able to compare a year of no change in trend (1954–1955) with a year in which the introduction of the drugs constituted the only apparent innovation (1955–1956) and these with a two-year period (1956–1958) in which a number of favorable factors besides drugs were added.

The figure on page 43 is taken from their study (1959). It shows, in a graphic fashion, how the need for restraint and seclusion of patients decreased and all but disappeared in inverse ratio to the increase in patients receiving tranquilizing drugs. It also shows the over-all downward trend in the resident population. The data are for the fiscal years, beginning March 31, 1954. The authors point out that there appeared to be no wearing off in the effect of the drugs on patient behavior, such as could be attributed to initial enthusiasm. However, since the physicians did not stick to chlorpromazine and reserpine but tended to try newer products in the tranquilizer group, the authors interpreted the choice of *which drug* as to be of no decisive importance. This leaves room for interpreting the drug benefits as partly psychological; that is, as patients quiet down and become less disturbing, staff morale goes up and relations with patients improve.

Brill and Patton concluded (1957) that use of the drugs largely caused the abrupt resident population fall in the first year (1954–1955). They also pointed out (1959) that in 1956 the Department of



This figure shows trends in percentage of patients requiring seclusion (restraint) and in total number of patients residing in New York State hospitals in the four years following the introduction and during the increasing use of tranquilizing drugs.

SOURCE: Brill and Patton, 1959, p. 498.

Mental Hygiene began a new program of intensified treatment for newly admitted patients, gradually extended through all institutions, and also began conversion to an open-hospital system. This more liberal philosophy brought freedom of the grounds to some 60 per cent of all cases by 1959, ten times the number who had such freedom in 1956.

The investigators, sharing the general view of the hospital staffs, were inclined to give the drugs the principal credit for making it

possible to unlock wards and treat the mentally ill more like general hospital patients and less like prisoners. As an additional dividend, the number of suicides remained consistently below the average for the preceding ten years.

The New York study dealt with a variety of questions, all requiring answers in order to assess the place of the tranquilizers in the treatment of the mentally ill. Because of their pertinence, we will briefly summarize some other findings from this study.

Whereas first admissions previously exceeded discharges (all releases alive), discharges exceeded first admissions slightly for the first time in 1958–1959. About 50 per cent of the patients were maintained on drug therapy after leaving the hospital. The relapse rate (all patients returning to the hospital) was about 35 per cent, but, in contrast to the findings of some other investigators, this was no higher than in predrug days.

No sickness associated with long-term use of the drugs was identified clinically.

The greatest gain in the release of patients occurred in the age group from twenty-five to forty-four, with some reduction also occurring in the forty-five- to sixty-four-year-old group in the hospital. In contrast, there was an increase in the number of patients over sixty-five. Here, the drugs appear of little use.

From the standpoint of diagnosis, schizophrenic patients showed far greater benefit (as measured by release from the hospital within five years) than did patients with other types of psychosis or organic brain disease. The increase in releases was most marked among schizophrenics who had been in the hospital two to four years—"It would seem that we may have gained less in speed of therapy than in effectiveness in prevention of chronicity" (1959). As with the senile psychoses, alcoholic psychoses and character disorders likewise showed increases rather than reductions in the face of treatment with tranquilizers.

Brill and Patton showed the discharge rate among drug-treated patients in 1957–1958 to be twice that for patients not treated with tranquilizers—roughly 20 per cent as opposed to 10 per cent.

The New York study substantiated the general observation, as remarked to us by Jonathan Cole: "The drugs do not move mountains." The authors summarize (1959):

> It now becomes important to analyze the trends for their significance with regard to future plans for mental hospitals, especially as many mental hospitals in various parts of the world have noted a decreased pressure for hospital beds or an outright fall in population. In some quarters these changes have been discounted as cyclical and unimportant and in others the attitude has been that it is now a matter of a relatively short time before mental hospitals will be empty and that the problem of hospital psychiatry has at long last been solved.
>
> Our own data lead us to take a position somewhat between these two extremes and considerably toward the conservative side. The persistence of reduction for four successive years seems to rule out any cyclical variation and the fact that the reduction of the population is limited to functional cases and most marked in schizophrenics points to the action of a specific therapeutic influence rather than a general change of policy. . . .
>
> If we looked only at the reduction in our population, we may forecast a rather gradual melting away of the chronic schizophrenic cases to perhaps 50 to 75% of their present number which is a humane and practical advance that would relieve New York State of a quarter of its present mental hospital population. . . .

In their appraisals, Brill and Patton did not, of course, look *only* at the reduction in the State hospital population but also at the continued increase in total admissions and in certain types of admissions —senile psychoses, juvenile-behavior disorders, adult character disorders, alcoholism—"a sort of deferred business." Here the outlook remains less cheerful.

Not mentioned in their study is the fact (cited in Chapter I) that the net decrease in State hospital inpatients, now a well-established trend, cannot be observed in the patient loads of Veterans Administration mental hospitals, general hospital psychiatric units, or private mental hospitals. Looking beyond the immediate effects of the drugs, what we seem to be witnessing is an as yet small, overall shift of the mental hospital patient load away from State hospitals and toward other types of care. Inasmuch as senile psychosis is the No. 1 reason for admission to mental hospitals and this category does

not especially benefit from tranquilizers, we might predict that the effects of an aging population will become the predominant factor in determining future trends in the State hospital patient load. Unlike schizophrenia, the No. 2 reason for admission, senile psychosis can quickly flood crowded facilities for chronic patients and yet not have a long-range cumulative effect; the older patients die within a few years after admission whereas schizophrenics live on for many years.

THE NEW MENTAL HOSPITAL: A THERAPEUTIC COMMUNITY

In the typical general hospital, where there are more than two employees per patient, the approach of the doctors, nurses, and technicians in some instances may seem impersonal and routine, but the patient takes it for granted they are there to make him comfortable and to get him well; the staff, in turn, takes it for granted that they enjoy his confidence and cooperation in these objectives. Whether private or charity patient, the individual retains his rights as a citizen and acquires special rights as a sick person in need of help. He fully expects to be treated as a human being and, with few exceptions, is so treated. None of this can be taken for granted on the locked wards of the typical State hospital; here, there are three patients for every employee, physicians and nurses seldom attend the patient, he loses his rights as an individual and acquires none as a patient, he is encouraged to fade into the herdlike background, and his illness attracts attention only as it may create a disturbance and require his further restriction. The system effectively deprives him of all hope. Here, in the mass view, we are still fighting the battle of Pinel, who was among the first to observe that such hospitalization can convert an acute breakdown into a chronic state.

This negative contribution of the State hospital has been repeatedly observed, and nowhere has been better expounded than in the comments of Dr. Robert C. Hunt, Superintendent of the Hudson River State Hospital, one of the most progressive large mental hospitals in the United States:

Much of the unnecessary crippling of the mentally ill must be laid at the door of the state mental hospital both from the standpoint of how it functions internally and how it is used by the society it serves. Despite the glorious early history of our state hospitals as first-rate treatment institutions; despite recent advances in the effectiveness of treatment; despite all the propaganda to the effect that these are hospitals for the treatment of the ill; despite the dedicated zeal of treatment-minded staff, commitment to the state hospital continues, in most cases, to represent to the patient and to his family major social surgery by "putting him away." At best it is likely to be a regretful acceptance of permanent loss with family readjustments which make it difficult to reverse the process. The machinery for bringing about the admission, especially in the larger cities, does nothing to mitigate this. The police ambulance, the rapid impersonal processing in a huge psychopathic hospital, the judicial proceedings, and the mass transportation to a remote fortress, must seem to many like a casting out of the unfit.

It is a common experience that the patient who arrives at the state hospital fearful of the legendary horrors, is surprised and grateful at finding that he is treated with kindness, gentleness, and understanding, with genuine concern for his welfare. Overt cruelty is probably less common in a well-run state hospital than in the average neighborhood outside. Well-meaning kindness can itself be a cause of disability, however, when based upon false premises. The certified mental patient in our culture is traditionally regarded as one who has lost all capacity for managing his own affairs. For his own protection and welfare and for the safety of the public, his every move must be directed and supervised. He is ordered to get out of bed, is told what clothing to put on, when and where he may smoke a cigarette. He is ordered to take part in occupational therapy, to toss a medicine ball, or watch a movie. He takes a bath at the prescribed time and under the immediate supervision of an attendant. To make sure that no patient can escape from this well-intentioned coddling, all but a tiny minority spend their lives behind locked doors and barred windows with their occasional airings strictly guarded by watchful attendants. . . . In our enlightened times, most of us working in public mental hospitals have been satisfied that we were applying the lessons learned from Pinel, that at least we were not making our patients worse by medieval brutalities even though our treatment techniques left something to be desired. This smugness has been shattered by such pioneers as Macmillan and Rees [Duncan Macmillan and T. P. Rees, British pioneers of the open hospital movement] who have rediscovered the values of the open hospital. Their experiences . . . have shown beyond question that much of the aggressive, disturbed, suicidal, and regressive behavior of the mentally ill is not necessarily or inherently part of the illness as such but is very largely an artificial by-product of the way of life imposed upon them. The virtual disappearance of

antisocial and irresponsible behavior when patients are treated and trusted as responsible fellow human beings is most convincing and forces us to a total re-examination of our traditional procedures. . . .

The tranquilizing drugs have brought about dramatic changes in some of the outward manifestations of the hospital culture but do not in and of themselves change the basic structure. . . .

The foregoing critical remarks should not be misunderstood as just another denunciation of that whipping boy of American psychiatry, the state hospital. I have no patience with those ostensibly well-meaning crusaders who place the blame for the custodial culture on such internal factors as too few doctors, too few nurses, too little therapy, and too few dollars. A basic assumption in many reform waves seems to be that the addition of therapeutic tools and viewpoints to the mental hospital will automatically convert it from a custodial to a treatment institution. . . . The presence of a treatment-minded staff, and of humane and enlightened administration, doubtless mitigates some of the evils of the custodial function, but does not and cannot by itself abolish the function. The point I am trying to make is that the custodial culture within the mental hospital is in large part an inevitable consequence of the expectations of the population we serve. Our society *hopes* for successful treatment, but it *demands* safe custody of those whom it rejects. The pressure for security is constant, unremitting, and a long accumulation of responses to this pressure for safe custody is embodied in hospital customs, traditions, regulations, laws, and architecture. We also live through times of acute exacerbation of these pressures, during which we are excoriated by the judiciary, crucified by the press, and harassed by litigants over our supposed lapses from security. In times like these it is a rarely courageous hospital superintendent who does not tighten his security measures and become more restrictive in release policies. The custodial function of the mental hospital is a necessary and inevitable product of the community demand and can never be abolished by measures taken within the hospital alone . . . (Hunt, 1958, pp. 12–15).

Hunt regards the open hospital as an essential factor in achieving community tolerance of the mentally ill, holding the unlocked door to be the greatest therapeutic development of the present generation, even more important than the tranquilizers. He summarizes his convictions, patterned after those of Schwartz, Greenblatt, and other experimenters in social-psychiatric treatment (the therapeutic community in a broad sense) as follows (1958, p. 21):

1. The enormous disability associated with mental illness is to a large extent superimposed, is preventable and treatable.

2. Disability is superimposed by the rejection mechanisms stemming from cultural attitudes.

3. Hospitalization as such is an important cause of disability.

4. The best of treatment-minded state hospitals perform a disabling custodial function.

5. The custodial culture within a state hospital is largely created by public pressure for security.

6. Some of the treatment functions and most of the custodial functions of the hospital should be returned to the community.

7. This can be accomplished only by a change in public attitudes and concepts of responsibility.

8. Public attitudes cannot be expected to change until hospitals demonstrate the value and safety of community care by becoming open hospitals.

The present discussion has concerned itself largely with what a therapeutic community *is not.* A more *positive* view of what it *is* may be found in discussions of new patterns of mental patient care in the first and last sections of Chapter IV.

THE MENTAL HEALTH CLINIC

It is apparent that the modern concept of treatment and the modern reality of mounting costs of State hospital operation have combined to stimulate efforts to keep mental patients out of mental hospitals as long as possible and to discharge them as quickly as possible. In either the instance of early treatment on an outpatient basis, or that of aftercare of discharged patients, the mental health clinic occupies a pivotal position. It is also the fulcrum of efforts to remove the barriers isolating mental hospitals from the community.

We are indebted here to Anita K. Bahn and Vivian B. Norman (1959) of the N.I.M.H. Biometrics Branch for the first national data on the characteristics of patients and the services received in mental health clinics.

Their statistical study concerns 499 of a total of 1294 mental health clinics known to be operating in 1956 and refers to clinic experience in 1955. For the purposes of illustration, we believe that this seemingly dated experience is still currently applicable; in any event, it is the only report of this nature available.

The N.I.M.H. defines a mental health clinic as "outpatient psychiatric services with a psychiatrist in attendance at regularly scheduled hours who takes the medical responsibility for all clinic patients." Under such supervision, diagnosis and treatment may be carried out by a psychologist or social worker.

It is of general interest to note the variety of clinics fitting this description. Of the 1294 total, 280 were operated by State mental hospitals, 250 were operated by other State agencies, 300 were operated by voluntary agencies with State aid, 400 were privately operated, and 64 were operated by the Veterans Administration. Some 750 served children and adults, 400 served children only, and 144 served adults only.

The distribution of mental health clinics by States was uneven, but tended to follow concentration of population. New York State (330), and Massachusetts (102), had by far the largest numbers, followed by Illinois (71); New Jersey (65); Pennsylvania (65); California (64); Michigan (51); Ohio (44); Connecticut (35); New Hampshire (26); Virginia (24); and Wisconsin (22). Florida, Kansas, and Texas each had 21 mental health clinics. In many other States, this approach appeared less well developed.

Total mental health clinic patients were estimated at 379,000, of whom 197,000 (52 per cent) were children under eighteen years and 182,000 (48 per cent) were adults. Males outnumbered females both for children and for adults.

The 499 clinics reporting showed a rapid turnover during the year, with 60 per cent of patients being newly admitted, 10 per cent readmitted, and 30 per cent continued from the previous year. A person became a patient as the result of one face-to-face interview (or, in the case of a child, after an interview with a parent or parent substitute presenting the child's difficulty).

The most common diagnosis for children (36 per cent) was "transient situational personality disorder," meaning a reaction appearing to be an acute response to a situation without underlying personality disturbance. But personality disorders—meaning a defect of behavior patterns with little sense of anxiety or distress—and mental deficiency

—a defect of intelligence existing since birth—were also common (21 and 17.6 per cent, respectively).

Among adults, personality disorders were most common (32 per cent), closely followed by psychoneurotic disorders, (30.9 per cent). Psychotic disorders (19.5 per cent), presented the third largest problem among adults. Psychoneurosis was defined as a disorder chiefly characterized by "anxiety" expressed either directly or through various psychological defense mechanisms. Psychosis was defined as a disorder characterized by a varying degree of personality disintegration and failure to test and evaluate external reality correctly. Schizophrenic reactions strongly predominated among the psychoses.

As Bahn and Norman point out, "The type and amount of service a clinic patient receives is determined by such factors as clinic policies, availability of clinic staff and other community resources, reasons for referral to the clinic, and patient and family cooperation, as well as diagnosis." In any case, their findings indicate that the present operation of clinics leaves much to be desired if we continue, as we have throughout this final report, to set adequate or sufficient therapeutic services as our goal.

Of each 10 patients for whom service was terminated, they found, 8 received a diagnostic evaluation but only 3 received treatment. The other 2 included those only partially evaluated or referred elsewhere prior to diagnosis, or those who received other services.

The amount of service a patient receives is indicated by the number of face-to-face interviews with the patient or with his family or with others, such as an agency worker on behalf of the patient. Length and quality of interviews are not measured. Interviews over the telephone, case conferences, and a variety of other clinic activities in the interest of the patient are not counted.

For most patients, services were terminated after only a few interviews. More than one-fifth had only one interview and three-fifths had less than five; the median number of interviews was three. . . . Approximately one-half of all reported interviews on behalf of patients for whom services were terminated were interviews with the 8 per cent who had 25 or more interviews (Bahn and Norman, 1959).

In both children and adults, psychoneurotic disorders received the most attention, the median number of interviews for children with

this diagnosis being eight and for adults, four. These patients also showed the greatest amount of improvement in the best judgment of the clinician—70 to 80 per cent as compared with 45 to 55 per cent of those with more severe conditions, including psychosis and some personality disorders as well as mental deficiency.

WHAT WE KNOW ABOUT TREATMENT

In the absence of knowledge about specific causes and specific cures in the diagnosis and treatment of the psychoses, the therapeutic task becomes one of creating a group environment or a man-to-man relationship in which the self-healing capacity of the sick mind can operate to its maximum extent. It is implicit that treatment need not be confined to a hospital. The evidence that we have summarized in this chapter, in a few selections from investigations far too voluminous for us to record, has demonstrated that the healing process can be either helped or hindered by persons and institutions acting with what they suppose to be the best intentions. In the progress in the care of psychotics from moral toward scientific treatment four principles appear to have emerged.

1. *The late nineteenth-century medical dictum that schizophrenia is a hopeless, incurable disease requiring the person to be removed from human society for the rest of his life is baseless.* The one-in-five chance for spontaneous recovery without individual treatment refutes the incurable dictum; the fact that an additional two or three out of five patients can improve sufficiently as a result of proper treatment to lead useful lives in the community further refutes it. It is true, however, that the outlook for the schizophrenic is substantially hopeless under the long-established, still-prevalent pattern of punitive and authoritarian care of the mentally ill.

2. *The widely held concept of "total insanity" likewise is without foundation.* This concept is akin to the now thoroughly discredited all-or-none "laws" of general medicine. Medical psychology has consistently observed, and generally accepts, the fact that a functional psychosis involves only certain of the components of the personality (the intellect, feelings, individual character, and social atti-

tudes of the person). As in any other illness, the patient is sick in some ways and healthy in others, disabled in some directions and able in others. Rational treatment directs itself toward achieving a favorable balance between his mental assets and liabilities.

Schizophrenia, to illustrate, might be said to be a kind of arthritis of the mind, crippling one part or another, attacking and retreating, but not usually progressing rapidly or with 100 per cent certainty to an end point of total and permanent disability.

Modern therapy seeks in principle to work with the healthy parts of the mind against, or sometimes around, the sick parts. Various theories have been set forth to explain the effects of one treatment or another, but none of them are wholly convincing on the basis of indisputable evidence, with the exception of one observation: the schizophrenic often responds despite himself to continual personal attention or well-directed social activity. The process as described may involve many qualities—unsolicited love, brotherly love, the healing touch, lawyer-like tolerance. The approach needs to be tailored to the individual involved. We are not attempting here to preserve too much professional terminology, but we can stress that love alone is not enough. It is possible, as some therapists have shown, to fight verbally with a patient, or adopt a stern attitude toward him, and yet get him well if the therapist can somehow convey that he is fighting or working on the patient's side—that is, the *well* side. Friendliness is essential, but is worthless without firmness. (The great virtue of the tranquilizers seems to be that they make the patient a more appealing person to all those who must work with him.)

3. *The normal human being regards loss of liberty, forcible detention, removal from the community, and imprisonment, as punishment for wrongdoing; the mentally ill, having grown up with the same viewpoints, are no exception.* At the height of an acute episode or attack, the mental patient is *not* unconscious of how he is handled, but is usually hypersensitive, quick to resent injustice, and apt to interpret harsh and punitive handling as substantiation of his own sense of guilt or persecution, of being "no good," or of feeling that everyone is against him. To be rejected by one's family, removed by the police, and placed behind locked doors can only be interpreted,

sanely, as punishment and imprisonment, rather than hospitalization. Anger begets anger; force invites counterforce. Only a relatively few psychotics are dangerous to others or to themselves; most can be handled without physical seizure or restraint. Modern psychiatry pursues the therapeutic principle of accepting the patient as a human being who retains the right to be treated as one.

4. *The present state of scientific knowledge in the mental health professions does not permit as yet the formulation of exact tests of "cure."* In fact, the pursuit of "cures" in the mental health movement constitutes something of a *cul de sac*. Psychiatry and its associated professions are now deeply engaged in attempts to progress from the status of fine art to science, and we in these professions are prone to criticize ourselves and each other over such questions as what constitutes treatment, who can give treatment, and what are the results of treatment. In addition, our own criticisms are often thrown back at us by our colleagues in other branches of medicine; by lawyers, propagandists, and the lay press. It is true that mental health workers face difficulties of intellectual proportions that would exasperate and frustrate those working with physical diseases—difficulties involving controlled observation, measurement, demonstration, objective recording, standardization, and reproduction of the phenomena under study. Yet these limitations, while perhaps more hampering to the behavioral sciences, are not peculiar to them, but are a general characteristic of all biological sciences.

In his thought-provoking book, *Mirage of Health* (1959, p. 138), René J. Dubos makes the problem clear by taking as an example a disease against which science has made great strides in specific treatment without concomitant strides in ascertaining cause or achieving cure:

> The relation of insulin to diabetes illustrates another type of difficulty in the control of disease by the use of drugs. Thanks to insulin, many millions of diabetic persons all over the world can now live long, happy, and useful years. Unfortunately, effective control of the symptoms of diabetes is not synonymous with cure of the diabetic patient, let alone with conquest of the disease. Even when adequately treated with insulin, the diabetic individual is at risk of developing vascular disorders during old age. Still more important from the

social point of view is the fact that his children are likely to inherit a tendency to the disease. Thus, the very effectiveness of insulin therapy is bringing about an increase in the prevalence of diabetes in our communities, and a time may soon come when it will prove necessary to weigh the distant consequences of this biological situation.

To diabetes we could add many other diseases presenting similar control problems: anemia, cancer, arthritis, arteriosclerosis, schizophrenia. Whether or not schizophrenia is ultimately found to arise in a hereditary defect of the cell nucleus, a defect of cell metabolism, a defect in the individual's social environment and how he learns to handle stress and react to life, or some combination of these or other factors, our state of knowledge about it closely resembles that concerning other chronic diseases today. The *disease* of schizophrenia—or, as some would say, is it a *disease* or merely some *defect* of learning or of socialization?—has been the subject of intensive study for a hundred years: the scientific literature on it is mountainous, but we have only hints of possible final answers, and are only now learning some of the most elementary lessons of medicine.

One of these lessons is that the first responsibility of the physician is, and always has been since Hippocrates, *to attend the sick,* to give them confidence and comfort, and *to do nothing to harm them.* In treating the functional psychoses, we believe that this primary approach is scientifically sound; the available evidence indicates it is possible to double or triple the spontaneous remission rate and achieve improvement or recovery in the majority of cases so approached. Good results are discernible in how the patient thinks, feels and behaves—in the *subjective* conviction of the patient and of his doctor that he *is* better. These results then remain to be demonstrated to the patient's family and friends, since his continued improvement depends not only on his own behavior but on how others accept him —on his reacceptance as a member of human society.

We can no longer delay answering our pivotal question from Chapter I: *Why have our efforts to provide effective treatment for the mentally ill lagged?*

III

Rejection of the Mentally Ill

The way society handles its mentally ill has been the subject of scandalized public attack many times. Humane, healing care for the mentally ill, historically well tested, and further clarified in the last decade, remains the great unfinished business of the mental health movement. We can scarcely hope to convince the public of how much the sciences of behavior can help in achieving human understanding and providing more satisfying human relations in general if we cannot solve this old, notorious problem of human relations. A large proportion of mental patients at present, as in the past, are not treated in accordance with democratic, humanitarian, scientific, and therapeutic principles. We have substantially failed the majority of them on all counts. It is our purpose in this chapter to explore the various dimensions, and some of the consequences, of our attitudes toward these patients.

The psychiatric, journalistic, and sociological literature on the status of our mental hospitals is monumental; the Joint Commission has increased this literature. In the last fifteen years, millions of words have been spoken and written about mental illness as a major national health problem. Many of them have been well spoken and well written. Most seem predicated on the assumption that if the plight—the shameful, dehumanized condition—of mentally sick people who populate the back wards of State hospitals were sufficiently well exposed, the public would rise in moral indignation, and demand and enact reforms in which, at long last, we as a civilized people could take full pride. The assumption is ordinarily a valid

one in a democracy—that well-informed public opinion will seek and progressively obtain redress of social shortcomings and injustices—but something is missing in all of this eloquence.

We do note some signs of progress. We can see that the tranquilizing drugs have made patients more agreeable to work with, making it in turn easier to demonstrate the basic validity of the friendly, accepting approach symbolized by the unlocking of wards. The drugs have made it possible to change the institutional atmosphere of routine fortitude, solemn vigilance, and covert resignation to one of therapeutic enthusiasm and constructive activity. As Erwin L. Linn (1959) dramatically describes it in his study at St. Elizabeth's in Washington, D.C., the rise in staff spirit is contagious and results in an increased return to the community not only of patients receiving the drugs but also of those *not* receiving them. Yet, as we have recognized previously, "the drugs do not move mountains."

THE IMMEDIATE ISSUE

To return to the theme of this chapter, neither does public scandal move mountains. Moral indignation fails to come to grips with the fundamental problem. The immediate question is *why not?* Why is it *not* correct to assume that public education regarding the facts about mental illness and health will stimulate action to bring about the desired reforms? Why have past efforts failed?

If we cannot formulate a satisfactory answer now, then we have little reason to hope that the future will be very different from the past. Such a hope would become as false as the above assumption. The public has had shockers made available to it *ad nauseam* since Nellie Bly wrote "Ten Days in a Mad-House" for *The New York World* in 1887.

The care received by the mentally ill in the United States is the product of two great human forces: the drives to punish and to pity; or, more broadly, to drive out evil and to personify goodness. The first approach has underwritten every extreme in inhuman disposal of the insane; the second has been the basis for both emotional and

rational approaches finding their wellspring in feelings of mercy and acts of wisdom toward the unfortunate. Obviously, of the two forces, punishment has exerted a greater effect than pity.

We can now come to the point. One reason the public does not react desirably is that the mentally ill lack appeal. They eventually become a nuisance to other people and are generally treated as such. In contrast, it is the special view of the mental health worker that people should understand and accept the mentally ill and do something about their plight. People do seem to feel sorry for them; but in the balance, *they do not feel as sorry as they do relieved to have out of the way persons whose behavior disturbs and offends them.*

The point has been stated with a good deal of literary force by R. S. deRopp (1957, pp. 167–168): "Madness severs the strongest bonds that hold human beings together. It separates husband from wife, mother from child. It is death without death's finality and without death's dignity."

Perhaps an explanation so disarmingly simple may remain unconvincing to the skeptic, at least until we have had an opportunity fully to demonstrate that an attitude or effect of rejection tends to pervade every line of attack on major mental illness, whether it be a public or a professional approach, and whether we examine the historical past or the topical present. Rejection, as practiced against the psychotic patient, takes many forms; some tantamount to complete denial of his right to human existence.

As a reaction to deviant behavior, rejection is, of course, a well-established characteristic of any social group. Society depends on a system of order, conformity, solidarity; it uses rejection as a threat to exact thorough individual compliance with the expectations of the group. Thus, what we shall say may not strike the sociologist or social psychologist as new. On the other hand, we believe the peculiar significance of the typical person's feelings toward the madman has been widely overlooked, even by social scientists, as a key reason for the lag in hard-hitting efforts to provide decent care for the mentally ill. It is difficult to hit hard if we do not recognize where we must hit and aim accordingly.

THE STRANGER AND THE ESTRANGED

The nonconformist—whether he be foreigner or "odd ball," intellectual or idiot, genius or jester, individualist or hobo, physically or mentally abnormal—pays a penalty for "being different," unless his peculiarity is considered acceptable for his particular group, or unless he lives in a place or period of particularly high tolerance or enlightenment. The socially visible characteristic of the psychotic person is that he becomes a stranger among his own people.

For more than 160 years, the few physicians who have accepted the responsibility of watching over the mentally ill, together with the few benevolent laymen who have elected to work in behalf of mental patients, have inveighed against the necessity of this estrangement. They have maintained that these people are human beings, are sick in the same sense as the physically sick, and should be treated in the same humane manner we customarily treat other sick persons.

With the development of psychiatry and psychology as sciences during the last half century or so, the friends of the mentally ill have been able to go farther and point to clear evidence that normal and abnormal behavior, mental health and mental illness are not entities, but relative terms, with no clear line of demarcation between them; indeed, they mean different things to different people, as Marie Jahoda (1958) made clear in the Joint Commission monograph, *Current Concepts of Positive Mental Health*. Furthermore, there is no fence line between physical and mental illness; many physical illnesses are characterized by mental disturbances, and vice versa.

The principle of *sameness* as applied to the mentally sick versus the physically sick and the mentally sick versus the mentally well has become a cardinal tenet of mental health education. But this principle has largely fallen on deaf ears, a fact we shall presently document.

The "deaf ears" of society translate in less anatomical terms as the "stigma of insanity." It has been observed countless times that the sight or thought of major mental illness, as our culture has come to

understand it, stimulates fear—fear of what an irrational person might do, fear of what we ourselves might do if we acted out our impulses in a similar manner, fear arising from the power of suggestion that we, too, might suffer a similar fate. For the normal person, the problem is one of self-control; under stress, we sometimes feel as if we might lose control. As the forthcoming Schwartz monograph, *New Perspectives on Mental Patient Care,* points out, the social stigma of mental illness is a real and still persistent problem, despite efforts to combat it. The greatest evidence of this, as we interpret it, is that many hospitals for mental patients remain hospitals in name only—or, put another way, persons released from mental hospitals are not regarded as ordinary convalescents.

DIVERGENT ATTITUDES TOWARD MENTAL AND PHYSICAL DISEASE

The stigma hurdle and the atypical character of mental hospitals contrast with what we have witnessed in modern times in relation to other health problems. Many diseases, such as tuberculosis, syphilis, and cancer, have stigmatized their victims at some time. Yet in our day the stigma has not deterred determined, organized, and expensive efforts to identify these people and to control these diseases. There is still considerable tuberculosis in the population, but our horror of the Great White Plague of the nineteenth century seems all but gone; syphilis continues to be quite prevalent, but the aversion to public action against this disease is gone. Death from cancer continues to terrify, but not nearly so much as when cancer was less prevalent; to be a cancer victim evokes sympathy rather than revulsion nowadays. Good medical care is generally available within the limits of scientific knowledge and professional skills. The public has been able to face the problem and make malignant growth a primary target of medical research. As public information has made these diseases and the methods of combating them tangible and matter of fact, public dread of contact with their victims seems to have declined. We have had parallel hopes but not parallel results in the case of mental illness.

Today, surprisingly, we actually carry rejection of certain forms of mental disability much further than formerly, as René Dubos (1959, p. 173) shows in *Mirage of Health:*

> Like all quantitative statements pertaining to human affairs . . . enumeration of disturbed persons or of psychiatric beds gives but a distorted impression of the change in the incidence of mental diseases in modern times. . . . The village fool who used to be an accepted member of any rural setting, the semi-senile oldster who was expected to spend his last years rocking on the porch of the family homestead, and even the timid soul who escaped competition by retiring into a sheltered home atmosphere are likely now to become inmates of mental institutions because they cannot find a safe place in the crowded high-pressure environment of modern life. Thus, the problem of our time may be less an actual increase in the numbers of mental defectives than a decrease in the tolerance of society for them.

Dubos (p. 127) also provides useful insight in the divergent paths followed in the evolution of mental hospitals and those for other diseases. He points out that the early reformation of the pesthouses as institutions for therapeutic purposes sprang, not as did modern general hospitals, out of the later phenomenon of scientific medicine, but as part of the great wave of social and moral reforms stimulated by the human squalor produced by the Industrial Revolution in the late eighteenth and early nineteenth centuries. The reforms were aimed at restoring the natural condition of man, presumed to be one of goodness and health; hence the emphasis on *pure* food, *pure* water, *pure* air, and sanitariums as places for healthy living.

> It is a remarkable fact that the greatest strides in health improvement have been achieved in the field of diseases that respond to social and economic reforms after industrialization. The nutritional deficiencies that were so frequent in the nineteenth century have all but disappeared in the Western world, not through the administration of pure vitamins but as a result of over-all better nutrition. The great microbial epidemics were brought under control not by treatment with drugs but largely by sanitation and by the general raising of living standards. In contrast, the cancers, the vascular disorders, the mental diseases, which were not affected by the sanitary movement, have remained great health problems and their solution is not yet in sight (p. 137).

It is ironic that the early reforms that produced the State hospital system today handling 1,000,000 patients a year did follow the sani-

tation pattern in one sense but with nontherapeutic consequences for the patients. With the growth of urbanization, the care of the mentally ill took the form of removing social rejects through a disposal system isolating them well beyond the city limits in large "asylums" functioning as human dumps.

It was not the intent of their originators that State hospitals function as dumping grounds, of course. The leader in the mental health movement at this stage, midway in the nineteenth century, and perhaps the most indefatigably militant crusader in the whole history of the movement, was Miss Dorothea Lynde Dix, a retired Boston schoolteacher (1802–1887). Miss Dix devoted the last half of her life to exposing cruelties to the indigent insane and in obtaining State legislation for public mental hospitals. This lady, one of the famous feminists of her time, reacted to two contemporary policies for the care of the mentally ill. The one she first noted was the herding of the harmless insane into filthy, unheated almshouses and jails. Conversely, she was impressed with the small moral treatment hospitals of the day, a few of them State-operated. Miss Dix set out to create State hospitals for the indigent insane. Traveling thousands of miles, visiting hundreds of county jails and local poorhouses, and speaking as a "self-appointed lunacy commissioner" before a score of legislatures, she was able to convince as many States that they should assume responsibility for these sick people and build public hospitals for them.

Unfortunately, moral treatment declined with the rise of large State hospitals, due to a combination of circumstances that cast the mentally ill under an ill star for a century to come. The first circumstance stemmed directly from the force of Miss Dix's crusade. When legislatures declared the indigent insane to be wards of the State, the town- or county-operated almshouses and jails were happy to transfer their burden to the new or enlarged State hospitals and thus save further local tax expense. State facilities rapidly became loaded with chronic patients with a poor outlook for recovery.

Secondly, this overcrowding was aggravated by the enormous foreign immigration during the last half of the nineteenth century. In fact, the decline of moral treatment in New England appears

to have coincided with the wave of immigration following the Irish potato blight and famine of 1845. Native Yankee physicians, complaining bitterly of the influx of "foreign pauper insane," found it difficult to extend their brotherly love for fellow Anglo-Saxons to alien peasants (Bockoven, 1956). There even were pleas that Yankee and Irish patients be segregated. Our State hospital system never has recovered from this original overcrowding and its facilities never have kept abreast of continued population growth.

The new-found dignity obtained for the mentally ill by rational humanitarians suffered another blow when Dr. John P. Gray of the Utica State Hospital, as new editor of the *American Journal of Insanity,* became spokesman for American psychiatry. Gray maintained that mental patients were really physically ill with a brain disease. He rejected the psychological implications of moral treatment and the concept of a *mental* illness, stating (1885): "The mind is not, itself, ever diseased. It is incapable of disease or of its final consequence, death." Gray equated the mind with the immortal soul, or spirit.

This differentiation between mind and body predominated in medical and physiological thought of the time, and still lingers on despite experimental proof to the contrary. Disease, the early organicists maintained, could not exist without some organic defect or injury; if no such lesion could be found, as was the case with functional psychoses, then insanity could not be regarded as a disease, or the patient as sick. Rather, he was simply immoral or criminal.

Eventually it became clearly established that psychological feelings such as fear and anger produce physical signs and symptoms of distress. Such discoveries led to the concept of psychosomatic medicine and the disease effects of stress, which, to take the case of stomach ulcers as an example, holds the lesion to be the effect rather than the source of the disease. Even so, many physicians today are loath to accept psychological explanations of illness except as a last resort, and at that point they may dismiss the patient as malingering or as imagining things, or, in case of gross irrationality, refer him to a psychiatrist.

It was easy for nineteenth century asylum superintendents to carry

this institutional form of rejection a step farther and rate insanity as an incurable condition, as in fact it usually became under the State custodial system. One psychiatric leader who switched from moral treatment and optimism in his early career to an attitude of pessimism in later years was Dr. Pliny Earle of Northampton, Massachusetts. He accused his moral treatment colleagues of grossly exaggerating their "cures," as some probably did, but himself went to the opposite length of grossly underrating potentialities for recovery.

Lastly, the geographically isolated State hospital offers little challenge to the medical student from the standpoint of teaching, research, or private practice. As modern medical education evolved, doctors received their basic education and first practical experience in medical schools and affiliated teaching hospitals, where the older men and the young men, working in stimulating competition, perpetuated the tested truths, discarded the tried but untrue, tested out new theories and techniques. Medical schools, their hospitals, and their laboratories, became predominantly interested in internal medicine, surgery, pathology, bacteriology, physiology, and eventually radiology. Psychiatry for a long time existed, quite literally, on the lunatic fringe.

Thus, State hospitals found themselves without influence in recruitment and replacement. From a distance, the average medical graduate saw them as peculiarly repelling institutions. The bulk of energetic young doctors—it has been generally observed—turn to areas and techniques in which they believe they can do something tangible for patients, or otherwise satisfy themselves in careers as teachers and scientists. They develop their interests for a blend of reasons—professional, personal, scientific, practical, humanitarian, economic. Not the least is the satisfaction of seeing the good they can do for their patients. Hospital psychiatry has lagged in these kinds of motivation. The pill and the scalpel have more appeal.

It was in this same period that the first American volunteer movement against mental illness came into being (1880). The National Association for the Protection of the Insane and the Prevention of Insanity, an offspring of the National Conference of Social Work, composed mainly of reform-minded psychiatrists, neurologists, and

social workers, attacked Dr. Gray and asylum evils in general. It thus invited the antagonism of the Association of Medical Superintendents of American Institutions for the Insane, the parent organization of the American Psychiatric Association. The public likewise rejected the new organization's efforts to obtain support; these new friends of the insane disappeared in friendless fashion some four or five years later.

Remote history? Not at all. As the demand for the Mental Health Study Act of 1955 implied, and as our subsequent review of the Joint Commission's monograph studies will show, mental illness has a way of dragging its lengthy history and its unsolved problems across the doorstep of the present.

By the beginning of the twentieth century, the profile of the "State asylum for the incurably insane" was stereotyped, both professionally and socially—it was an institution where hopeless cases were put away for the good of society. Psychiatry, as a descriptive science, was well launched, but with pessimistic overtones. Dr. Emil Kraepelin had described the most common functional form of psychosis as dementia praecox, or *early* dementia (now called schizophrenia); he held such disorders to be essentially incurable. Thus, science seemed to have confirmed what society already believed. The circle of rejection was complete.

Mental hospital superintendents who saw patients accumulate and continue to live their lives out in locked wards became steeped in this negative outlook. Far from feeling they had failed in a social and a medical responsibility, these first psychiatrists apparently were satisfied that they were fulfilling the mission that the State had assigned them. This was to take custody of any and all persons committed to their institutions by the courts and thenceforth guard the public and patients against the latter's irrational acts, if any. The superintendents' primary responsibility ended, under State laws, with keeping the mentally ill alive, the emphasis being on physical rather than mental well-being. For example, if the patient would not eat, he was force-fed; but if he would not talk, it was not considered important to encourage him to do so.

Dr. Francis Peabody (1927) observed that, "The secret of the care

of the patient is in caring for the patient." The medical superintendents of mental hospitals have been geographically, politically, and philosophically isolated from the main body of the medical profession and from its humane and healing traditions. They have borne much harsh denunciation and, in the spirit of self-examination, sometimes even have invited outside criticism. In "A Critique of Psychiatry," delivered on the 100th anniversary of the American Psychiatric Association, the late Dr. Alan Gregg (1944) was not harsh but understanding:

> No other specialty of medicine has had a history so strange, nor a relation to human thought so intimate as psychiatry. The three most powerful traditions or historical heritages of psychiatry are still, as they have been from time immemorial, the horror which mental disease inspires, the power and subtlety with which psychiatric symptoms influence human relations, and the tendency of man to think of spirit as not only separable but already separate from body. These are the inveterate, the inevitable handicaps of psychiatry. . . .
>
> Yours has been a long struggle waged with patient heroism, none the less admirable for being at times perhaps despondent and bewildered. Nor is it as yet a battle fully won. So-called mental diseases are still regarded by mankind with fear, aversion and ostracism, and society still pays the inexorable penalties of him who fights and runs away, and so might fight another day.

MENTAL HYGIENE: DIVERSIONARY MOVEMENT OR ACTION GROUP?

The history of the National Committee for Mental Hygiene, forerunner of the National Association of Mental Health, may be taken as a further illustration of Gregg's last point. Any number of mental health workers have pondered why the mental hygiene movement did not *move* with the times as did other voluntary health organizations which have grown and come into the public eye as action groups. The answer, according to our analysis, lies in the rejection phenomenon as it extends itself into the problem of organizing and leading a public attack on mental illness.

It is apparent that one characteristic of most health movements is a *strong public pressure group,* voluntarily organized by professional persons and laymen with mutual respect for one another, and exist-

ing for the purpose of stimulating public action to solve the problem it is concerned with. Such a group, possessing great singlemindedness of purpose and some of the more constructive characteristics of the watchdog and gadfly, has been as necessary for the control of mental illness as for the fight against cancer, tuberculosis, poliomyelitis, or heart disease.

The success of a national voluntary health organization in our culture inescapably depends on the use of techniques well known to American business—strong individual leadership, aggressive organization, well-defined policy, sharp focus of goals, personal salesmanship, much publicity, and large income. Leaders in psychiatry and mental health have regarded some of these techniques as objectionable. The techniques for public education may give rise to anxiety (an almost universal symptom in mental illness) and to obsessive overemphasis. An intelligent balance in the three main elements of voluntary health movements—service, education, and research—is presumably achievable, however.

Only in the last few years has the voluntary mental health movement displayed any eagerness for a well-rounded public program focusing on the "core problem" of major mental illness. This recent shift in emphasis may be seen, to take one example, in the independent National Mental Health Committee's change of name to the National Committee Against Mental Illness. But whether the movement is "for mental health" or "against mental illness," the difficulty of overcoming rejecting attitudes, and society's tendency to run away from the primary problem, remain today fundamentally the same as they were in the time of Clifford Whittingham Beers (1876–1943).

Beers, a Yale graduate from a respectable New Haven family, had the misfortune to become a patient in two private mental hospitals and one State hospital during a three-year period, between 1900 and 1903, and thus had an opportunity to experience the brutality against violent and disturbed patients condoned by some hospital physicians and practiced by many attendants.

Beers' manic-depressive psychosis began in his late teens with the obsessive fear that he would develop epilepsy (an older brother had been diagnosed as having epilepsy but actually died of a brain tumor).

In his early twenties, Beers attempted suicide by dropping from his fourth-story bedroom window, and was thereafter institutionalized, with the delusion that he had been arrested and would be tried for his "crime."

He was choked and thrown about at various times and kept in prison-like cells in a painfully uncomfortable strait jacket. He spent twenty-one successive nights and parts of the intervening days thus physically bound.

His capacity to provoke and take punishment was as incredible as the method in his madness. He determined to gather evidence, write a book exposing mental hospitals, and launch a reform. He informed his keepers of his plan and warned them that he would overthrow the system and put them in jail. He did ingeniously succeed in evading censorship and in getting to the Governor of Connecticut a 4000-word letter written in India ink on thirty-two sheets of heavy drawing paper. Wrote Beers (1921, pp. 198–99):

> I have decided to devote the next few years of my life to correcting abuses now in existence in every asylum in this country. I know how these abuses can be corrected and I intend—later on, when I understand the subject better—to draw up a Bill of Rights for the Insane. Every State in the Union will pass it, because it will be founded on the Golden Rule. I am desirous of having the co-operation of the Governor of Connecticut, but if my plans do not appeal to him I shall deal directly with his only superior, the President of the United States. When Theodore Roosevelt hears my story his blood will boil. . . .

Nothing much came of this first wild shot, fired from within a State hospital, but finally Beers was paroled and later discharged. He got his Wall Street job back and spent several years writing a book, published in 1908. This book, *A Mind that Found Itself,* has become a classic in the literature of social reform and muckraking, akin to such books as *Les Miserables, Oliver Twist,* and *Uncle Tom's Cabin* (Beers' acknowledged model).

In his book, Beers stated that "madmen are too often man made," another early recognition that the deprivation of personal dignity and individual rights commonly occurring in locked-ward hospitals may upset and infuriate a psychotic patient as much as it would a normal person.

Beers' manuscript, his energy, and his enthusiasm attracted Dr. William James, the great psychologist, Dr. Adolf Meyer, the leading American psychiatrist of that day, and Dr. William H. Welch, "father of American pathology." The result was the formation, in 1909, of the National Committee for Mental Hygiene, with Beers as secretary and these doctors and other prominent citizens as officers.

Beers' passionate interest, as we have seen, was aimed at improving the *care* of the mentally ill. But his doctor friends of those days were more interested in the possibilities of *preventing* mental illness, inspired by the examples set in the control of epidemic diseases through sanitation and immunization. No equivalent techniques were available in psychiatry, but public education in such matters as child guidance, birth control, eugenics, and early treatment for emotional disturbances were seen as logical approaches.

Beers apparently was persuaded of the superiority of the preventive approach, particularly when psychiatrists told him that early treatment might have prevented his major breakdown. The thinking of the founders of the National Committee for Mental Hygiene can be discerned from the words of Dr. Llewellys F. Barker, an internist and one of the organization's early presidents:

> The general problems of mental hygiene become obvious; broadly conceived, they consist, first, in providing for the birth of children endowed with good brains, denying, as far as possible, the privilege of parenthood to the manifestly unfit who are almost certain to transmit bad nervous systems to their offspring —that is to say, the problem of eugenics; and second, in supplying all individuals, from the moment of fusion of the parental germ-cells onward, and whether ancestrally well begun or not, with the environment best suited for the welfare of their mentality (Beers, pp. 297–299).

As time went on, the National Committee for Mental Hygiene distinguished itself for its pioneering efforts in establishing mental hygiene and child guidance clinics, generally accepted as appropriate means of instituting early treatment of mental illnesses (secondary prevention) and as vehicles of public information about emotional disturbances. But while the Committee fostered introduction of the statistical reporting on mental hospitals and their patients and initi-

ated a mental hospital inspection service, it did not become the dynamic reform group that Beers had envisioned.

Until after World War II, there was little effort toward organizing the American volunteer public for aggressive, nationwide action in behalf of the mentally ill. Beers had the idea of establishing "aftercare of the insane," a program of voluntary service to patients about to be discharged from mental hospitals and thereafter to help them with their jobs and social relations. Some such efforts, some excellent and some of questionable value, now have been made, but attempts to organize former mental patients in groups comparable to Alcoholics Anonymous, for instance, remain singularly unsuccessful for the most part (as Charlotte Schwartz and her associates have made clear in the expatient section of *New Perspectives on Mental Patient Care*).

In the last few years, the principal legatee of the mental hygiene movement, the National Association for Mental Health, has shown some disposition to revive Beers' basic idea of a crusade in behalf of mental patients, as may be gathered, for example, from a poster plea of the N.A.M.H. that the public not turn its back on the mentally ill.

Our major criticism of the orientation of the mental hygiene movement toward prevention of mental illness is that, while its views (as stated above by Barker) contain some broad biological truths, these truths are too diffuse for scientific application to human beings in a democracy. In 1960, we are no closer to predetermining reproduction of "good brains," or to identifying the "manifestly unfit." Mental illness strikes in some of the *best* families as well as the *worst*. Furthermore, some of our most original and creative thinkers have had bad nerves or disturbed minds. Even if we could agree on what kind of men and women we wanted to produce, we could not predict the outcome in a given family due to the multiplicity of uncontrolled variables—such as the mathematics of inherited characteristics. Thus, primary prevention of mental illness has remained largely an article of scientific faith rather than an applicable scientific truth.

Nor have we as yet been able to control, or even agree on, a proper

mental environment for our children. In the years between the beginning of the mental hygiene movement and the present it has become increasingly apparent that raising children so as to prevent major or minor mental illness is not the same as, but a more complex order of achievement than, preventing diphtheria by building antibodies or preventing rickets with Vitamin D. Robert C. Hunt (1958) put it this way: "Our hopes of preventing mental illness by mental health education and child guidance clinics have been disappointed, and there is no convincing evidence that anyone has ever been kept out of the state hospital by such measures. . . ."

LEADERS, FOLLOWERS, AND THE IDENTIFICATION PROBLEM

To advise society not to turn its back on the mentally ill begs the question of why it has insisted on doing so—even, it would appear, in the mental hygiene movement itself. Adolf Meyer proclaimed Clifford Beers as "at last what we need: a man for a cause." But Beers, who accepted the risk of identifying himself as a mental patient and published a book bristling with new hope and fighting spirit, was unable to arouse the public to follow him in a strong movement for better care of mental hospital patients, although he continued as secretary of the National Committee for Mental Hygiene until his death in a mental hospital in 1943. Nor has any person—layman or doctor—since Beers been able to organize the crusade he envisioned, a crusade which by modern standards would require a national organization, a vast field army, a multimillion-dollar fund-raising capacity, and, ideally, a program effectively combining service to patients with public and professional education and scientific research. In other words, a campaign commensurate to the size of the problem, or second to none. The strength of a leader, in the last analysis, can be measured only by the number he can induce to follow him in the cause he represents.

How, then, is one to achieve the necessary identification with the mentally ill?

Those well acquainted with the mentally ill and with attitudes

toward them will recognize this as a critical question. Bockoven, in the *Journal of Nervous and Mental Disease* (1956), appears to be one of the few to have pinpointed this issue. "Social progress is usually made through the organized efforts of those who themselves are the victims of deprivation. The very essence of mental illness, however, is an incapacity to get along with other people, hence organization behind a leader is impossible. The friends or relatives of the mentally ill are equally immobilized through fear of stigmatizing themselves."

When the National Foundation for Infantile Paralysis, subsequent to the development of the Salk vaccine, sought new health worlds to conquer, Mr. Basil O'Connor in a press interview agreed that mental health was a possibility. This led to a great deal of gossip in mental health circles, and to the frequently expressed hope that at last the movement against mental illness would have the benefit of driving leadership, strong organization, and a "success" formula. In 1958, however, the Foundation re-formed simply as the National Foundation and broadened its interests to include not only polio and other virus infections but rheumatic diseases and birth defects. Once more, the public—in this case the polio public—turned its back on mental illness. The National Foundation's reasoning was as follows:

> Mental health was considered. Tremendous pressure was brought to make this the extension of program, for the need is admittedly great. Yet of all the extensions of program considered, mental health proved to be the most difficult to develop. It would make minimal use of the scientific skills the National Foundation's grantees had acquired. The almost total absence of professional personnel required for treatment in local communities, and the need for a volunteer group substantially different in composition from those who were primarily responsible for making the National Foundation what it is today, would make for an organization so different in character that there was serious doubt whether it was wise or feasible for the organization to undertake the mental health proposal at this time (National Foundation for Infantile Paralysis, 1958).

Who *will* fight the battle for the mentally sick? Psychiatrists, who have lived with the problem, might be prone to say that is precisely what *they* have been doing—they and their associates in allied professions. They accept responsibility for looking after the mentally ill.

Had they been wholly effective, of course, the mandate for this Mental Health Study would not have materialized.

Where have they failed?

In general, it can be said that psychiatry does not produce strong leaders of the kind necessary for aggressive public action; the kind common in industry, politics, and, of course, war. We do not need to look far for reasons. The psychiatrist by nature is not an organization man but a clinician, accustomed to the one-to-one relationship of doctor and patient, where he is commonly inclined to play a permissive, nondirective role. Further, as a scientific student of many unresolved questions of cause and effect in human behavior, he may be hesitant to assert or commit himself except in small professional groups where he is fairly sure of mutual respect. In public life, he must be prepared to court criticism, and even ridicule.

One primary characteristic of a strong leader is a willingness to commit himself to a position and pursue a course of action consistent with his stand, whatever the risks. To be sure, many psychiatrists are able administrators in their own hospitals, where their authority is uncontested, and their success is not ordinarily subject to annual review in terms of profit or loss, victory or defeat, or of beds filled or emptied. But no psychiatrist has stepped forth, in behalf of patients, to provide national leadership for an aggressive, national, voluntary campaign against mental illness. Rather, the attitude of psychiatry toward the voluntary mental health movement has been one of passive participation and mixed hope and fear; hope that a leader, psychiatrist or layman, would emerge, but fear that, if he did, he might become *too powerful* or do the *wrong thing*. In short, it seems fair to say that psychiatrists have not previously wanted strong leadership at the public level of effort.

THE CIRCLES OF REJECTION: PUBLIC ATTITUDES

If we search our souls, we may find another reason for our past disinclination to do such searching in public. This is the inescapable conclusion that none of us are wholly immune from the rejection phenomenon, although some of us perceive the problem clearly

enough to be challenged by it and are stimulated to seek its solution. We can approach this, as we see it, all-encompassing dilemma from the innermost circle—the patient—or from the outermost circle —people in general. (Mental patients commonly manifest rejecting attitudes toward themselves—in anger turned inward, in fear of their own acts, in self-destructive tendencies, in self-denunciation, and in frank contempt toward themselves.)

We have documentation on modern public attitudes regarding mental illness from two sources outside of the Mental Health Study: A study by Drs. J. C. Nunnally and C. E. Osgood and their staff in the Mental Health Project, Institute of Communications Research, University of Illinois (1960), and a study by Dr. Shirley Star of the National Opinion Research Center, University of Chicago.

The results of a questionnaire survey conducted by the Illinois group in Champaign-Urbana, Illinois, Nashville, Tennessee, and Eugene, Oregon, confirm what we had every reason to suspect—the general public regards the mentally ill with fear, distrust, and dislike. This applies both to psychotics and neurotics, but psychotics are held in lower esteem than neurotics because they are more unpredictable in their behavior. The survey found that there is a small but significant tendency for better educated persons to hold less derogatory attitudes toward the mentally ill, although it is not sufficiently favorable for us to assume that educated persons find the mentally ill appealing to them.

The public, the study found, has moderately favorable attitudes toward psychologists, psychiatrists, and psychoanalysts, with little or no differentiation between psychiatrist and psychologist. However, it regards physicians, nurses, and others who treat "physical" problems with much higher favor. The authors deduce that any word containing "psych" or "psycho" to some extent stigmatizes the professional as well as the patient. This could indicate that the mental health worker's emphatic preference for the word "psychotic" as against "insane" has availed little in improving attitudes toward the mentally ill. It also would indicate the futility of further attack on lay terms.

The Joint Commission staff has had access to Dr. Star's unpub-

lished monograph, *The Dilemmas of Mental Illness*. Her findings in a nationwide sampling survey support the Nunnally-Osgood evidence of the public's aversion for mental illness. She goes farther, however, in indicating how people manage to live with the mentally ill and still not be unduly fearful of the consequences.

Star found that only the most extreme forms of mentally ill behavior (severe forms of psychosis) are recognized as such by most people. The tendency is to resist calling anyone "mentally ill," and to do so more or less as a last resort.

She tested the attitudes of 3500 interviewees on the basis of their reactions to six types of cases presented to them. In order to demonstrate the wide range of deviant behavior readily recognizable to experts but not to laymen as mental illness, we repeat her descriptions here, as she gave them:

Paranoid Schizophrenic. I'm thinking of a man—let's call him Frank Jones—who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks people he sees on the street are talking about him or following him around. A couple of times now, he has beaten up men who didn't even know him, because he thought that they were plotting against him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her, because, he said, she was working against him, too, just like everyone else.

Simple Schizophrenic. Now here's a young woman in her twenties, let's call her Betty Smith. . . . She has never had a job, and she doesn't seem to want to go out and look for one. She is a very quiet girl, she doesn't talk much to anyone—even her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and daydreams all the time, and shows no interest in anything or anybody.

Chronic Anxiety Neurotic. Here's another kind of man; we can call him George Brown. . . . He has a good job and is doing pretty well at it. Most of the time he gets along all right with people, but he is always very touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about little things, and he seems to be moody and unhappy all the time. Everything is going along all right for him, but he can't sleep nights, brooding about the past, and worrying about things that *might* go wrong.

Compulsive Phobic. Here's a different sort of girl—let's call her Mary

White. She seems happy and cheerful; she's pretty, has a good enough job, and is engaged to marry a nice young man. She has loads of friends; everybody likes her, and she's always busy and active. However, she just can't leave the house without going back to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one other thing about her: she's afraid to ride up and down in elevators; she just won't go any place where she'd have to ride in an elevator to get there.

Alcoholic. How about Bill Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking, and never seems to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

Behavior Disorder. Now, the last person I'd like to describe is a twelve-year-old boy—Bobby Grey. He's bright enough and in good health, and he comes from a comfortable home. But his father and mother have found out that he's been telling lies for a long time now. He's been stealing things from stores, and taking money from his mother's purse, and he has been playing truant, staying away from school whenever he can. His parents are very upset about the way he acts, but he pays no attention to them (*Confidential Forecast,* 1952, pp. 4–5).

The interviewees were asked to state, in each case, whether there was anything wrong with the person and if so, what. Was it mental illness? Was it serious?

Only in the case of the paranoid schizophrenic was a majority (75 per cent) of the people interviewed able (or willing) to recognize mental illness. In the other five instances, the recognition ranged from 34 down to 7 per cent; the majorities found nonstigmatizing, "natural" explanations for the behavior.

Star drew a sharp contrast between these findings and data in another part of her survey demonstrating that "the average American adult knows that mental illness can be treated and knows that its treatment involves special facilities—psychiatrists and institutions. . . ."

What the study found was a kind of lip service being paid mental health information to the effect that psychotics *are* sick and *are* treatable, but behind this, a rejecting attitude toward patients and toward treatment. She observed: "There is a consistent tendency to belittle the serious and deep-seated nature of neuroses and emotional disturb-

ances other than psychoses, and an equally consistent tendency to exaggerate the seriousness of psychoses. . . . The basic assumption is that the neurotic individual, unlike the psychotic, is able to profit from rational advice. The 'neurotic' is looked upon with moral disapproval; the psychotic, as 'dangerous.' "

Sixty per cent indicated that they would not feel or act normally toward an ex-mental patient. The prevalent attitude of rejection became more complete in that "relatively few people thought of psychiatry as something which had any relevance for themselves or for the kind of people they knew," and that "people almost invariably associated the practice of psychiatry with the treatment of noninstitutionalized patients rather than with mental hospitals."

Combining our earlier comments about the typical nontherapeutic State hospital with this last observation, we may surmise that the American people, though uninformed about psychology and psychopathology, and not helpful to the mentally ill, manifest a certain amount of practical sense. They do not like to think of mental illness, even in others; they do not like to think of themselves or anyone else as needing a psychiatrist; they have found no reason to regard mental hospitals as places of hope. Above all, as stressed by Drs. Elaine and John Cumming in *Closed Ranks* (1957), is the importance of maintaining order in one's life. The Cummings conceive the secret of people living together in normal, everyday life as this: "Most of the time most of the people will want to do what they have to do."

Psychiatry has intensively concerned itself with the precise description and theoretical explanations of the psychotic process in the schizophrenias for the last seventy-five years. Little can be said that psychiatry has not thought of on this subject, but it has looked at the problem of mental patient care from the standpoint of the patient; more precisely, from the standpoint of the doctor of a sick patient who, in his symptoms, is not so different from many of his fellow humans. Psychiatry has tried diligently to make society see the mentally ill its way, and has railed at the public's antipathy or indifference. Wise men long have counseled that when a problem cannot be attacked frontally with good results it should be turned around

and viewed from the opposite side. We in the mental health professions have proceeded as if society were unreasonable in its attitudes toward the mentally ill, when, as it reacts to them, it is quite reasonably engaged in its first order of business—making people want to do what they have to do.

REJECTION BY THE LEARNED

There is still another aspect of people's ubiquitous will to reject not only the mentally sick but also the idea of a mental as opposed to a physical illness. This deals with the resistance that many persons, sometimes mental health workers themselves, experience in thinking about mental or psychological processes.

Doctors in other branches of medicine commonly evince an antipathy for psychiatry and psychiatrists. Medical education, in its traditional approach, has been basically anatomical and physiological and oriented toward quantification. There is evidence, for example, that general practitioners, the largest group in the medical profession, frequently extend this aspect of rejection of the psychological to patients whose illnesses are centered in thoughts and feelings that cannot be visually examined, palpated, heard through a stethoscope, counted on a glass slide, or captured in a test tube, but which must be ascertained mainly through interpretation and evaluation of what the patient says and how he behaves.

In an analytical study of North Carolina general practice, reported in the *Journal of Medical Education* (1956), Dr. Osler L. Peterson and his associates found that only 17 per cent of the doctors investigated recognized emotional problems in their patients and treated them with sufficient competence to demonstrate a grasp of treatment methods. Another 54 per cent recognized emotional problems but did not attempt psychological treatment or treated physical aspects of the complaints only; a final 29 per cent did not generally recognize emotional problems or attempt to treat them. Commented the investigators:

> Emotional problems appear to constitute an enigma for the practicing physician; many physicians completely failed to recognize these problems in their

practices. Others, while recognizing the problems, were either indifferent to them or appeared to be made uncomfortable by patients with such problems. References to malingering, hypochondriacs, "problem patients" or "getting them out of the office quickly" were frequently heard, all indicating that some physicians were not prepared to deal sympathetically with these patients.

What do we find when we narrow the circle of rejection to psychiatry itself?

In the minds of the reading public, it would appear that *psychiatrist* is almost synonymous with *psychoanalyst.* This, however, is far from the case, and some clarification is needed here. Psychoanalysis is a subspecialty of the specialty of psychiatry, the branch of medicine concerning itself with the diagnosis and treatment of mental disorders. Of the nation's nearly 12,000 trained psychiatrists, only 850 are qualified psychoanalysts.

As introduced by Dr. Sigmund Freud, psychoanalysis in its original and restricted sense means a method of psychotherapy applicable to certain emotional disorders, broadly the *neuroses.* Neurotic behavior is commonly attended by some sign or symptom of anxiety, open or disguised. Psychoanalysis at the same time provides a technique for investigating the deeper mental processes underlying memories, thoughts, feelings, impulses, habits, and the like. Lastly, psychoanalysis describes the total body of knowledge created by the application of this therapeutic and research tool, and in this sense connotes "the science of the unconscious."

The psychoanalytic method of treatment depends upon communication of thoughts and feelings through the free association of ideas. The aim of the psychoanalysts is to enable the patient to "re-live" (recall to mind) and "work through" (resolve) distressing events in his life that have apparently interfered with the development of his personality. This involves bringing into the patient's consciousness emotions of which he previously was unconscious. He thereby may gain better control of himself.

Psychoanalytic treatment has many limitations. It is time-consuming, requiring a minimum of four treatment hours a week for a period of four or more years. It is necessarily expensive because of the amount of professional time required for each patient. The practicing

psychoanalyst can treat only a few patients on a closely ordered schedule of office visits, imposing an inflexibility that makes it difficult, if not impossible, for him to answer emergency calls as the conventional "good physician" feels himself obliged to do. Other physicians send psychoanalysts many mentally ill patients not suited for psychoanalysis; when the analyst faces this fact and turns down the patient, he is not apt to win the applause of the referring physician, who may not fully appreciate that the psychoanalyst cannot adhere to the principle of medical ethics requiring that all patients be seen and cared for whether they are treatable and curable or not. Lastly, while any informed observer will recognize the stimulation and fund of useful information psychoanalysis has contributed to our understanding of the human mind, its emotions, and its motivations, the results of psychoanalytic treatment, as of other forms of psychotherapy, are difficult to measure in any scientifically objective manner. Usually, the patient completing treatment feels he has been helped.

In sum, then, psychoanalysis is adapted neither to the treatment of the psychoses nor to mass application of any kind. It is principally effective for a limited number of carefully selected patients who are not totally incapacitated by their illness and do not require hospitalization. It is the preferred treatment for adult neuroses and for some children with severe deviations in their personality development. The fact that psychoanalysts have influenced literature and education and have enjoyed considerable popularity among the intelligentsia plus the fact that they are not interested in and offer little help or hope for the psychotic quite possibly has had the side effect of reinforcing the fatalistic attitude toward mental patients requiring hospitalization, thus seemingly deepening rather than lifting the heavy atmosphere of social rejection.

What is true of psychoanalysts, who are small in number, is in varying degrees true of the two-thirds of all psychiatrists who engage in private practice and use forms of psychotherapy not involving psychoanalysis. While an increasing number of psychiatrists divide their time between private and public psychiatry (by working part time in public mental health clinics and public mental hospitals), the fact remains that a large proportion of all psychiatrists devote the greater

portion of their time to their own practice and there, to a great extent, concentrate on the minor and more easily treatable kinds of mental illness, as do psychoanalysts. The private psychiatrist often acts in relation to major mental illness in the same fashion as would a general practitioner or a policeman; as a transmitting agent in moving patients with acute psychotic breakdowns out of the community and into institutions.

In some instances, the private psychiatrist may treat psychotic patients in the psychiatric wards of general hospitals or in private mental hospitals with techniques such as electric or insulin shock and drugs as well as psychotherapy. General hospitals in increasing numbers are admitting short-term mental patients. This is all to the good as long as the patient responds to early and intensive treatment; but if he does not, or if the family's financial resources are exhausted during the early treatment phase, the customary rejecting and dumping effects resume. The sick person winds up in that vast part of the mental patient population attended by the smallest number of psychiatrists—the State hospital population. The vast majority of those most seriously ill, in other words, collect in institutions least able, in ratio of physicians to patients, to provide psychotherapy or *any* form of psychiatric service conducive to their recovery.

A few public mental hospital physicians, who total about 3750, have been brave enough to comment on this dual system of psychiatric care and its effects. For example, Bockoven (1956), invites the ire of his colleagues in private and mental hospital practice by stating flatly that they contribute to the stigma of mental illness:

> The irony of the psychiatric profession today is that it subscribes to the great therapeutic value of dynamic psychiatry in mental illness yet fails to apply its principles in the care of those who are in the greatest need: namely psychotic patients legally confined in our mental hospitals. This failure is largely based on indecision as to the curability of psychosis. The stigma of hopelessness associated with psychosis in the public mind is, to be sure, sorely lamented by psychiatrists. Nevertheless by their own actions they contribute to the stigma by handling psychotic patients as intractable prisoners incapable of benefiting from *any* treatment. The very fact that such a method of handling predominates throughout the world strongly suggests that psychiatrists themselves harbor belief in the very stigma they would remove from society by public

education. Such a discrepancy between what is preached and what is practiced does not bespeak cynicism in the profession but rather a lag in the spread of newer knowledge from research and teaching centers which do the preaching to the outlying mental hospitals which receive the vast majority of patients.

Hunt (1956, p. 19) reduces the circle of rejection to the medical superintendent of the public mental hospital himself, he being the final person to accept responsibility for the care of psychotics:

> How often we have preached to the public that the mentally ill are simply sick people, that there should not be any stigma attached to the illness, that they should be treated with human kindness and dignity and be provided with good treatment facilities. Then after the meeting, we go back and make rounds through the wards checking to make sure that there has been no break in the security measures. It is largely futile to go on preaching tolerance as long as we practice intolerance in our own institutions. It cannot be very convincing to tell people that the mentally ill *ought* to be treated like normal human beings until such time as we are able to show in our daily practice that they *can* be so treated.

WHY WE REJECT PSYCHOTICS

Two summary points remain to be made. Unless we become conscious, at an action level, that these points are of critical importance in the lag in the care of the mentally ill, we have little hope of overcoming them.

The points are that (1) people find it difficult to think about and recognize psychological illness as illness, or to see sickness as having psychological forms, and (2) the mentally ill as a class lack in capacity to evoke sympathy, which is to say that they are overburdened with liabilities as persons and as patients.

To elaborate our speculations on the first point:

Man is prima facie an outward-looking, thing-oriented creature, the man of medicine or science not excepted. From birth, our minds learn about the world around us by physical contact, first through our skins and then through physical objects that we can see, touch, hear, taste, or smell. Most of our tools are eye-and-hand or eye-hand-and-ear extensions of our brain, which itself operates as a master control, using our unique human intelligence principally to think

about picturable, tangible, concrete, measurable, recordable things. Even the atom and molecule, too small to be seen or touched, are visualized, measured, and diagramed as quantitative things.

Recent anthropological and neurological evidence tends to bear out this view of man as an observer and manipulator of concrete things. The more intellectually felicitous assumption that the human brain evolved from that of the man-like apes and *then* created tools has been upset by discoveries indicating that some of the prehistoric walking apes used stone tools in the absence of human cranial equipment; Stone Age man in the course of evolution as a human being brought his tool kit with him, so to speak. The significance of this new evidence is apparent, for it clearly suggests that continued use of tools may have conditioned the way in which the human brain developed (Sherwood L. Washburn, 1960). This interesting deduction gains some support from the distinguished work of Dr. Wilder Penfield and his group at the Montreal Neurological Institute. Their mapping of the sensory and motor cortex of the human brain has disclosed that areas devoted to the function of the hand and five fingers exceed those for the entire body excepting the mouth. It would seem that in the mental capacities for moving and feeling man is figuratively all hands and mouth. He would seem much better equipped for controlling his environment than himself; this interpretation is borne out, of course, by the greater advancement of the physical and mathematical sciences in comparison with the behavioral and social sciences and the fact that the most crucial questions of the day, the fate of civilization and of mankind, involve psychological and social conduct, which is to say, they are questions of intellectual and emotional maturity.

Having shaped itself to this system of objectification, even the educated mind may find it extremely difficult to think in a detached manner about itself and, similarly, to think objectively about another mind's thoughts. As Albert Einstein expressed it: "What does a fish know about the water in which he swims all his life?" The difficulty can be and is being overcome, but against great odds, it would appear, for the mind seems to resist the process, as if in the universe of knowledge, with all its variables, it was the one constant—fixed, dependable,

invincible, *sane*. In any event, education of the average man as a practical matter appears to favor greater understanding of matter than of mind. Most of us are in this way psychologically handicapped persons, mentally blind to our physical bias.

As to the second point, we can see a full circle of explanations of why people reject the mentally ill, particularly psychotics. These are of a kind that have shaped public attitudes, and include alienation, indigency, and irresponsibility (witness the old Yankee term "Foreign pauper insane"). They also have shaped the attitudes of the medical and other learned professions, both because of "thing orientation," or the bias toward organic thinking, and because of limitations in specific diagnostic and therapeutic knowledge.

The mental patient often presents himself as "stubbornly ill" and an "uncooperative patient," a final dimension of the phenomena resulting in rejection.

As the mental hospital often notes upon admitting a patient, it is not so much the symptoms themselves that bring him to book—there are many people in the general population who have equally strange symptoms—but that his behavior has reached a point where people no longer can stand it. It is not so much that he physically endangers them (though they may fear this); violence is more the exception than the rule among psychotic patients, popular misconceptions to the contrary. Basically, normal people are disturbed by his refusal to comply with expectations of time and place.

As Schwartz points out, the mentally ill tend to require other people to adjust *to them* at every point in their illness from onset to recovery. They resist change for the better, often, and are difficult to work with in a systematic, efficient manner. Psychiatrists, learning in training full well that schizophrenics constitute the most challenging problem in their field, have set out in practice to devote their attention to psychotics only to find they cannot take them, at least not as a steady practice; the patients prove to be *too wearing, too trying, too tiring*. Thus, even the most conscientious and devoted doctor may turn his back on them, meanwhile feeling guilty about doing so and thus the more defensive when others look to him for leadership in solving the problem of this class of the mentally ill.

It should now be clear that one way around the impasse of public and professional attitudes that we appear to have erected would be to emphasize that persons with major mental illnesses are in certain ways *different* from the ordinary sick. Information embodying this new emphasis would require an explanation of why they are different and also an explanation of why society behaves as it does toward the mentally ill. With such an understanding, it might then be possible to proceed in the light of fuller reason to adopt more helpful attitudes.

IV

Some Significant Findings Relating to Recognition of Mental Health Problems, the Demand for Treatment, and Its Supply

THE PROBLEM that plagues us in the mental health field, as we have analyzed it in the preceding chapter, is to help a class of persons lacking in human appeal and humanly neglected because of this lack of appeal.

These persons are "sick" for physiological, psychological, and sociological reasons so closely intertwined that so far science has been unable to unravel the causes and establish their relative importance. Thus it is that we witness, and must perforce applaud, research in the causes of the psychoses as far ranging as studies of mother love, the baby's physical contact with mother objects, analysis of the blood of schizophrenics, and exploration of the molecular structure of their brain cells.

It is characteristic of psychotic patients that they do not behave as ordinary sick persons, who, feeling helpless, turn to others for help and, receiving help, are responsive to it. Commonly, the acutely ill psychotic does not appear to want help or expect help but, quite the reverse, thinks he is not sick, and may believe he is being harmed. Often, he *is* harmed, by the process of rejection that reaches its epitome in the traditional State hospital system. Both he and his fellow men appear generally unaware of their pantomime of action and re-

action, provocation and retaliation, leading inescapably to his alienation from society.

It is commonly stated, on the basis of certain surveys, that one in ten people is mentally ill. This refers to mental illness in all forms, major and minor, and includes much mental illness that is not recognized and treated as such. When the number of mentally ill is limited to those coming to professional attention with symptoms disruptive enough to result in diagnosis and hospitalization (and thus to be caught in the rejection network), the ratio is perhaps about one in 100. Lacking in effective moral strength and medical means to help this one person in 100, society has organized itself out of primary concern for the 99 who behave in tolerable fashion or are cast in such circumstances that they do not disturb the peace of their fellow men sufficiently to acquire the mental patient label. This attitude is not out of line with what we know of conservation among other living organisms; the weak members are sacrificed for the good of the strong. This does not mean, however, that human society—either lay or medical—would hesitate long in modifying the pattern of exiling the psychotic or otherwise socially unacceptable patient from normal human conditions if it were presented with a more effective, more desirable alternative. We would then find it wholly feasible to adopt a more positive attitude about mental illness.

We would be blind to the signs of our times, on the other hand, if we did not recognize the growing conviction of the last few years that a more effective and desirable alternative does exist, even in the absence of any scientific breakthrough in the matter of causes and cures. Furthermore, there are indications that a more positive attitude toward persons with psychological problems is emerging, at least among some people of importance in shaping public opinion.

Actually, there is a wide variety of experience to show that the negative attitudes of the American public toward the mentally ill are not absolutes and need not be accepted as insurmountable roadblocks. In the mental health professions we have evidence that some therapists can work individually with psychotics more effectively than others, as shown in the Whitehorn study, and we have evidence that social treatment of psychotics also gets results, as shown in the work

of Schwartz, Greenblatt, and others. Above all, we have good evidence that the tranquilizing drugs make mental hospital patients easier to work with and live with. We cannot say that the therapeutic task is simple or easy, and yet therapists or therapeutic teams who are unafraid, and who refuse to be overwhelmed by the patients' rejection of *them,* are having successes every day in the treatment of these "impossible people." The secret seems to be that the therapist or the team has to be stronger and more durable and stubborn than the patient, and meanwhile receive strong supervisory support and counsel. Indeed, what it takes to produce improvement or recovery is great self-confidence, responsiveness to challenge, enjoyment of a contest, and a different kind of incurability—incurable optimism.

We need not regard the behavior of the psychotic patient as too much even for the untrained layman to withstand. Evidence that rejection is not an inescapable attitude, but is something that we acquire and therefore can modify through greater understanding, can be dramatized in the elaboration of one example out of many. This one comes from the Metropolitan State Hospital in Waltham, Massachusetts, where volunteer students from Harvard, Radcliffe College, and Brandeis University have been working with chronic psychotics on an organized basis for six years. The work has taken two forms, ward improvement and individual case aid, and to date has involved upwards of 1000 students who during the college year have spent a half day each week with patients in the hospital or outside of it on field trips.

The student volunteer program represents an extension of a similar effort begun in 1952 at Boston Psychopathic Hospital and Metropolitan State under the stimulation of Drs. Solomon and Greenblatt and with the support of the Russell Sage Foundation.

This first effort demonstrated that student nurses—untrained young women—could, at first under the supervision of a strong occupational therapy department and later the nursing department, safely and effectively work with chronic schizophrenic patients, both women and men. The women patients were mostly "fixed chair sitters"; some were disturbed, some incontinent, some only partly dressed; most spent their lives staring idly or muttering to them-

selves. When it was found that under this program the majority improved in appearance and behavior and those who engaged in constructive social activity increased from 4 to nearly 40 per cent, the project was extended to include 65 men of the same chronic type, mainly quiet sitters left to shift for themselves. None had underwear, only 30 had chairs, 19 had pillows, and most were unshaven and unwashed.

For women to venture on this ward, it was remarked, was like conducting a Miss America pageant on West Madison Street, Chicago, or on the Bowery in New York City. Assault and rape were freely predicted, and even some of the patients themselves were alarmed. One woman attendant wrote in her notes: "Mr. M. asked me tonight if I realized where I was working. I told him I did. Then he asked, 'You realize this is an asylum full of crazy men, but you still go along and mind your business. What would you do if you were attacked?' I answered, 'Fight.' " (Greenblatt *et al.,* 1955, p. 393). But no incidents took place. The biggest problem was that the men were shy.

The college students encountered the same situation in the wards that they visited. The back wards of this State hospital, as in others, represented the ultimate in rejection of mental patients, by their families, their friends, by the State, and by the hospital staff. The patients had been written off as an unrecoverable loss. The few attendants on duty were there primarily to watch the patients, see that they were fed and toileted, and either supervise or themselves do the daily ward chores of cleaning and bed making. They had neither time nor interest in sitting with patients and talking with them. The rounds of the psychiatrists were infrequent and hurried. A few of the patients had been sitting in rows of straight-backed chairs, or lying on the floor, since the hospital had opened in 1930.

The college volunteer program began in this way: J. Lawrence Dohan, then a Harvard junior, worked as a volunteer attendant at "Boston Psycho" and learned what prolonged hospitalization may do to a mental patient. In 1954, the Boston Psychopathic Hospital organized an affiliated teaching program at Metropolitan State, and encouraged Dohan to propose to the Phillips Brooks House Associa-

tion, a Harvard volunteer social service organization, that it sponsor a mental hospital volunteer program (Umbarger, *et al.,* 1960). Through the *Harvard Crimson* and rallies, posters, postcards, and telephone calls, Dohan, in an arresting display of personal leadership, interested 500 college students, mainly from Harvard, Radcliffe, and Brandeis, in visiting Metropolitan State. Of this number, 200 made 10 to 30 half-day visits to the hospital, dividing their interest in the ratio of about two to one between the children's unit and the adult wards. Nineteen elected to do case aide work, spending an hour each week with a single patient and a second hour in discussion with a supervising psychiatric social worker, Mr. David Kantor. Student volunteers have continued to return to the hospital at the rate of about 200 each year, an average of 135 continuing to volunteer throughout the college year.

The student volunteers were selected simply on the basis of sustained interest after an initial visit—in short, self-selected. Many had fears, but apparently were more challenged than afraid, and soon learned there was little to fear. Some of their youthful enthusiasm, energy, and pioneer spirit may be sensed from the words with which Dohan introduced them to the back ward scenes:

> You are about to see the most shameful, the most wasteful thing in the country today. People who are sick and miserable just left to vegetate. Partly, no one knows what to do for them. Mostly, nobody is even trying. They lie on the floor or they sit. They don't do much else. Most of them don't even have shoes to wear, and many haven't been outdoors in years. Maybe it's not too late for some of them. Maybe we can help. But remember this: They are human beings, just like you and me. They have their hopes, aspirations, their fears. They're not monsters. They have their problems, just as you and I have, only theirs are magnified.
>
> You'll see them now. You'll smell the foul air they must breathe all day. You'll see the rotten chairs they use and the rags they wear. As citizens of this country, I want you to know that I hold each of you personally responsible for this thing.

The positive effects of this well-conceived and progressively systematized effort to improve the human condition and total outlook of rejected patients were readily apparent. Colorless, drab, despair-filled wards became brightly decorated, cheerful halls where patients,

students, and increasingly the attendants talked, sang, smiled, and even laughed. Chronic patients became more active and enjoyed normal social contacts. By spending time with patients, the students learned information of therapeutic use to the doctors and the doctors in turn asked for their help with certain patients. The volunteers were particularly useful with patients whose acute symptoms had long since subsided and who were ready for discharge except that there had been no one to prepare them for outside living. By the end of the first year, 11 of 15 patients visited by student case aides were released from the hospital—some to come back later, but others to remain in the community. The student assumed responsibility for meeting the patient's family, investigating placement in rest homes or job possibilities, and visiting the patients after their release.

Each volunteer faced the same problem, whether working with an individual patient or a group: how to develop a relationship that would work toward the patient's recovery. Group discussion and professional consultation gave the volunteers the help they needed.

For "a bunch of college kids" to descend on a State hospital does not make it overnight into a place of high spirits and good cheer; the weight of the responsibility, the surfeit of tragedy, sheer numbers, and the years of undermanned efforts are too heavy to be lifted solely by youthful hope and flexibility. The encouragement from top hospital officials made the volunteer program possible, but the patient cry, "Here come the volunteers," was apt to provoke resentment among attendants, who lacked the benefits of psychology courses and a college education and were left to do the dirty work. They and some of the professional personnel, too, resented the freely expressed moral indignation and cries of shame on the part of the students. The attendants wanted to keep a ward quiet; the students, to disturb it. The attendants saw the patients' needs as new furniture and clothing; the students, as friendship and love. With greater mutual appreciation, however, the reactionary viewpoint presented no great obstacle. By 1958, student lay leaders and attendants sometimes traded jobs, the attendants taking over group activities and the students, ward duties.

One unexpected result of the college volunteer program has been that some students have become interested in the welfare and future of a paroled patient to the point of maintaining regular contact with him after the close of the college year, during which the student receives course credit for his hospital work. As further implementation of this continued interest, the Brooks House group recently decided to open a Harvard-style "halfway house," a place where released patients may come and live in a transitional phase between the hospital and return to independent community life.

Another unlooked-for result has been that some of the volunteers, caught at a time they were in the process of making a career choice, have elected to enter one of the mental health professions. Thus, college volunteer work acts as a manpower recruitment device.

As important as the help to patients and the opportunity to see life at its worst and, from this exposure, to develop a desire for humanitarian service, is the fact that the college volunteers constitute a convincing public demonstration that it is indeed possible to adopt and pursue friendly, helpful attitudes toward persons lacking in normal appeal. They have shown that rejection of the mentally ill is not the only course, but that it is possible even for laymen knowingly to associate with mental patients without prejudice, and without harm either to themselves or to the patients. The main ingredients appear to be sufficient enlightenment, motivation, and personal courage. The significance of the Metropolitan State experiment in reversing popular attitudes is instantly recognizable, as may be judged from the article about the program, "They Befriend the Mentally Ill," by Steven M. Spencer in *The Saturday Evening Post,* October 5, 1957. As the hospital's clinic director told the volunteers: "Your whole program made us realize that something like this *could* work, given some supervision, and that we didn't need to fear outside help. . . . The case aide program has demonstrated its value by showing that relatively untrained people can work with the mentally ill under supervision." One woman, on the same chronic ward for five years, at the time she was released explained the benefit of the volunteer's attention in this way: "What you did for me was to treat me like a

human being, like someone you wanted for a friend and could like. What you did for me is too much to explain."

Perhaps the entire problem might now be restated in terms not of shame, scandal or shock that we treat the mentally ill as poorly as we do—for the process of rejection would appear to be a successful social defense and a matter of "doing what comes naturally" or "taking the easy way out"—but in terms of the wasteful and uneconomic shortsightedness resulting from *a failure to recognize the dominant pattern of rejection and consciously and systematically seek ways around it.* As society itself has abundantly demonstrated in different times, places, and ways, it is quite possible to develop an *accepting* attitude toward the mentally ill. Many mental health workers do have this accepting attitude, of course, else no progress would have been made and our hopeful outlook would be invalid. It is a characteristic of the mentally ill that they behave in an irresponsible manner; it is a characteristic of society that we behave toward them in the same manner. This circle can be broken.

The findings of the Mental Health Study projects bear out our belief that, with conscious effort, negative attitudes can be overcome and are, among better-educated people, already in the process of reversing themselves. The studies to be reviewed in this chapter all reflect a tremendous demand both for authoritative information about mental illness and for adequate service when it occurs.

PEOPLE TELL US THEIR TROUBLES

In evaluating national resources for coping with the human and economic problems of mental illness, the Joint Commission became aware at the outset that no nationwide information was available on what the American people themselves thought of their mental health.

How well or badly adjusted do they consider themselves to be? Are they happy or unhappy, worried or unworried, optimistic or pessimistic in their outlook? Do they feel strong or weak; adequate or inadequate? What troubles Americans, as they see themselves?

And what do people do about their troubles? Do they solve their

problems by themselves? Do they learn to live with them? Do they turn to someone for help?

When they feel the need for help, where do they turn? What kind of help do they get? How effective do they think this help is?

To be sure, answers to such questions constitute only one measure of "mental health" or "mental illness" inasmuch as the person interviewed might see his troubles or lack of them quite differently from the way the professional expert or other outsiders, such as the person's friends, might view them.

Yet such answers have more value than that of simple human interest. In a democracy, the needs of the people—as they themselves feel them, come to understand them, and express them—ultimately determine the ways in which organized efforts will be made to meet these needs. Expressed needs also will serve as a measure of how much of a given need is being met or remains unmet. These needs also serve to predict the extent of self-initiated help seeking.

The Joint Commission staff, in its design of the Mental Health Study, conceived that each individual has within his life span a given potential for mental health or illness depending on a complex of biological, psychological, and sociological forces affecting his behavior. Those forces relate, so to speak, to the raw materials of which he is made, and to how these materials are shaped and molded through family and experiences, some of which impose critical stresses. According to this view, everyone will at times experience psychological trouble, or feel troubled. The individual may successfully cope with these stresses, or fail to do so, in varying degree. Thus, we assumed, mental health springs not from avoiding all stress or always staying out of trouble but from a capacity to accept normal amounts of stress, with some ability to rebound or to handle trouble. When he feels unable to do so through his own resources, the individual may or may not seek help from others, and he may or may not get it.

We selected the University of Michigan's Survey Research Center to seek the answers to our questions, using the same sort of scientifically proved techniques, based on probability sampling methods, that have been developed for assessing public opinion. The study group,

headed by Drs. Gerald Gurin, Joseph Veroff and Sheila Feld, co-authors of *Americans View Their Mental Health* (1960), interviewed a sample of Americans over the age of twenty-one living at home, selected so as to be representative of the total population in such characteristics as age, sex, education, income, occupation, and place of residence. Transients and all individuals in hospitals, prisons or other institutions at the time were excluded. The interviewed group therefore constituted an accurately proportioned miniature of the "normal," stable, adult population of the United States.

Interviews conducted by experienced interviewers were unusually long, ranging from one to four hours and averaging nearly two hours. Only 8 per cent of all persons approached refused to be interviewed—about the average for a public opinion survey. Furthermore, the majority of the respondents talked with remarkable frankness.

The kinds of questions asked by the survey fall into two general categories. The first deals with the way people feel they have adjusted to life—whether they think they are happy or unhappy, worried or unworried, the picture they have of themselves—and their attitudes toward the three most important areas of their lives—marriage, parenthood, and work.

The second group of questions follows from the first. How do people cope with problems? What motivates them to seek help and where do they turn for it? How effective do they think help has been? Why do some people fail to look for help, and how do they get along without it? The authors were particularly interested to discover if there is any connection between the attitudes that different kinds of people adopt toward themselves and the extent to which they seek help for their problems.

Sources of Unhappiness and Worry Among Different Groups

According to this study, money and other material and economic considerations (or the lack of them) are a major source of happiness or unhappiness. Three out of ten say money is central to their happiness. They see money, however, in the light of the material comforts, adequacy of living, and security it can buy rather than in terms of luxury.

On the other hand, roughly the same proportion of people regard their children as one of their primary sources of happiness. In addition, one out of five sees marriage as the wellspring of happiness, and approximately the same percentage look to their family in general.

All in all, it is clear that well over half the population finds its greatest happiness in the home, a state that is conditioned strongly by feelings of economic security.

It may come as a surprise to persons heavily involved in public affairs that international tensions, fear of atomic extinction, and the anxious atmosphere of a troubled world do not figure importantly among the things the American people say trouble them. Fewer than one in ten expressed an outstanding concern for community, national, or world problems. The reason for this finding is unclear. This seeming indifference may be due partly to the fact that most of us are concerned with the realities of our immediate environments, and that the extent to which sources of worry and tension affect us decreases in proportion to their remoteness. It may also reflect a retreat from the realities of the larger world, a sense of helplessness in the face of events that the individual feels are beyond his ability to control.

The meaning of "unhappiness" for Americans is not the same as the meaning of "worried." That being happy does not imply an absence of worries can be seen by the fact that most people (about 90 per cent) say they are "very happy" or "pretty happy" rather than that they are "not too happy," but at the same time one out of four admits that he worries "a lot" or "all the time." Two out of five worriers blame money for their troubles.

Why is it that people who worry are not necessarily unhappy? Gurin and his collaborators note some interesting differences between these two states of mind. Unhappy people are pessimistic about the future and the possibilities of change; they are apathetic and have a deficit of psychological resources. The worrier, however, is likely to be more optimistic about the future; he believes things can change for the better and proceeds accordingly; he is active and positive in his approach to life.

Economic and material considerations are even greater sources of

worrying (six out of ten) than of unhappiness. The focus of these concerns is material comfort and adequacy and their tie-in with aspirations. People in the middle income group making from $3000 to $6000 a year report the most financial worries. They have minimal adequacy but not security, and therefore the stronger aspirations to higher incomes. Those in the low income brackets are more resigned and apathetic about the possibilities of raising their economic station in life.

A further contrast between unhappiness and worrying is seen in the comparison of people of different ages and educational backgrounds.

Younger and better-educated people are happier but worry more than those who are older or less educated. Younger people have their futures ahead of them and feel they have higher stakes in life. Along with the better educated, their aspirations and expectations are higher. Older people, conversely, have their lives largely behind them; they are unhappier but worry less than the younger generation in spite of the association of economic insecurity with old age. The greater unhappiness of those with less education may stem partly from their feelings of frustration in a society that places a high value on education as a tool for advancement.

These findings illustrate the point that any evaluation of relative mental health of different groups depends upon the particular definition of mental health used. Thus, if the absence of worrying rather than the presence of happiness were taken as the criterion for mental health a different set of people—the older and less educated—would be considered healthier.

Levels of Self-perception

One of the most sensitive and difficult areas probed by the survey is the realm of self-perception. The problem was to get behind the façade that all of us present to the world to one degree or another, and to obtain some hint at least of the way people really feel about themselves.

Most people have no difficulty in identifying qualities in themselves of which they are proud, and very few explicitly state that they have none. More than two-thirds believe that in some positive way they are

different from other people. The strong points most people mention fall into the category of the stereotyped virtues; they regard themselves as good churchgoers, providers, housewives. In other words, they judge themselves in the light of their ability to come to terms with the external world rather than their ability to deal with their inner conflicts and personal problems. This suggests that most of us are preoccupied with conforming to accepted standards of behavior and that it is difficult for us to construct our own individual values and be guided by them when they differ from the expectations of our fellows.

It is interesting that the most-educated groups are not only most prone to be self-critical but also, when they are self-critical, are prone to refer to "deeper" personality characteristics. It would seem that they are more attuned to their highly personal weaknesses—the kinds of inadequacies that often bring people to psychiatric resources.

Differing Attitudes toward Home and Family

The data on the way Americans view their functioning as husbands, wives, and parents point up some interesting differences between men and women, young people and old people, and the less and more educated.

Earlier we found that most Americans look to the home for their greatest happiness and satisfaction. Upon closer questioning, it appears that for women the home also is a great source of distress, more so than for men; women admit more unhappiness with marriage, show more awareness of problems with it. This holds true in their roles as parents as well as spouses; they feel more inadequate as parents and have more problems with their children. The greater distress of women is borne out by other parts of the study. Their outlook is more negative and passive, more introspective; they are more sensitive about their personal relationships with other people.

Although men are less self-questioning than women, they are not without their feelings of inadequacy and distress. As fathers, men show an increasing concern over the tendency they see in themselves to neglect the emotional needs of their children; they feel some sense of failure in the amount of time they spend with their children. And

in discussing their marital problems, they actually blame themselves more for marital difficulties than do women.

Older people seem to feel little self-doubt. Time rounds off the sharp corners. Things that appeared to be of vital importance to them when they were younger do not count so much as they grow older. Thus the survey found that older people give fewer negative self-appraisals; they are more satisfied about the way they have carried out their responsibilities as husbands, wives, and parents. It may be that, on the one hand, older husbands and wives have learned to compromise their differences; and on the other, that their influence over their children has waned, and they feel less responsibility for them.

Yet older people do not feel happier with their marriages than younger people, and they evaluate their entire current life as less happy than do younger people. As in the findings that older people were generally more unhappy and yet worried less, these feelings toward marriage and parenthood seem to reflect a resignation, apathy, and passive acceptance of life and oneself.

The more educated are more personally involved in marriage and parenthood, have higher expectations of their husbands or wives and children, and hence are presented with greater opportunities for both gratification and distress. They seem therefore to feel both happier with their marriages and yet more dissatisfied with the ways they have carried out their family responsibilities.

Job Stresses

The attitudes of American men toward their jobs are conditioned by several factors, including the status their work carries with it, their income, their education and their age. As was expected, men with jobs that society regards as highly desirable also tend to be well educated and to have high incomes. It is not surprising, therefore, that they say they get the most satisfaction from their work. But if their jobs are sources of considerable gratification to them, they are equally the source of greater worry and distress, because they attach more importance to their work and are more vulnerable to dissatisfaction or disappointment.

The authors discovered that men with less desirable jobs do not express much dissatisfaction with their jobs. They do not tend to see the lack of individuality, interest, or creativity in these jobs as a source of frustration. Many observers had believed that increasing automation and specialization in industry and office work brought with them so much drudgery and alienation of the worker from his work that he encountered special problems of psychological adjustment. Hence many attempts have been made to provide these workers with other emotional outlets and to cater to their psychological deprivation. But men in lower job categories in the sample displayed less frustration and distress of this type than had been expected. Possibly their distress has found other outlets. Perhaps the industrial programs designed to meet their emotional needs are successful to some extent, or perhaps their aspirations in these areas are not as high as has been supposed and they are merely not as frustrated as has been thought. Or perhaps they have become resigned or adjusted to the lack of creative potential in their jobs.

In contrast to their general state of apathy, older men are both more satisfied and report fewer work problems with their jobs than younger men. The job may be an area where, rather than apathy, a sense of greater investment comes with increasing years.

Reactions to Stress

The people in the sample reported a variety of psychological and physical symptoms under stress. Women score high on all counts. Older people and the less educated are more preoccupied with their health; they score higher on a bodily symptom list, but they are prey to less psychological inertia. (Incidentally, older women show more anxiety than younger women, whereas older and younger men do not differ in anxiety symptoms, an indication that the aging process may be harder on women psychologically even though they tend to live longer.) The fact that older people report more physical symptoms is apparently due, however, more to the increasing incidence of real illness that accompanies aging than it is to heightened distress. People with less education react to problems with physical symptoms, whereas the better educated show more stress in a psychological manner.

To the question, "Have you ever felt that you were going to have a nervous breakdown?" one out of five replied, "Yes." Definition of what he meant by "nervous breakdown" was left to the interviewee, the assumption being that a "nervous breakdown" was a popular label for a variety of severe mental disorders.

Two-fifths of the people who said that they had experienced an emotional crisis of this magnitude blamed it on something external to themselves; the most frequently mentioned reason was death, illness, or separation involving a loved one; other reasons were tension connected with the job and financial or other external conditions. Another large group (one out of five) mentioned a physical illness. More specific psychological reasons given for the crisis included personality problems, general tension, and difficulties in relationships with others.

Evidence of the fact that many people are receptive to the idea of getting help with their problems shows up in the finding that almost half of those who felt they were going to have a breakdown consulted a professional source of help. Nearly nine out of ten of these reported seeing a doctor.

Up to this point it is clear that the way Americans view their mental health tends to be conditioned by their sex and age, the extent of their education and the amount of money they make (a factor that is intimately connected with educational level). Is it possible that other differences, though less basic, are equally important to the mental health of the average American adult? One example of these lesser differences taken by the survey is place of residence. The results are not at all clear cut. The region in which various people lived did not seem to have any effect on their responses to the questions asked. The differences between farmers, city dwellers, and suburbanites leveled out, and the authors comment that "a young, educated, male farmer is more like a young, educated, male New Yorker than either is like his own father."

Male clerical workers and the wives of unskilled workers are the most discontented and unhappy of all occupational groups. Managers, farmers, and salesmen worry most about their jobs, and the

wives of professional men and salesmen complain most that their husbands' jobs interfere with their marriages.

Surprisingly, single women, proverbially frustrated in popular conception, are happier and more active in working out their problems than the supposedly carefree bachelors, although neither are as satisfied with life as married persons. Widows and widowers are especially unhappy.

People who attend church regularly report less distress than those who go to church infrequently, a finding that is perhaps related to both the religious commitment involved in frequent church attendance and its reflection of social integration in the community. People who come from homes disrupted by death or divorce in their childhood experience more distress than people from intact homes. Within this general difference, individuals whose fathers or mothers died while they were growing up are better able to deal with their problems than those whose homes were broken by divorce or separation; the latter have greater difficulty in working out their development and are less successful in their own marriages.

But by and large these more specific differences among Americans are not as striking as the similarities. They variously worry about children, money, work and health, as a group, according to their age, sex and education. By our standards these are "good things" to worry about, and furthermore, "things" that are in part solvable by medical and social programs.

WHERE PEOPLE TURN FOR HELP

The second part of *Americans View Their Mental Health* takes up the way people approach or fail to meet their problems.

Asked if he ever had a problem in which professional help would have been useful, nearly one person in four said he had. The interview was not framed to indicate time of occurrence.

One out of seven actually had sought help of some kind for past problems. This group was dominated by women, younger persons, and the better educated. These types, as we have observed, are in-

clined to be introspective, self-critical, and more concerned with themselves. In other words, they have a tendency to define their problems in psychological terms and to seek some form of psychological help.

Among those who sought help, 42 per cent reported their problems centered around their marriages, 18 per cent reported personal adjustment difficulties, and 12 per cent designated troubles involving their children.

Where did they go for help? Forty-two per cent consulted clergymen, 29 per cent physicians in general, 18 per cent psychiatrists or psychologists, and 10 per cent social agencies or marriage clinics.

People who saw their problems as arising from sources outside themselves, such as marital troubles they blamed on their partners, were less likely to go to psychiatrists than those who perceived the problem as a defect in themselves (or involving their children). In fact, two out of five who blamed themselves went to a psychiatrist. Similarly, people with more education tended to use psychiatrists.

Despite the fact that it seems to take an unusual degree of insight for an individual to admit that he needs help with a mental or emotional problem, only about one-fourth of those who sought assistance traced their problems back to their own inadequacies with any clarity. Most were looking for support and advice; few were prepared to be told that they must accept at least a share of the responsibility for their problems and that they must change themselves accordingly. This may be why so many chose the support of the clergyman and physician over the more searching, difficult, and prolonged therapy offered by the psychiatrist.

Fifty-eight per cent stated unequivocally that they were helped with their problems, while 14 per cent said they had received help, but with qualifications. One out of five reported that he received no help.

Marital problems and other troubles seen as arising from sources outside the individual fared worst; people with personal adjustment problems most often reported that the assistance they received was of value to them.

Sixty-five per cent of people who visited either clergymen or physicians said they were helped, while less than half (46 per cent) of those who went to psychiatrists felt they were helped.

As implied by the nature of the most common troubles presented to them, clergymen and physicians are usually confronted with the more peripheral mental health problems. They appeared more successful than psychiatrists and psychologists in their efforts to tender support and give advice, but they were not often seen as effecting "cures."

Psychiatrists, apparently, play a self-limiting role. Tending to regard support and comfort as secondary to therapy, they therefore may be restricted—in the amount of help they can give—to patients who have enough self-awareness to accept the necessity for exploration of their personalities and subsequent re-education. This may help to explain the large proportion of people who did not feel helped by their contact with a psychiatrist or psychologist.

Only 28 per cent of the people who sought professional help spontaneously mentioned that someone else referred them to that source of help. The helping process seems to stop with the clergyman and physician in the majority of cases, and far more so with the clergyman than with the physician.

One in seven sought help as indicated above. An additional one out of ten who did not actually seek help recognized that he had a problem in the past that might have benefited from professional help. Among these latter persons, a fifth said they didn't know where to go for help, and one out of seven gave a sense of shame or feeling of stigma connected with emotional problems as his reason for not seeking assistance.

These people who felt they could have used help either did nothing about their problem (three out of ten), or tried to work it out themselves (one out of four), or with the help of families or friends (one out of ten). A small number (3 per cent) said they resorted to prayer.

While the people who sought help were more educated, had higher incomes, and came more often from urban areas than those who felt they could have used help but did not actually seek it, the differences

between these two groups in the kinds of problems they faced, or the kinds of help they considered seeking, actually were not striking. The latter were somewhat more vague about the nature of their difficulties and the possibilities for help and ended up by doing nothing or muddling through. The authors believe that a critical factor that led some to seek expert help was the availability of help and their awareness of it.

When psychiatric treatment facilities were available in the community, as distinguished from public mental hospitals, they were used predominantly and most effectively by people with better educations and higher incomes who thought in psychological terms, who were more aware of the presence and purpose of these facilities, and who could best afford them. The presence of mental health resources made it easier for people who were already disposed to look for this help to obtain it, rather than actually motivating people to seek assistance. These findings confirm on a national scale the conclusion of August B. Hollingshead and Frederick C. Redlich in *Social Class and Mental Illness* (1958) that noninstitutional psychiatric facilities in New Haven, Connecticut, were used mostly by the higher education and income groups in that city. Patients from the lower groups were more often diagnosed as schizophrenic and sent to State hospitals.

One other major question was asked about the ways people handled their problems: What did they do about day-to-day worries, or their periods of unhappiness that are *not* seen as requiring professional assistance? Many did nothing or forgot about it, essentially passive reactions that permit the situation to run its own course. Those who tried to cope with their troubles on their own often turned to their spouses, other members of their families, or friends. Another sizeable group prayed. Sixteen per cent prayed as a means of handling their daily worries and even more (one-third) prayed when faced with a critical unhappy period in their lives. Rarely did they put their faith in bartenders, taxi drivers, fortune tellers, or other supposedly popular but unorthodox confidants (or if they did, they didn't admit it to the interviewers).

The more active attempts to handle these situations—on one's own

or with the aid of family and friends—were more common among men, younger people, the more educated, and the higher income groups. Prayer and passive reactions were more common among women, the less educated, those with lower incomes, and older people. Thus we can conclude that the people who seek professional help when confronted with major personal problems—the better educated people with higher incomes—also take more initiative in trying to cope with less serious life problems.

What does the Survey Research Center's methodologically precise study tell us by way of conclusions or implications? *What, for example, does it suggest in sum about Americans' mental health?*

First, it tends to support other observations that many persons are anxious and insecure. At the same time, it fails to document two other contentions: that Americans are luxury-oriented, and that international tensions and the threat of nuclear war are a significant source of anxiety. The data indicate that most people seek comfort and adequacy rather than luxury. And the sources of their anxiety, as people express them, appear to spring from their immediate environment.

Second, many men, perhaps reflecting the competition between home and job, feel unsure of themselves in their family relationships, on the one hand, and hard pressed to gain or keep status in their life work, on the other. Their wives, perhaps seeing themselves still cast in a secondary role, may be striving to achieve satisfactions that are not restricted to marriage and child-rearing. This is one possible source of their distress and unhappiness.

Third, older people are most consistently the ones in the culture who have achieved acceptance of themselves and have learned to live with their personal relationships, their work, and their fate. But this achievement occurs at the cost of resignation and apathy, and lower happiness and gratification.

Fourth, younger people, especially the well educated, approach their lives, their relationships with others and their careers with higher optimism and greater expectations. They possess greater potentials for satisfaction and also for frustration. This is seen in

their greater happiness and satisfaction, accompanied by more problems and self-doubt.

What can be concluded from the study about the way Americans are facing their problems?

First, they have more chance for dealing with their troubles when they approach them subjectively, when they see them in internal-psychological, rather than external-physical, terms, and at the same time wrestle with them actively instead of accepting them with apathy.

Second, their ability to adopt this attitude of "healthful worry" is more than any other factor dependent upon education. The higher their education, the greater their self-awareness, the greater their knowledge of channels for help, and, as a corollary to education, the more they can afford to spend on expert, effective help.

Third, most people have to rely on their own inner resources as they face their problems. When they do obtain help, it is usually informal, expedient, and temporary.

Fourth, the problem of obtaining adequate professional help is particularly important in the lower status groups of the population. They have the least access to it, partly because they are less able to recognize their problems, and do not know where to look for help, and also because this type of help is not so readily available to them because of where they live and their low incomes. Not only professional help but their own resources are inadequate. The low use of psychiatric help by these groups has been found in other studies, like the one by Hollingshead and Redlich (1958). The present study adds the knowledge that these people also make less active use of other professional resources, their own resources, and of informal resources (family and friends). In addition, it is clear from the present study that lack of help-seeking in these groups does not stem simply from a lack of distress or motivation.

In general, the Gurin-Veroff-Feld monograph supports the community surveys showing a high prevalence of persons with various psychiatric or psychological illnesses or maladjustments as determined through psychiatric diagnosis of symptoms. For the more con-

ventional question, "How healthy do *we* think you are?" the present authors in effect substituted the question, "How healthy do *you* think you are?" Nearly one in four adult Americans has felt sufficiently troubled to need help at some time. One in seven sought it.

This summation in itself indicates a rather high degree of self-perception among Americans and willingness to admit that they have weaknesses and problems, although they do not always identify the psychological aspects of their difficulty, and often see it as organic or external to themselves. Whether perceived as psychological problems or not, their troubles all appear to have a mental or emotional component, requiring understanding of the behavior of themselves and others.

PUBLIC RECOGNITION OF PSYCHOLOGICAL PROBLEMS

The Gurin study additionally provides convincing evidence that public information related to mental health and human behavior during the present generation has increased general understanding of the human mind. It is still unclear what avenues and kinds of information are most effective, but it is clear that the younger, better-educated group—the one which presumably has been exposed to the most mental health information in school or in its personal reading—has much greater recognition of the psychological aspect of many of their problems and, hence, more appreciation of the mental health professions as a resource when help is needed.

Americans View Their Mental Health thus indicates the potential value of attempts to reach more people and different classes of people with mental health information. But recognition of this fact merely begs the question of where we will get the manpower to meet the increased demand for mental health services. Here we have opposite sides of the same coin—the vast unmet need of the American people for help in recognizing and dealing with their mental and emotional troubles.

The shortage of trained mental health personnel works totally against the purposes of mental health education. Increased awareness

of mental illness only serves to tax already inadequate mental health services. Inasmuch as present services tend to gravitate toward the best informed, it would appear that the psychologically rich get richer and the poor get poorer. We shall return to the problem of professionally trained manpower later in this chapter, but first we want to note other evidence of increased demand for a psychiatric approach to psychological problems.

COMMUNITY RESOURCES IN MENTAL HEALTH

There is a demand for psychiatric and other mental health services in agencies not previously thought to require such professional help in carrying out their business. This demand is growing. An example is the growth in the use of psychological testing, measurements, and assessments in industry for personnel management. Another is the expansion of services to courts, prisons, and juvenile agencies. Once content with diagnostic services from psychiatrists and psychologists, these agencies now demand treatment for their clientele; furthermore, by treatment, they mean one-to-one intensive psychotherapy, psychoanalysis, or, at a minimum, intensive group therapy. One State now has more than sixty psychiatrists and psychologists giving intensive therapy to offenders at the court or prison level—this, in addition to diagnostic services.

The demand from communities for mental health clinics and allied services is growing more rapidly than the manpower pool for staffing new services. In addition, the extension of these new services is not always carefully planned. New services are often started without coordination and full use of existing ones. At times, there seems to be a desire to create new services out of the wish to do something, and perhaps the belief that the creation of a mental health clinic or a counseling and guidance service will automatically care for the social ills and unhappiness of a community. In some instances, there is a trend toward substituting a mental health service for intelligent leadership and planning in community organizations, and a similar tendency may perhaps have crept into certain areas of the armed forces.

More recently, there has been a tendency for communities to make a survey of their needs and resources before embarking on the development of new services. This tendency, noted in the early phases of our project on community resources, led the staff of the Joint Commission in 1957 to prepare a 31-page outline, *Suggestions for a Community Mental Health Survey;* it was necessary to reprint this study design several times. Approximately 4000 copies were distributed and interested communities eventually were encouraged to reproduce the brochure themselves. Many communities used this brochure as a basis for their own surveys.

Drs. Reginald Robinson and David F. DeMarche and Miss Mildred K. Wagle, authors of *Community Resources in Mental Health* (1960), noted in our *Second Annual Report* (1957):

> There is . . . a real eagerness on the part of citizens and professional workers throughout the country to take action with respect to improving services in support of mental health. This interest and concern is evident not only in major centers and among national leaders but also to a surprising degree in smaller communities with relatively few resources.
>
> Local community leaders are hungry for advice and help on what to do and how to do it. This interest runs all the way from how to conduct local studies to advice on what kinds of mental health service and programs to establish.
>
> There is a ready acceptance of the role of the supportive services [such as schools, churches, public health and social service agencies—Ed.] and a recognition of their potentialities in the total mental health program. This interest is especially significant in the many communities where there are few, if any, psychiatric services and where much of the burden of the program falls on the supportive agencies.
>
> There is a great deal of confusion in regard to what kinds of supportive mental health service communities should be developing. This current uncertainty highlights the importance of the Commission's working out, on the basis of its studies, definite patterns or guide lines which can be tested and used by those responsible for sound development of supportive services. There is no question about the demand for such patterns nor, from our observations so far, about the readiness to put them to use.

When, three years later, we lay their finished report, *Community Resources in Mental Health,* beside the above statement, we cannot help but express, once more, a profound discouragement.

The specific object of the study by Dr. Robinson and his associ-

ates was to ascertain what resources for mental health we have in the United States over and beyond those provided by psychiatry and other mental health professions whose work is centered in medical institutions. In Chapter II, we touched upon the new direction of broadening professional mental health services from a hospital-centered to a community-centered base and will explore it further in the findings of the present chapter. What are local communities doing to enhance this movement?

In several sections of the nation virtually nothing is being done, the authors found. In others, highly complex constellations of resources exist for the advancement of mental health. The big cities are relatively rich in these resources, while the rural areas are likely to be entirely barren. Severe shortages of adequately trained personnel were found in every area the authors investigated. Hardly an agency or service could be found with sufficient financing.

Two observations are especially distressing. One is the national neglect of millions of children with mental health problems, youngsters who are terribly ill prepared to take their places in the adult world that created their problems. The other is a widespread lack of understanding of how to launch and carry on mental health programs at every level from the national scene down to the smallest hamlet. Efforts to formulate mental health programs are too often haphazard and uncoordinated, well intentioned, but amateurish and without professional guidance.

But the attempts are being made, increasingly, and in this the authors see a hopeful sign, for everywhere they encountered deep concern and genuine desire to take action against this great problem of mental illness. Invariably the missing ingredients, the needed catalysts, were guidance, leadership, and money.

For the framework of their study the authors assembled data nationally (the first time this has been attempted) on the supply of certain health and welfare resources in the 3103 counties in the continental United States. Then, in order to add meaning to this information, they selected fifteen representative counties for intensive field studies of the nature of mental health resources in specific situations. These findings are reported in detail below.

Public Health

The Robinson team first examined the established public health services in the counties to determine how effectively public health personnel were able to deal with mental health problems. Although public health officials in 10 of the 15 counties studied in the field were exerting effective leadership in mental health programs, only 73 per cent of all the nation's counties had full-time local health units in 1956 and many had staffs and resources too small to cope with the problems; those counties that lacked such units held 10 per cent of the population.

It is unlikely that public health nurses are discovering and referring for treatment mental health problems in significant volume. They are already burdened with growing loads of chronic illness cases. Although they see many instances of acute mental and emotional problems in the course of their work, they must usually give priority to their general medical responsibilities. There is an overall 20 per cent shortage of public health nurses, a shortage that is sharpened by the fact that about a third of those trained in public health are employed as school nurses. About 19 per cent of the counties had no public health nurses at all (in one instance two nurses covered a county of 5000 square miles).

The public health nurse, the authors conclude, could deal more effectively with mental health problems if she had more training in this aspect of her duties and especially if she could seek the advice of professional consultants who now are rarely accessible to her. (Public health nursing services are discussed more fully under *New Perspectives on Mental Patient Care,* below.)

Public Welfare

Few problems cause more chronic anxiety, emotional turmoil, and mental distress than economic hardship. What is being done for the millions of Americans who, for a variety of reasons, are unable fully to provide for themselves and their families?

Social Security, the authors note, is the foundation of the American public welfare system. As insurance protection for the elderly, for

survivors, and for the disabled, it helps substantially to allay financial hardship, but in too many cases it only enables the recipient to eke out a marginal existence.

The authors express special concern about the hazards to mental health in economically depressed communities with serious unemployment, particularly where unemployment insurance benefits are inadequate or have expired.

Social insurance provides some measure of protection for an increasing number of Americans, but it remains inadequate in millions of cases of hardship. Federal insurance frequently must be supplemented by noncontributory public assistance to meet even a minimum budget. The administration of such assistance rests with the States and local governmental units. It is in this area that the most glaring inequities, discriminations, and contradictions exist. The qualifications of local personnel and their ability to deal with problems of mental health were found to vary widely from State to State and from county to county.

General assistance, for example, is the only help available to those who have no insurance coverage and who do not meet the rigid eligibility requirements of the Federal or State assistance programs. Nevertheless, sixteen States, containing nearly half of the nation's counties, provide no funds for general assistance. Where this kind of aid is available, it is usually meager and often dispensed out of a philosophy that traces back to the Elizabethan Poor Laws of the seventeenth century. Indeed, communities in some sections of New England still publish Paupers' Lists.

In their study of the fifteen counties, the authors concluded that general assistance is "a last resort after all possible sources of funds from the public have been tapped. It was usually inadequate in amount, haphazardly given, and temporary even though the need remained. It was degrading to the dignity of the recipient, who was often forced to beg for help, to accept a grocery order that proclaimed him a 'reliefer,' and in some cases to be labeled a pauper in public print."

In a nation known for its constantly shifting population, needy nonresidents and transients pose a special problem. Every State but

New York makes legal residence a requirement for assistance eligibility. The residence laws of most states were outmoded centuries ago. In New Hampshire, for example, five years of residence is required before general assistance can be obtained, two years for admission to a mental hospital. The treatment of nonresidents and transients in all but one of the fifteen counties studied was discovered to be "primitive and calculated to damage instead of help them." The plight of these unfortunates who run into economic difficulty, the authors conclude, is "desperate and tragic. This is a group who have few rights as citizens under most of the State laws today."

Child Welfare

Especially poignant is the section discussing the administration of Aid to Dependent Children. There are more than two million children in America who "not only are financially destitute but also have experienced family disruption, conflict, and emotional deprivation." The total assistance provided the average ADC family is barely enough to cover the minimum cost of food as set forth by Department of Agriculture standards. Moreover, a premium is placed on desertion since families cannot get ADC payments if the unemployed father remains in the home; in some States, application for aid cannot be made until the father has been gone for six months. Attention is too often focused not on the needs of the children but on the moral behavior of the mother. As a consequence, ADC is the "whipping boy" of public assistance.

The authors found that a scarcity of qualified public welfare workers, ever-growing case loads, and limited funds characterize the entire public assistance program. They stress the need for recruitment and for improved educational and training standards.

Equally as distressing are their findings in respect to the care of children from broken homes. In 1958, 6.4 million children were living with only one parent, another 1.1 million with other relatives, and about 400,000 were in institutions, foster homes, or with other unrelated persons. There were 500,000 more divorces than in 1940, and they were occurring at the rate of 9.2 per 1000 married women.

The reproduction rate of unmarried parents was rising faster than that of married couples, and family life was undergoing deep changes as more and more mothers were finding jobs outside the home.

What effects do these disturbing trends have on the children whom they involve, their mental health, their ability to develop into well-adjusted adults? How are communities faring in their efforts to be mother and father to these children?

Thirty-seven per cent of the nation's counties, the authors report, have no child welfare services of any sort, and 49 per cent of those that do (containing a fourth of the country's children) lack public child welfare services. Moreover, where such services do function, they have not been able to keep pace with the growth in population.

There are not enough child welfare workers, and those available are usually overburdened with high case loads. State and local funds are used primarily for foster care payments, while Federal funds are intended to support professional services by helping to pay the salaries and to finance the education of personnel.

For those needing temporary placement who are not free to be adopted care in a foster family home is regarded as the most satisfactory alternative to care in the child's own home. But it is estimated that 60 per cent of the children in foster homes are emotionally disturbed.

Recent years have been marked by a sharp increase in adoptions. Yet, while there are ten applicants for each adoptable white child, there is only one for every ten nonwhite children. As a result, Negro mothers of illegitimate children are urged to keep them, and they are forced to turn to ADC for help. The authors see a need to increase adoptive services to parents and children and to improve the quality of work being done in this field. Again more money and more professional workers are required.

Institutions are being asked increasingly to care for children who must be removed from the community because their behavior is not tolerable or because they are not treatable in the home, foster home, school, or other agency. While the authors observed a growing recognition that an institution is not an adequate substitute for home and

family, many institutions devoted to the care of children seem to be so tradition-bound that they do not participate well in community planning efforts aimed at developing a total child welfare program.

A relatively new resource, the homemaker service, was devised to preserve family life when it is threatened by crisis. The service sends a specially trained woman into the home as a mother substitute until the crisis is past and family life returns to normal. The growth of the homemaker service has been very slow; only 150 of 3103 counties are known to have it—this in spite of the fact that it costs four times as much to keep a child in a foster home as in his own home.

Another community resource the authors found to be woefully neglected and almost without regulation is the day care service. Thirty of every 100 mothers with children under eighteen were working in 1958. Often there were economic problems in the home as well. Although many States have established standards for foster day care, too little apparently has been done to enforce them. The idea is prevalent that anyone can look after the children when the mother is away, and outside employment for mothers is "so generally accepted, encouraged and sometimes made mandatory by welfare agencies, that little thought is given to the effect on the personality and emotional development of the children when the mother is out of the home."

The authors found that psychiatric and psychological services available to child welfare agencies in the fifteen survey counties were negligible, although the desire on the part of those concerned with the welfare of children to obtain more assistance appeared to be universal. They conclude:

> Rapid social change has caused tension and conflict among adults and this, in turn, creates problems for children. Disturbed and disordered behavior and "problem children" result. Others, deprived of normal affectional ties and stable families, go through a passive childhood only to break down later when the responsibilities of adult life press upon them.
>
> The demands of society—quite apart from humanitarian concern for the welfare of the individual—necessitate a strong, thorough-going public effort to provide comprehensive services that will meet the needs of children, wherever they may live.

Court Services

The probation and parole services of the courts, the authors hold, are virtually important means of restoring the offender to a socially acceptable way of life. These court services were totally lacking in a quarter of the counties studied, and in many others they were performed by poorly equipped and low-paid personnel. The authors encountered a general lack of conviction as to the importance of special training for probation and parole officers; they estimate that the nation needs at least six times as many of these workers as it now has in order to meet the demands for minimum coverage and realistic case loads.

The development of the juvenile courts has not fulfilled the early hopes that they would play a vital role in the rehabilitation of the juvenile offender. This is due partly to their limited geographic coverage, but mostly to a chronic dearth of qualified treatment staff and facilities. A number of bills dealing with juvenile delinquency have been before Congress, and the authors express the hope that provision will be made in any new legislation for the training of personnel to work in this field.

Public Schools

Next to the family the schools are probably the most important unit of society for the protection of mental health. The obstacles to good education presented by rising school enrollments, outgrown facilities, large classes, and a short supply of teachers are well known. Most children can and will survive these handicaps. But how about the exceptional children—the retarded, the gifted, the physically handicapped, and the emotionally maladjusted? All are candidates for mental and emotional problems.

One out of every ten children needs special educational services. There is evidence that increasing attention is being directed to the retarded child, but within the limits of a severe shortage of specially trained teachers. More of this kind of service was found in secondary than in elementary schools, more in urban than in rural areas, more for the slow learner than for the mentally defective child. The gifted

child, on the other hand, seems to be faring better, and the authors predict that the National Defense Education Act of 1958 will concentrate even more attention on him. Likewise, greater help from the schools is coming the way of children with physical differences, and the socially and emotionally maladjusted.

As a rule, the wealthier city school districts are in the best position to secure counselors, psychologists, visiting teachers, social workers, attendance officers, nurses, and specially trained teachers. These personnel tend to gravitate to the secondary schools, although there is an even greater need for their services on the elementary level.

There is a prime need to train teachers to discover mental health problems among their pupils in their early stages. The mere presence of specialized personnel in the schools, however, does not guarantee a flow of referrals to the treatment resources of the community. This bottleneck seems to be compounded of the reluctance of teachers to refer (seeing it as a reflection on their ability to cope with problems) and a lack of treatment facilities able to take referrals. (The Robinson report was designed to picture community resources in cross section; schools have been singled out for special consideration in *The Role of Schools in Mental Health,* which is summarized later in this chapter.)

Recreation

The way we spend our spare time can have a good deal of bearing on our mental well-being; on the one hand, it is symptomatic of the state of our mental health, while, on the other, it can be used to promote and support it. If more planned recreation and group activities were available to more Americans, it would provide a healthy release for tensions and a respite from anxiety-producing home situations and social environments.

The authors discovered that 2215 of the 3103 counties in the United States had no public recreation program at all, while another 287—largely in the cities—had only an indoor center with no paid staff. Such programs as did exist were rarely countywide; they tended to thrive in the large cities only. Hence the smaller communities and rural areas need assistance, best found in the form of expanded

county, State, and Federal services. The Agricultural Extension Service of the Department of Agriculture is singled out for praise by the authors, who observe that it is making important contributions on the county level through 4-H Clubs, home demonstration clubs, and community meetings.

Private agencies, by their nature relieved of the responsibility for providing public facilities and large activities programs, can concentrate on organizing, recruiting, and training leadership and on supervising smaller, continuing groups. In the great majority of counties, the Boy and Girl Scouts, followed by the YMCA, were the predominant or sole private recreational agencies. There was wide variation in their availability and in all programs—both public and private—there were more opportunities for boys than for girls and fewer for older teen-agers, young people, and adults, although there is a growing interest in providing services for the aged.

A hopeful sign is the creation by several cities of youth service projects designed to combat juvenile delinquency, one of the most notable being the New York City Youth Board. Again, these efforts are plagued by shortages of trained personnel in the recreational field. Another reason for optimism is the awareness of leaders in national recreational agencies of their role in maintaining mental health and of their responsibilities for working locally with individuals and families having special problems.

Churches

The recreational, social, and family education programs of churches, Dr. Robinson and his associates believe, can help to promote and maintain the mental health of their members. While recognizing that the clergyman can often function in a supportive role, the authors inject a word of caution: "Perhaps those clergymen with psychological insight but with little or no training in pastoral counseling may counsel on personal or interpersonal problems with little emotional content. The difficulty comes in recognizing the complexity of the problem. Only clergymen with intensive training in clinical practice under expert supervision should ever attempt counseling persons with mental and emotional problems." (As in the case of schools,

The Churches and Mental Health is a separate study and is summarized more fully in a subsequent section.)

Family Case Work Agencies

Where such agencies exist, they are important mental health resources. However, only 9 per cent of the counties in this country have such a service. Most of the agencies are found in the large urban areas where mental health clinics are also present. Staffed by graduate social workers and usually employing psychiatric consultants, these agencies at times appear scarcely distinguishable from mental health clinics. Their role in the community, the authors point out, should not be that of a clinic, as they have a broader function and are social rather than medical services. More attention needs to be given to determining the levels of treatment and the kinds of mental and emotional problems that can best be dealt with by different community services. Only in this way will scarce mental health manpower be utilized to full advantage.

Mental Health Clinics

Less than a fourth of the counties in the nation have mental health clinics. The rest usually lack other supportive services as well. Where there are clinics, long waiting lists are almost universal.

How, then, does the mental health clinic fit into the picture of community resources? The authors see the function of the clinics as closely related to other community services. The clinics must concentrate on providing psychiatric treatment for acute mental illness cases and for patients who can be helped either short of admission to a mental hospital or following discharge. The job of community education and mental health promotion should be left to the health departments and mental health associations, the authors feel. (The outpatient system is further elaborated under *New Perspectives on Mental Patient Care,* the final section of this chapter.)

Community Planning

Moving from their consideration of the kinds of community resources that are concerned with mental health, the Robinson group

examined briefly the status of more general community planning and the success with which these resources are being integrated with other services.

They report that local mental health associations affiliated with the National Association for Mental Health are generally eager to move ahead but need professional assistance in planning programs that are compatible with the needs of their communities and the activities of other organizations in the same field.

Only 9 per cent of the nation's counties have community welfare councils with an executive staff. Although they are concerned with mental health and related activities, they are found mostly only in the larger cities.

While the development of federated financing through United Funds and Community Chests has been a significant factor in community planning, only 18 per cent of the counties have fund-raising bodies operating under a year-round executive staff, an important requisite for overall, continuing financing of member agency work.

Counties with a paucity of mental health resources as judged by the authors' index are found throughout the United States, but especially in the South, North Central and Mountain regions. Big cities and manufacturing centers have the best supply, thinly populated agricultural areas the poorest.

Dr. Robinson and his associates feel that the rural counties with few urban centers will have to share many key resources such as psychiatric, public health, child welfare, probationary, group work and recreational services with neighboring counties. To fill out the picture, other resources must be developed locally, and where the only facilities in some counties are nonpsychiatric, some kind of outpatient psychiatric service must be made available to serve a larger area.

In those areas fortunate enough to have more complex configurations of resources, promotional and supportive agencies evidently are in touch with or aware of many more problems than the combined resources of the community can handle effectively. Psychiatric clinics are invariably asked to accept more cases than they can treat. Since their possibilities of expansion are limited, it is imperative that

the clinics and the supportive agencies determine their respective roles in such a way as to provide appropriate treatment for more people. The authors stress the necessity for community planning around all of the mental health resources, instead of around the clinical treatment services only, as is the current tendency.

Four broad recommendations are made by Dr. Robinson and his co-authors in conclusion:

1. Since cultural, social and economic settings vary greatly, the dynamic effects of these factors make it imperative to shape community mental health programs around local needs.

2. The desire to develop mental health resources is everywhere. But too many communities are left on their own to work out programs as best they can. They cannot move ahead intelligently without professional help. Initiative must be taken, most logically by the States, to provide consultation in depth for local community planning.

3. The demand for manpower in the promotional and supportive agencies is as pressing as it is in the hospital and clinics. A greatly expanded national educational effort is needed to recruit college graduates from the existing manpower pool in the resources area for advanced graduate work. More opportunities must also be made for on-the-job training, paid educational leaves, and training institutes. And salaries must be such as to compete successfully with those in other professions.

4. A broad research program should be undertaken. It is suggested that a continuing body of current information be maintained from a 100-county sample which could be used for studies and experiments in the epidemiology of mental illness, cultural factors in mental illness and health, and the movement of cases, and for controlled trials in supplying additional services to fill out gaps in the total mental health resources constellation.

The findings of *Community Resources in Mental Health* suggest that an increasing number of trained persons who are not themselves psychiatrists will have to be relied upon for supportive treatment of the mentally disturbed if millions of them are to get any help at all.

The authors have shown, in fact, that as soon as a community gets behind a mental health program the implications for treatment are tremendous because it must take place wherever the need arises.

The conclusion is inescapable, therefore, that during the foreseeable future treatment is destined to become more horizontal and less vertical in scope. We cannot deny the fact that it is being undertaken in some fashion or another by teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, clergymen, and many others. Whatever their qualifications, they are trying to do something to help individuals with mental problems; they know that if they don't make the attempt, the chances are that no one will.

Every effort must be made, then, to provide nonpsychiatrically trained personnel in many fields with as much knowledge of mental illness and principles of its treatment as possible. They *are* treating the mentally and emotionally disturbed and will *continue to do so.* They must be given additional skill.

Local communities can hardly be blamed for their failure to initiate effective programs in behalf of mental health. Undoubtedly the desire to take action is universal. But the presence of a will does not guarantee a way. Hence the second point of central importance that emerges from *Community Resources in Mental Health* is this: The initiative for the creation and development and coordination of mental health resources in communities rests solidly with mental health leaders. It is up to them to show the way. And in the process of helping to develop these resources, they will have to recognize and learn to live with their reliance on many other individuals who, by the force of circumstances, are involved in the treatment of mental and emotional disturbances.

THE SCHOOL AS A MENTAL HEALTH RESOURCE

Few would deny that the family is the best of all possible settings for the promotion of mental health. Here are concentrated the crucial influences and relationships that shape the development of the child and young adult, for better or for worse. Unfortunately, the family

is a rather isolated unit of modern society; its members go forth from the home as individuals but may return to it as components of a different group. The family is not readily accessible to outside help, except as it seeks it, and society has no pervasive mental health resources that encompass the family within their structure.

The school, however, comes remarkably close to achieving this relationship with the family. At least it is in a position to do so. In an era of universal, compulsory education, the school is the one institution of society through which each of us must pass. During our formative years we are influenced to varying degrees by this educational experience, which takes place against the background of the family, yet apart from it. Here, then, is a ready-made setting with the potentiality for directing, reinforcing, or correcting mental health. The school may not only guide, strengthen, and even treat the mental health of the pupil but also, through the role of the pupil as a family member, seek means of improving home situations for the sake of all of the members of the family. Viewing the role of the school in this light, Pope's couplet (Bartlett, 1948, p. 209) takes on new meaning:

> 'Tis education forms the common mind:
> Just as the twig is bent, the tree's inclined.

How much responsibility should the schools have in promoting the mental health and treating the disorders of our children? How should this role be related to the more formal and traditional function of instruction? What part of the burden should fall on the teacher, what part on the school system itself?

Drs. Wesley Allinsmith and George W. Goethals investigate these and related questions in *The Role of Schools in Mental Health*. Their findings are, as in the case of our other studies, disturbing. The thesis of the book, which is concerned mainly with teachers and teaching, is essentially that American schools ought to have a tremendously powerful influence in conditioning the mental health of future generations. It says some sharp things about teachers and their attitudes toward themselves and their work, and these controversial analyses have implications that extend well beyond the immediate scope of the Mental Health Study.

The Role of Schools in Mental Health concerns itself especially with the question of whether and to what extent the classroom teacher should become involved with the emotional problems of the student. The authors have not attempted to include organic mental disorders or such special problems as juvenile delinquency, racial integration, the mentally and physically handicapped, the gifted student, and adult education within the scope of their study. And although they cover the educational scene from nursery school through the university, they give greatest emphasis to the elementary and secondary grades.

As background for their analysis, Allinsmith and Goethals take note of the controversy in the schools over the emphasis that should be placed on their responsibilities for mental health vis-à-vis instruction. Should the promotion of mental health be conducted by means of special programs or through the established curriculum? This debate has crystallized into five points of view:

1. The curriculum should remain subject-centered. In this traditional, fundamentalist, and still persistent concept, mental health is seen as a concomitant of the mental discipline presumably acquired in the learning process.

2. The curriculum should be designed to bend the student to the realities of society, especially by way of vocational education. Here the onus is on the individual to adjust under pressure of conformity.

3. Instructional aims (preparing for life work, etc.) are less important than providing an environment conducive to personality development. The authors note that this position was officially adopted by the 1950 White House Conference on Education but question whether it does not perhaps go too far in emphasis on life adjustment rather than scholarship in basic subjects.

4. The curriculum should be designed to promote mental health as an instrument for social progress and as a means of altering the culture, preventing war, and so forth.

5. Mental health is a good thing, but there has been too much emphasis on it in the schools, with the result that the teacher is losing his effectiveness both as instructor and guide.

The authors subscribe to no one of these positions but favor a

synthesis of the strong points of each. Although Allinsmith and Goethals offer few details of the synthesis they desire, Dr. David V. Tiedeman, a member of the Joint Commission, informs us that these details have been evolving over the past half century largely within the areas of counseling, educational, industrial, and school psychologies. Essentially, this guidance psychology, as Dr. Tiedeman frames the common elements of these several other psychologies, aims both at *secondary* prevention of mental illness (that is, early detection of emotional disturbance or mental illness and counseling with referral as needed) and at *primary* prevention (that is, a general psychosocial program aimed at strengthening ego functioning in all youth in school and college and of adults at work in enlightened governmental and commercial enterprises). Allinsmith and Goethals in the main consider only secondary prevention in *The Role of the School in Mental Health.* We shall return to the matter of primary prevention after dealing more fully with the important matter of secondary prevention of mental illness in school and college.

There are "a number of specific ways in which teachers, without overburdening themselves or subverting their instructional obligations, can at times contribute to the avoidance or alleviation of mental illness and thus help reduce immaturity in our population," Allinsmith and Goethals conclude. They discuss these ways in terms of the potential contribution schools can make to mental health.

The students regarded by the authors as good subjects for the kind of help in secondary prevention that schools might provide are divided into three categories: those who present difficulties to the school in respect to deportment, attendance, and learning ability; those with emotional problems that do not interfere with their performance; and those who are well now but in whom may be discerned the seeds of future problems.

Teachers, the authors believe, can make significant if varying contributions to mental health in each of eight areas: detection, diagnosis and prognosis, first aid, referral, treatment, rehabilitation, follow-up, and prevention.

There is evidence that teachers can detect mental disorders when they have been alerted to the symptoms although they are more apt

to focus on misbehavior problems in the classroom. The maximum opportunity for detection occurs in nursery school, kindergarten, and the early elementary grades, where more attention can be given to the behavioral patterns of the child. Teachers should have access to cumulative information about their pupils, but they should not be expected to act as guidance counselors. An occasional teacher may fail to follow up his suspicions that a problem is present for fear that to reveal one may constitute a reflection on his ability to handle classroom difficulties.

While the teacher should not attempt to diagnose a problem, especially if it has attained the proportions of mental illness, he can contribute to the diagnosis by his evaluation of the pupil's behavior.

"First aid" is another aspect of secondary prevention, a kind of timely action of which the sensitive and perceptive teacher is capable. This may be given almost intuitively and with excellent results to normal children who show stress or to those experiencing an emotional upset that may continue unless help is provided.

Ideally, the teacher should refer a child who needs professional help to guidance personnel in the school system. Lacking this service, the teacher may have the responsibility of referring the child to an outside community agency. Unfortunately, these resources may also be lacking, and the authors suggest that in this event the teacher may seek advice from one of the national agencies concerned with mental health. The problem and the solution, however, are not this simple, for the average, overburdened teacher simply cannot be expected to assume the responsibility for seeking out treatment facilities for a disturbed pupil when none are readily available. Providing or finding the means of treatment should be the obligation of the school system, not the teacher. Every school system should either employ or have direct access to well-trained school psychologists.

Allinsmith and Goethals outline five areas in which they suggest that the teacher can play a limited treatment role. He can help to reduce feelings of tension in the pupil, but usually only as a first aid measure. He can help to eliminate external sources of tension by easing the pressures on the pupil in the classroom. He can restrict expressions of unruly behavior as a normal part of the process of main-

taining discipline, but he probably should refrain from attempting to motivate the pupil to seek help or to find a more acceptable symptomatic expression of his problem. He can help the pupil to develop skills or gather information that may enable him to alter his sources of conflict, although this method may be limited by the range of topics in the curriculum. And he may help the pupil to gain insight by discussing his problems with him, but he should beware of encouraging confidences whose implications he may be unable to cope with. Under no circumstances, however, should the teacher attempt to assume the role of psychotherapist.

(The comment is also made by the authors that more can be accomplished for the pupil through teacher-parent cooperation than is generally realized, especially since children with incipient neurotic problems quite commonly have relatively effective, healthy, and cooperative parents.)

Again, in the areas of rehabilitation and follow up, it is suggested that the teacher can fulfill an important role in reinforcing the results of professional treatment.

In the important area of prevention, there are many subtle ways in which the teacher can take steps designed to prepare his pupils to meet the difficult situations of the future. Here a great advantage can be gained by giving the teacher enhanced understanding of the motivational aspects of behavior. He can help to avoid or limit sources of tension in the classroom by protecting pupils from the influence of disturbed classmates and by endeavoring to have them work at appropriate levels of difficulty that are challenging but not overwhelming. He can also help to minimize the pathological response of pupils to unavoidable events such as initial entry into school and puberty and adolescence.

Viewing the range of the mental health activities in which the teacher may participate, Allinsmith and Goethals believe that as a general rule teachers who are not in active contact with guidance personnel should restrict themselves to detection and referral, avoiding any treatment measures beyond first aid. Under proper supervision of guidance psychologists, these rules might well be expanded with benefit to youth and without harm to academic standards.

Clearly, then, teachers are in a key position to influence the mental health of their pupils. How well prepared are they to carry out this responsibility?

The authors find that teachers' training is liable to be deficient not only as it specifically equips them for work in this area but also as it grounds them in teaching objectives and techniques that have a less direct, but just as significant, influence on personality development.

Everyone can agree that it is imperative both to accelerate the recruitment of teachers by making the profession more attractive and to improve the quality of teaching generally. Getting down to cases, the authors recommend increased teacher-training emphasis on a more thorough grounding in the subjects to be taught and on technical improvements in the methods of instruction. Teachers should be better trained in the means of determining differences in pupil aptitudes, motivations, and personalities. Furthermore, they need to know a great deal more than most of them now do about mental hygiene so that they may understand individual differences in terms of inner conflicts and recognize the pupils' means of resolving these conflicts by adjustment, conformity, or hostility. Finally, too many teachers are vague about their own roles and objectives; this confusion and conflict spills over into the classroom and affects their relations with their pupils. Hence teachers must come to understand the necessity for discussion and analysis with their colleagues regarding their profession and its goals. They must become sufficiently aware of their own values to sense their biases and to make appropriate allowance for them in their relationships with pupils.

In secondary prevention of mental illness, it is reasonable to expect the teacher to engage in discovery, support, and direction of mental illness only to the extent that such activity is consistent with his primary instructional role. The necessary distinctions ordinarily are best clarified and instruction least damaged when guidance psychologists are an integral and important part of the staff of a school or college. Schools or colleges usually assign to their guidance psychologists responsibility for professional detection, diagnosis, and treatment including short-term ego counseling as needed. Educational institutions also quite frequently augment this least understood

aspect of secondary prevention with a strong program in short-term ego counseling aimed at resolution of specific problems of vocational development during the years in junior and senior high school and college. This type of activity provided for all youth and young adults is an integral part of primary prevention.

Primary prevention of mental illness requires strengthening of the fabric of society at its most vital point—the individual's ego. There are many concepts and theories of how the ego may be fortified and the personality integrated—in lay parlance, of how to build character or achieve personal success. An example of one such concept is given in Appendix V, Footnote 4–1.

Mental health work in the field of education is not particularly attractive to psychologists and other members of the health professions. Relatively few psychiatrists are interested in specializing in the treatment of children. Many psychologists do work in the schools. But a large proportion of them have had little training beyond the bachelor's degree, a state of affairs which has resulted in mediocre psychometric testing of pupils. The authors contend that the psychologists best suited for work in schools are explicitly trained at the doctoral level in school psychology or guidance. Such psychologists will need to direct greatly elaborated staffs of counselors with at least one or two years of graduate training if the goal is to be met in the elementary and secondary schools of the nation. The National Defense Education Act of 1958 is alleviating the shortage of counselors somewhat but the Act is too limited in scope and in support to provide much of what we hold to be needed.

Schools sometimes do not establish and integrate mental health services within their structure because school administrators either do not understand the significance of such services or experience conflict with their school boards. There is a need for school administrators and their school boards to understand primary and secondary prevention in mental health. Otherwise we have small purchase on the immense problem of preventing mental illness. The mental health worker could accomplish much more as a *part* of a school faculty.

And yet the burden will rest, in the main, on the shoulders of the teacher. As Allinsmith and Goethals conclude, "If anything is to be done about emotional disorders among American youth . . . then teachers must be called upon to assist. No adequate number of other personnel will probably ever be available." The resulting possible conflict of goals can be largely eliminated if guidance psychologists adequate to the task are hired to fill the breach. Such augmentation of the *professional* staff of schools should deter a shame upon which the authors comment; namely, "The school tends to incorporate into its structure various approaches to education and then justify them in slogans proper for a particular moment in history. At a time when the school is under great criticism to adopt this or that course of action in terms of the need for engineers, scientists, or even 'well-adjusted human beings,' it is not reassuring to see a situation in which clear school policy seems to be nonexistent." The right to decide must be kept for the individual. This right a professional in guidance is trained to insure.

Schools, of course, do reflect the goals and aspirations and fads of the society that supports them. In America currently there is rebirth of interest in the curriculum touched off by Soviet scientific progress and a desire to compete with Russia in the realm of science. Whether this preoccupation with scientific education will prove to be contagious and will spread to other areas of cultural achievement remains to be seen. In any event it is bound to re-emphasize the instructional side of teaching.

On the other hand, there is growing concern with the state of the nation's mental health and an undeniable awareness that the educational system stands in a unique position to condition the mental well-being of future generations for the good.

These pressures are converging on the teacher, and there is a danger that we will come to expect too much of him. Perhaps we hope that the teacher will assume responsibilities that should really be handled by the home—such as instilling in our children the desire to learn and preparing them for a mature adulthood. The teacher cannot be all things to all men, and there is grave doubt whether he

can pursue the exacting career of educator while at the same time carrying on the exhausting job of meeting and grappling with the emotional needs and problems of his pupils.

Until we are willing to think clearly about the future of our children and visualize the kind of adults we hope they will be, our schools will continue to reflect this uncertainty, and a mature and steady balance in the education of the whole person will remain unachieved. The schools need to augment their staff in guidance to insure proper attention to this matter.

THE CHURCH AS A MENTAL HEALTH RESOURCE

More than 100 million Americans are church members; about 170 million, or 95 per cent of the population, say they believe in God. As noted previously in this chapter, mentally troubled Americans most frequently turn for help to clergymen, more so even than to family physicians. Therefore, the church offers as great a potential as a mental health resource for adults as does the school for children. Consequently, we approach the study made by Dr. Richard V. McCann, *The Churches and Mental Health,* with more than usual interest.

An examination of religion as a source of mental health or of mental illness lies beyond the scope of Dr. McCann's study. Rather, he confined himself to an examination of the mental health service role of organized religion, as manifested through the churches and specifically through the clergy. What are they doing, and what might they do, in behalf of the mental health of their members and also of nonmembers?

To obtain some idea of what people think about religion and psychiatry as sources of help, 160 individuals in two cities were interviewed about their family, religious beliefs, perception of the clergy, personal problems, and perception of psychiatrists. One group was comprised of marginal workers living in a deteriorated section of an eastern city. Three-fourths of them were Catholic. The other group lived in a section of a predominantly Catholic midwest city but contained a higher percentage of Protestants and had a higher socioeconomic and educational level. This investigation, it should be

understood, constituted a preliminary scouting of the question and not a scientific study.

The religious attitudes of most respondents in both groups were characterized by a strong supportive trust in God, the base being more emotional than intellectual. The eastern group tended to regard God as a source of order, a sort of universal policeman; the midwestern sample, on the other hand, saw God as giving meaning and purpose to life. The marginal inhabitants of the eastern city also appeared to repress, disguise, and externalize their problems to a considerable degree.

The respondents in both groups were observed to be constantly coping with problems on their own, moving from crisis to crisis, usually successfully, although often at the cost of other members of the family. Most indicated they wanted to continue to meet problems without assistance. This strong desire for self-sufficiency is seen by Dr. McCann as a barrier against seeking help from either clergymen or psychiatrists. Other factors working against the use of psychiatric assistance were its cost and a reluctance on the part of respondents to admit the need for help or to indulge in the self-examination that might lead to this conclusion. The personality of the clergyman appeared to be more significant in determining whether a parishioner sought his help than either religious faith or social and economic status.

Dr. McCann also analyzed in detail portions of the data gathered in the Survey Research Center's nationwide opinion survey. Regular church attenders were reported to enjoy a higher degree of marital and overall happiness than those who went to church infrequently or not at all. This index, however, bore little or no relation to the religious habits of those respondents who at some time had felt they were going to have a nervous breakdown. A much stronger correlation was found between higher education, higher income, and greater happiness, a relationship that was enhanced, however, by frequent church attendance. Dr. McCann concludes that variations among religious groups in respect to the feelings of happiness expressed by their members are due less to differences in doctrine and faith than to factors such as education and income.

These observations are equivocal, as the author points out. Are some people "happy" because they attend church regularly, or do they attend church because they are happy? Where religion in its myriad forms and expressions is so nearly universal, it is difficult to know what to attribute to it.

A more specific way to approach the problem is to ask what organized religion is doing in the field of mental health.

Religion and welfare activities receive 1.3 per cent of total personal expenditures in the nation. About $57,000,000 a year, or 3 per cent of all Protestant giving, is earmarked for church-related welfare agencies, and only a small proportion of this goes to psychiatric facilities such as are found in Protestant-operated general hospitals. Eight Protestant psychiatric hospitals in the United States receive an estimated $555,000 annually—.2 per cent of all Protestant benevolences. Figures on thirteen Catholic psychiatric hospitals were not available.

"The churches," comments Dr. McCann, "are given relatively little money to spend, relatively little of what they spend goes to health and welfare, and relatively little of what goes to health and welfare goes to the care and treatment of the mentally ill." Church spending, therefore, appears to parallel spending in general.

Pastoral counseling by clergymen is unquestionably the single most important activity of the churches in the mental health field. Clinical pastoral education is primarily a Protestant phenomenon. Its purpose is to provide the theological student or clergyman with better understanding of human behavior as he meets it in a clinical situation so that he may apply it in his usual relations with his parishioners and to a limited extent in the prevention and treatment of mental illness.

There are 343 programs in clinical pastoral training, counseling or psychology offered by 212 Protestant seminaries. Those that are affiliated with general hospitals, in the author's view, may be closer to the parish situation, since students deal there with patients under various kinds of stress rather than with those suffering from mental illness only.

Catholic programs are more oriented to academic instruction, although there are seven Catholic centers for the clinical training of priests and chaplains. Most courses in the three major Jewish theo-

logical schools tend to be theoretical, a major concern being the pastoral rather than institutional aspects of counseling.

The National Institute of Mental Health in 1956 launched five-year pilot programs seeking a curriculum incorporating the behavioral sciences into theological education at Loyola University, the Harvard Divinity School, and Yeshiva University. It is hoped that this experiment will bring general recognition of the importance of extending theological education to include an understanding of human behavior based on scientific studies.

It is estimated that between 8000 and 9000 clergymen have taken formal courses in clinical pastoral training. Many workshops and refresher courses are available to the 226,000 who have not. One sponsor of such training is the Academy of Religion and Mental Health; about one-tenth of the nation's nearly 12,000 psychiatrists and 1000 out of 235,000 clergymen are members of the Academy.

The roles of the clergy in the three major faiths have a direct bearing on the type and extent of the counseling they undertake. There is some confusion in the Protestant clergy about their roles, arising out of a conflict among their various parish responsibilities. The author notes that administrative and organizing functions seem to be most frustrating to them, while they derive their greatest satisfaction from the pastoral role. The psychological sciences have apparently had their strongest impact among the Protestant denominations, and Protestant counseling tends to be on a more secular, psychological basis than that of the Catholic and Jewish faiths.

Dr. McCann remarks on the sharp division between the Catholic clergy and laity based on the priest's authority, accepted as part of his office; Catholic counseling, partly for this reason, has a primarily theological motivation.

The status of the Jewish rabbi is achieved through personal merit, based on the "scholar-saint" ideal of the religious leader. Rabbis are inclined to approach the problems of the laity from the standpoint of practical experience, and in general do not favor training in special counseling.

Analyzing other surveys, Dr. McCann finds that the amount of counseling the average clergyman gives is surprisingly low, averaging

2.2 hours a week. If the average counselee has 4 sessions with his pastor a year, the clergyman would be able to work with only 28 parishioners during that period. Sixty per cent of the clergy counsel less than 2 hours a week and depend largely on "common-sense" psychology. Only 7 per cent counsel between 10 and 22 hours a week, and this small minority have usually had graduate training in psychology.

Although women, young adults, and college graduates make the highest use of pastoral counseling, parishioners in distress do not tend to be highly selective about whom they choose for help. They go to the nearest concerned person who might have had some previous knowledge or experience with the type of problem they face, and to others known to be interested and available.

More than one-third of all counseling problems are estimated to be of serious psychiatric dimensions, although only one-tenth of these problems are ever referred by clergymen to psychiatric resources.

The replies to a nationwide questionnaire sent by the author to a number of clergymen, although not necessarily representative, disclose that many are deeply troubled by the challenges to modern religion. Some suggested that religion can have its most positive effects on mental health by relating the individual to the processes of growth and change, and that "fear" religion—emphasizing sin, guilt, and anxiety—works in the opposite direction. Most believed that their most critical and demanding problems were the problems of their parishioners and how to help them deal with them. Many were concerned over their own limitations in the counseling area, although only two of the respondents went so far as to comment that the substitution by the pastor of comfort for therapy creates the danger of masking deeper psychological problems.

"A picture emerges from our limited survey," writes the author, "not of clergymen with serene confidence in religion, in the church, in themselves when confronted with mental health problems, but rather of men in a dilemma, considerable ambivalence about the efficacy of religious resources, and at the same time reservations and anxiety about referring parishioners to psychiatrists and other professional resources."

Psychiatrists are outnumbered by the clergy 35 to 1. How do psychiatrists regard clergymen as a mental health resource? Are they anxious to enlist them as allies?

Twenty-two psychiatrists in a large metropolitan area in the east were asked these questions. Most of them were not themselves religious in any formal sense, and they reported that explicit religious themes were rarely encountered in the content of the illness of their patients, although there were more general and less traditional religious overtones to conflicts centering around conscience and guilt.

These professional mental health specialists said that referrals of patients from the clergy were rare, although conversely a majority said they utilize or favor the use of the clergy in connection with treatment and believe clergymen can be a useful resource, given proper training and experience.

In general, they thought clergymen should concentrate on the spiritual welfare of their parishioners with emphasis on their personal role as counselor, listening skillfully and understanding their own limitations and functions in this role. They suggested that the clergy should refer parishioners to professional resources when they appear sick, exhibit the danger signals of mental illness, or behave in a bizarre manner.

None of the psychiatrists interviewed said he was "against" religion or expressed a belief that the religious view of reality may create psychological problems.

The Churches and Mental Health next discusses the church counseling center, a new mental health resource that has appeared within the last decade; it is sponsored largely by Protestant denominations in the bigger urban areas.

These pastoral centers usually have been established as additions to existing agencies and not as substitutes for other mental health facilities. The author thinks this is the best organizational method for making the counseling functions of the ministry more widely available, even if centers do assume functions that many believe are more properly the responsibility of the individual pastor. While there is some concern that this medium may expose the community to inadequately trained personnel, it seems to be fostering greater co-

operation between religious and mental health resources and is valuable as a screening agency and as a center for advanced clinical training of the clergy in a parish setting.

Finally, Dr. McCann turns his attention to the manner in which the church ministers directly to the mentally ill, through the person of the mental hospital chaplain. There are approximately 400 chaplains of all faiths in the nation's mental hospitals. They make up .4 per cent of all mental hospital personnel; this amounts to one chaplain for every 1600 patients.

The chaplain often is in an anomalous position: his primary concern is religion, while that of the patients and other personnel is illness. Furthermore, because the usual mental hospital chaplaincy is established from the outside on the initiative of the church, the burden of communication with other personnel and of definition of his role usually falls on the chaplain.

Many chaplains have expressed frustration with their work, feeling that the ascendancy of the custodial over the therapeutic function that marks most State mental institutions relegates the chaplain to the role of a stabilizing agent. The author comments that the effectiveness of the mental hospital chaplain seems to lie much more with his personality and psychological orientation than with his religious attitudes.

Dr. McCann suggests that the churches consider subsidizing as many mental hospital chaplains as are now being supported on State salaries in order to double their number and decrease their ratio to patients to 1 to 800.

If the chaplain feels ineffective and frustrated in his role in the mental hospital, how does he look to the patients?

One hundred patients in each of two large State mental hospitals in the northeast were interviewed at random on the subject. The ratio of Catholics to Protestants was about 3 to 2.

Half of the patient-respondents said the chaplain gives help of some kind, and more than two-thirds of these regarded it in a religious rather than a secular context. Forty-five per cent reported they would welcome help from the chaplain in the future; half of these said they wanted such assistance to be of a religious and not

directly therapeutic nature, with the chaplain acting as a member of the therapeutic team whose function is to give sustaining spiritual support.

However, half of the patients said they had received no help from the chaplain, and more than half didn't want any. Only 5 of the 200 interviewed said they thought the chaplain played an important part in making them feel better.

Dr. McCann concludes from his study that the clergy "must realize that religion is only one aspect of the individual's total value system and orientation, and be able to discern that in the long-range growth process, other factors may be as important as religion. . . ."

It is difficult at best for the ministry's work with the mentally ill to be more than peripheral, he says. The clergy, therefore, might most effectively concentrate its efforts in the area of prevention, working especially with the close relatives of the mentally ill, with members of broken homes, and with others whose mental health is in jeopardy.

An important aspect of the clergyman's function in this respect should be to provide intervention during times of crisis—partly by means of religious rituals, partly by simple, direct support or action, assistance that is not so much psychiatrically motivated as it is wise and humane. Of particular importance to the clergyman's realization of this potential are his accessibility and the pre-existing relationship of the parishioner with a religious group and tradition.

Dr. McCann suggests that better preparation of the clergy for a significant role in the field of mental health can be provided by giving more attention to pretheological education, especially in the social sciences. Candidates for the clergy should be carefully screened and tested, with particular emphasis on their motivation, on a par with procedures for selecting graduate students in other fields, he suggests. And much more emphasis should be given intensive clinical training in the parish setting as a prelude to actual counseling.

The prevalence of religion in modern American society, as measured by church membership or affirmation of faith, does not seem to have had any measurable positive or negative effect on mental health. At least we must arrive at this conclusion in the absence of better methods of assessing these indistinct variables than we now

have. Moreover, the churches, as nearly as this study was able to determine, are not devoting much more attention to mental health than is society at large.

Finally, the effectiveness of clergymen as psychological counselors appears to depend much more on their capacity for understanding human behavior and on the warmth of their personalities than it does on their professional training or orientation. This may also apply to mental health personnel, and with more cogency than many of us in the field are willing to admit.

THE PROFESSIONAL MANPOWER DILEMMA

The Joint Commission asked Dr. George W. Albee, who had made a previous study in this area, to do an extensive analysis of manpower trends in the mental health professions as one of the high-priority tasks in the Mental Health Study. *Mental Health Manpower Trends* (1959), his report, concerns itself mainly with the supply and demand for psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers. These four categories include the professionally trained persons whose qualifications—given our present state of knowledge and our present system of mental hospital care—would appear to count most in bringing about the recovery of increased numbers of persons with major mental illness. This focus is not intended to minimize the contributions made by occupational therapists, nurse attendants, or others who are also mentioned in Dr. Albee's work.

The author concludes, with frank pessimism, that sufficient professional personnel to eliminate the glaring deficiencies in our care of mental patients will never become available if the present population trend continues without a commensurate increase in the recruitment and training of mental health manpower. The only possible ways of changing this negative outlook for hundreds of thousands of mental hospital patients would require either a great change in our social attitudes, with a consequent massive national effort in all areas of education, including large increases in the num-

ber of mental health personnel, or a sharp breakthrough in mental health research.

What Dr. Albee has succeeded in doing for the first time in a document of this magnitude, with great force and clarity, is to relate the shortages in mental health manpower to the shortages in other categories of professional manpower and to the deficiencies in our system of secondary and higher education insofar as it relates to stimulation of our bright young people to go into professional careers, particularly in science. He believes that the trend in our social and cultural values has been anti-intellectual, anti-educational, and anti-professional.

He first reviews the rise of modern man—his increased industrial productivity, his increased freedom from painful toil simply to stay alive, his longer, healthier life, his improved standard of living—and shows how these gains have depended on education and science, that is, man's capacity for systematic knowledge and creative thought.

From man's success in mass productivity has come a high respect for the producer and the rewards of manufacturing and selling the product, and also a collection of curious imbalances. The factory, the marketplace, public health, a lower death rate, and an increased birth rate have brought us urban life as the predominant pattern of living, and with it, crowding, tension, and conflict. This success has brought us relative freedom from poverty as it previously existed, but it also has brought us a concentration of slums, skid rows, blighted areas, crime and delinquency, various forms of air, water, and environmental pollution, and hideous damage to the natural beauties of our landscape.

Emphasis on liberty and the rewards of private initiative and enterprise—of primary importance to freedom-loving, prosperous, fortunate people—also has given us a deep-seated suspicion of government regulation and social planning. Leaders of industries who make and sell frivolous (as well as essential) goods often make more money than the leaders of government and voluntary agencies engaged in essential services. Skilled laborers earn more than public school teachers. While expanding productivity, we have neglected our social

responsibilities and our public services operated at the taxpayers' expense.

One manifestation of this deterioration of social responsibility is our State hospitals. Some improvement has occurred in the last few years, but the public is only now reaching the threshold of awareness of the kinds and numbers of professional persons needed to bring these hospitals up to the level of care available in the typical voluntary or public general hospital.

As Dr. Albee illustrates with a variety of indexes, the long-standing shortage—in some instances, the nearly complete absence—of competently and specially trained professional personnel in mental hospitals—particularly in many State hospitals—has been aggravated rather than relieved by a tremendously increased demand for mental health services in other agencies—for example, schools, courts, and prisons—as well as in private practice.

The problem is not only the one with which every legislator is personally familiar—the cry for increased appropriations—but also the fact that we cannot find persons with the necessary professional skills to fill the jobs that are budgeted. Surveys of State and county hospitals have revealed budgeted positions for physicians and psychologists standing nearly 25 per cent unfilled. We have been approximately 20 per cent short in filling budgeted jobs for psychiatric nurses and social workers. In contrast, only 4 per cent of nonprofessional jobs have remained vacant.

As indicated in Chapter I of this final report, the staffing of public mental hospitals falls far short of the minimum standards for adequate care set by the American Psychiatric Association (these are truly minimum and not optimum or ideal standards). By this criterion, our hospitals have been 23 per cent adequate in nursing staff and 40 per cent adequate in social workers. The adequacy was 57 per cent for physicians (with heavy reliance on foreign interns and residents) and 75 per cent for psychologists (Joint Information Service, 1960a). Inasmuch as in some instances more recent figures have become available since publication of the manpower monograph, we have updated the findings wherever necessary in this report.

The Doctor Shortage

Whether or not there exists a shortage of physicians in general has been for some years the subject of bitter debate between proponents of public extensions of medical service versus defenders of private medical practice. But no one has denied that there is a shortage of psychiatrists in public mental hospitals, or that these psychiatrists must first go to medical school.

In 1960, competent medical authorities all agree that a general doctor shortage confronts us in the near future if medical school production of graduates is not increased. Simply to maintain the present ratio of all physicians to patients in the United States in the face of a continued increase in the nation's population, we must expand our present medical schools and establish new ones "gradually and persistently." This is the conclusion of the Council on Medical Education and Hospitals of the American Medical Association in its 1959 annual report. The A.M.A. report underscored this point: *"The basic and urgent concern is that all estimates indicate a need for expansion of educational facilities in medicine in a brief period which far exceeds any expansion of such facilities that has occurred in a similar period in modern times."*

And, we may add, far exceeds any attack on the problem that yet has been staged.

On the basis of predicted population growth over the next 15 years, the A.M.A. Council estimated that the annual supply of medical graduates would need to be increased from 7000 in 1960 to 10,000 in 1975. The Surgeon General's Consultant Group on Medical Education, under the chairmanship of Mr. Frank Bane, made a rather similar estimate in 1959 except that it included doctors of osteopathy in estimating the need for more physicians (U.S. Department of Health, Education, and Welfare, 1959).

To increase the supply of physicians is a complex undertaking, as the Bane report makes clear. Our medical schools already face serious financial difficulties which have not been resolved. There has been strong resistance in organized medicine to Federal aid to medical education. Leading medical educators, however, support

Federal aid with safeguards against a rate of expansion that would reduce the quality of medical students and of their professional education.

The Shortage of Psychiatrists

The task that faces medical education and its public supporters offers little encouragement for expecting any great increase in psychiatrists in proportion to population. Albee suggests that this specialty may have a difficult time in holding its own if the upward population growth continues.

In Table 4, from *Research Resources in Mental Health,* Dr. William F. Soskin shows the percentage distribution of physicians listed as full time specialists in 1955, as well as the distribution of scientific researchers and of journal publications among the specialties of medicine. Only 6.7 per cent were psychiatrists and 2.0 per cent were neurologists, a total of 8.7 per cent in these two fields of special importance in the treatment of nervous and mental diseases. It is of interest to note that the Harvard Medical Alumni Association in 1960 questioned the graduates of ten Harvard Medical School classes from 1910 to 1955 as to their specialty. Some 5.6 per cent listed themselves as psychiatrists or neurologists.

It is true that the number of psychiatrists in the United States has tripled since World War II, from 4000 in 1946 to nearly 12,000 at present (at this writing, in 1960, the American Psychiatric Association has 11,787 members). The trend is encouraging; however, close consideration indicates that some part of the early increase was a postwar phenomenon, and must be considered a one-time benefit from the fact that many returnee physicians, medical officers during the war, elected to go into psychiatry.

There has been a continued increase of interest. For example, in the two-year period from August 1956 to August 1958, the number of resident doctors in psychiatric training increased 30 per cent from 2074 to 2723 (Joint Information Service, 1959b). This increase did not reflect a rise in the number of officially approved training centers (268) but an increase in the number of officially approved programs

Table 4—Comparison of Medical Specialties by Size of Specialty, and Number of Scientists, 1955

Specialty	*Full-time Specialists 1955* (per cent)	*Estimated No. of Scientists 1955* (per cent)	*Scientists in Specialty as Per Cent of Total Specialists 1955*
Internal Medicine:			
Int. Med.	21.3	——[a]	——
Derm. & Syph.	2.4	——	——
Phys. Med.	0.5	——	——
Total	24.2	40.0	12.4
Surgery:			
Surgery	18.7		
Orthopedic	3.7		
Urology	3.3		
Total	25.7	14.9	4.4
Ophthal.-Otorhin.	11.7	5.0	3.2
Obs. & Gyn.	8.7	3.5	3.1
Pediatrics	7.9	4.7	4.5
Psychiatry	6.7	7.6	8.8
Radiology	5.2	——[b]	——[c]
Pathology	3.1[c]	12.4	31.0
Anesthesiology	3.0	1.2	3.1
Public Health	2.0	6.7	25.0
Neurology	2.0	4.3	16.7
Total	100.0*	100.0	
Number	82,689	6,255	

* Figures do not add to 100 due to rounding.

[a] Data for separate specialties not available.

[b] Data for scientists could not be separated from radiobiology.

[c] Data for full-time specialists includes bacteriology; therefore the entry in the third column for pathology alone is too low. Remaining figures pertain to pathology only.

in which residents were enrolled—from 215 to 245. The bulk of the training programs were in New England and the Middle Atlantic States, there being 10 States with no psychiatric residents in training and 22 States with no psychiatric residents training in their State hospital centers.

Analysis of the 1956–1958 increase of psychiatrists-to-be modifies the picture of growth, revealing that a good part of it was due to foreign-trained physicians coming to the United States for graduate training, mainly in State hospitals. This may be seen from the following figures:

Residents	*1956*	*1958*	*Per Cent Gain*
Total	2,074	2,723	30
Foreign	693	1,071	54
American	1,381	1,652	23

But the greatest shrinkage in gain from the standpoint of improving psychiatric treatment of mental patients in public hospitals and public clinics is that the vast majority of psychiatrists go into private practice, or devote a large part of their time to private practice. The same statement applies to psychiatrists trained at Federal expense. The explanation is simple: Not only is treatment of severely psychotic patients more difficult and trying, but even those who are challenged by the problems of working with schizophrenic patients find the income from State institutions too small to support them and their families if appointments are undertaken on a full-time basis.

When we confront the total problem of care of the mentally ill, we find that, despite much talk and some progress, the greatest shortage still occurs in the area where patients with major mental illness are concentrated—in State hospitals. One result has been a bidding by one State against another for the services of the small number of hospital psychiatrists available. The inevitable result is that those States with the least available money have the fewest psychiatrists, and the average State hospital continues to occupy its historic position in the forgotten corner of medicine.

The supply of psychiatrists is dependent on what motivates a medical graduate to become a psychiatrist and, before that, what motivated the college graduate to become a physician. As yet, we are not too well informed on these motives, though we surely need to be. Personality and motivation studies have been undertaken by the Association of American Medical Colleges, the University of Pittsburgh, and Tulane University, with the aid of the Commonwealth Fund. We have not seen reports of results as yet.

Certain facts are generally known or can be assumed. All fields of interest compete for the medical student's attention. The field attracting the most candidates is apt to be one where (1) important discoveries recently have been made, (2) opportunities exist for helping some type of patient in a clear-cut manner, and (3) the student can foresee a career offering intellectual, social, and financial rewards.

What attracts the individual student will depend in some part on his own personality and ambitions. By and large, fields in which it is difficult for the doctor to see the good results of his efforts or where the general outlook of the patient is poor do not attract. Every branch of medicine is a mixture of art and science, but those preferred place fewer demands on individual creativity and judgment and depend more on scientific knowledge that can be reduced to routine, reproducible techniques.

In the candidate's two crucial decisions—to go into medicine and to enter a specialty—we can readily guess that the most heavily populated branches of medical practice will weigh most heavily in the scales of choice. These are internal medicine, surgery, and general practice, the general practitioner traditionally being conceived as a combination of medical man and surgeon. The assumption here is that imitation is a substantial factor in influencing the choice and that imitation depends on prevailing images and opportunities for contact with them. The most prevalent and also most forceful image is that of the surgeon.

The beginning of the recruitment process in medicine can be judged from studies reported in *The Student-Physician* (Merton *et al.,* 1957). Studies made among medical students at the University of Pennsylvania and Western Reserve University showed that well over 80 per cent of them first considered a medical career before they graduated from high school (by their seventeenth year), more than half by the time they were thirteen. Forty-four per cent in the Pennsylvania study reached a definite decision to study medicine before high school graduation. The peak time for this decision was in the first two years of college, 41 per cent reaching it between the ages of eighteen and twenty, and another 10 per cent by age twenty-two.

It is easy to see that if we want to increase sharply the proportion of medical doctors motivated to go into psychiatry, we must concern ourselves with the favorable exposure of high school youths to psychiatrists, and must regard the freshman and sophomore years of college as the last good chance of making an impression. Actually, of course, the decision to specialize need not be made until the student has graduated from medical school and entered his internship, but

it is logical that the student will have developed strong leanings by that time. As the Merton group points out (pp. 191–192), when fourth-year medical students at Pennsylvania, Cornell, and Western Reserve were asked what type of patients they preferred, it was not surprising that:

> The choice between patients with physical and emotional illnesses is so heavily weighted that almost no student *prefers* the latter. . . . Compared with the patient with discernible physical illness, the emotionally ill patient requires the doctor to explore a wide array of possible organic disturbances, for he must guard against failure to uncover a serious organic illness in the course of practicing an immature psychiatry. . . . And finally, it may not be clear what, if anything, can be done for the patient.

Is it any wonder that there are approximately three times as many doctors specializing in surgery as there are in psychiatry, exclusive of the larger number of general practitioners who do some surgery?

Reorienting General Practitioners

Our nationwide opinion survey showed that three out of ten mentally troubled persons turn for help to their family doctors. This immediately suggests the general practitioner as a great potential resource in the care of the mentally ill. Indeed, the National Institute of Mental Health has made valiant efforts to attract general practitioners into psychiatry in the last two years, and the American Academy of General Practice has pursued postgraduate training in psychiatry for its members with considerable vigor. These are worthwhile efforts both to produce more psychiatrists and to orient the practicing G.P. toward more effective recognition and treatment of mental ills. Yet we cannot soberly expect these efforts to provide any substantial solution of the vast problem of the untreated mentally ill.

As we saw in Chapter III, only 17 per cent of the general practitioners studied by the Peterson group demonstrated a readiness both to recognize and effectively to treat psychological problems in their patients, although another 54 per cent recognized such problems. The bias of the typical medical student toward physical treatment is fairly well fixed by the time he graduates, even though psychiatric and psychological subjects are a part of his basic and clinical training.

It is not that the student, his professors of medicine and surgery, and the young doctor himself as he enters internship and later practice are unaware of mental illness, or that they will not concede the importance of emotional factors in medical care, but that they are more interested in something else.

In any event, the patients of his community ordinarily present a family doctor with all he can do along conventional medical and surgical lines, such as the treatment of infections and injuries, without adaptation of his pattern of practice to the more time-consuming treatment of mental problems. In addition, some G.P.'s who have attended postgraduate courses and lectures given by psychiatrists on psychiatry in general practice complain that psychiatrists talk down to them and do not give them much useful information about psychodynamics and psychotherapy, in apparent fear that they will not understand or will attempt too much (Greengold, 1960). It seems to us that the mental health field is still some distance from achieving the much-heralded *rapprochement* between the psychiatrist and the family doctor.

The Supply of Psychologists

We have fared somewhat better in the total supply of psychologists, Dr. Albee reported. At the end of World War II, we had about an equal number of psychiatrists and of psychologists overall. The number of psychiatrists doubled in ten years' time. Meanwhile, the number of psychologists quadrupled. (In the last few years, however, the increase of psychiatrists has been somewhat higher than that of psychologists.) There are now more than 18,000 psychologists.

At first glance, this increase appears encouraging. In a way, it is, but only about one-third of all psychologists engage in clinical services, where their skills would count in the care of the mentally ill. The largest number are employed as college teachers. The second largest number of psychologists are employed by the Federal government, mainly for research, some of it related to mental health. Private industry employs a sizable number for aptitude testing and for personnel, management, and market research.

Albee attributes the larger supply of psychologists principally to a

more favorable recruitment situation. Psychiatry must depend on a medical school student, who is already a college graduate, becoming interested in this specialty. In contrast, psychologists have direct access to undergraduates in college courses in psychology, and the subject is a popular one. Thus, as college enrollments increase in the next fifteen years, psychology's manpower pool will increase. There is reason for optimism, he concludes, regarding a continued upward trend in supply. It may not be sufficient to meet the demand, however.

The Need for Social Workers

The prospects are not so bright in relieving the shortage of social workers. Part of the problem, this report indicates, is the lack of a clear-cut and favorable definition of the social worker's role, as the public sees him and as he sees himself.

To illustrate: The image of the physician as a friendly, helpful, healing figure is deeply etched in the average individual's mind. He is considered worthy of emulation; in fact, people envy him. The stereotype of the psychiatrist as peculiar or in some way different from other doctors persisted at least until the last war. Since then the psychiatrist's status as a member of the medical profession and a popular figure in our society has improved; this is probably due to the educated public's interest in human behavior, the psychiatrist's emergence as an expert, and his greater availability as a private practitioner. But the evidence of public attitude studies indicates that there is still room for improvement in his public acceptance.

The psychologist has been successful in making his profession appear attractive to youths in search of a career. His work is naturally interesting: human behavior, normal or abnormal, is interesting both in its psychological mechanisms and in its meanings.

But the social worker, who is a key figure in any clinic or hospital proposing to provide competent care of mental patients, including attention to their social and enonomic circumstances, presents a rather vague image in the minds of many people. Indeed, we have observed misinformation and prejudice, as on the part of a State legislator who objected to the term "social worker" on the grounds

that it implied socialism; "case worker" was acceptable to him, however.

Generally speaking, social work can be visualized as centering on the management of cases with the object of alleviating a crisis in the life of an individual, family, or group. This is done in a variety of ways, but always with the purpose of helping someone who needs help, without intent to use, control, or exploit him.

Only a tiny fraction of the 80,000 social workers in the United States are psychiatric social workers. The great majority are employed by Federal, State, or local governments. They are mainly college graduates, somewhat less than half of whom have had one, two, or more years of training in graduate schools of social work. Psychiatric social workers fall in the category with the highest training and are commonly regarded as an elite group in their profession. Because of the great shortage, there is a good deal of competition for their services and there is apt to be a rapid turnover in any given job.

Dr. Albee reported an estimated need for an additional 50,000 social workers by 1960. Schools of social work were training not more than 2000 a year. In the immediate past, these schools have not been able to fill their classes. The situation may improve somewhat with increased college enrollments, but the increase is not expected to meet estimates of need ranging from 4000 to 12,000 new social workers a year. Inasmuch as college students are not regularly exposed to social work as part of their undergraduate education, the schools of social work lack any ready-made recruitment device.

Recruitment of Psychiatric Nurses

Nursing is the largest of the health professions. It enjoys widespread social approval insofar as the nurse fulfills the public image of a tender, comforting figure who relieves the suffering of her patients.

A sizable number of high school girls aspire to be nurses. Although there has been a general shortage of nurses for some years, recruiting efforts on the part of the nursing profession have been effective and the number of general nurses has steadily increased. The increase has not kept up with demand, mainly because of a 5 per cent annual

drop-out rate, primarily due to marriage. As in social work, the prospect of relatively low pay in relation to professional training requirements handicaps recruitment, but working conditions have greatly improved.

This fairly wholesome outlook does not apply to psychiatric nursing. Although they have nearly half of all hospital patients under their care or supervision at any given time, psychiatric nurses make up only 5 per cent of nurses employed in hospitals.

The best opportunity for recruitment occurs during the nursing student's basic course in psychiatric nursing at which time she receives experience in a psychiatric ward of a general hospital or a mental hospital. What she may find, however, Dr. Albee remarks, is a kind of nursing duty quite different from any conception of bedside nursing. The psychiatric nurse's job is largely one of administration, teaching, and supervision of attendants. Her role often is more akin to management than to caring for patients, except in helping the physician in the administering of therapy involving technological skills.

This level of nursing duty, with its emphasis on teaching and supervision, is better served by graduate training beyond that encompassed either in the programs of hospital schools of nursing or in college nursing education programs, but there is a serious shortage of nurses with such advanced training. The annual requirement for nurses trained for leadership was 4000 by 1960, against the current output of 1000.

There was one nurse to every 53 beds in psychiatric hospitals compared to one to every 3 in general hospitals. When the comparison was limited to general-duty nurses alone, there was one nurse for every 4 beds in general hospitals and one for every 141 in psychiatric hospitals.

If psychiatric nursing continues to attract only 5 per cent or less of hospital nurses, we may expect an increased shortage as time goes on.

Occupational Therapy

Discussions of the mental health professions and the "mental health team" are prone to focus on the psychiatrist, psychologist, social

worker, and nurse and, in so doing, to neglect the profession of occupational therapy. While the group is a small one—in 1957 there were approximately 5500 occupational therapists registered with the American Occupational Therapy Association—the occupational therapist is a key figure in rehabilitation programs. The basic qualifications are a college education plus nine months of resident training in an occupational therapy program.

Occupational therapy, since its beginning more than a half century ago, has required a minimum of three full months of training in a psychiatric setting plus courses in mental illness and the theory of application of activities in treatment. In this respect, the profession has been a pioneer in recognizing the importance of an understanding of mental illness in the treatment of physical and social disabilities associated with it.

Miss Beatrice Wade, O.T.R., a Joint Commission member, comments:

> The shortage of manpower in occupational therapy is very great: in too many articles and literature . . . the writers confine mention to psychiatry, psychologists, nurses, and social workers when enumerating the existing manpower shortage. This disregard contributes adversely to the occupational therapy recruitment problem for young people are sensitive to its omission in many statements which are designed to attract people to the field of psychiatry.

Practical Nurses

The rise of the licensed practical nurse as an adjunct to hospital nursing service has been spectacular in general hospitals, and may be expected to continue. This movement, however, has been of little benefit to mental hospital patients. The typical practical nurse is an older, married woman with a family who wishes to work near home, usually in the hospital where she trained.

Attendants

The largest category of mental hospital personnel is attendants or psychiatric aides, as they are also called. They total between 80,000 and 90,000. Although there is some shortage, Dr. Albee reports, it is not great. In times past, attendants' jobs have been filled by untrained

persons paid disgracefully low salaries. Although many skilled and devoted persons have filled these jobs, the lack of specific qualifications has made it possible for some persons with serious personality problems of their own to drift into this occupation. In recent years in many States the attendant's job has been considerably upgraded as the result of on-the-job training programs, increased pay, and improved working conditions. Dr. Albee could find no accurate data on the extent of this improvement. An intensive study of the role of attendants is badly needed.

Professional Manpower in General

Albee reasons, quite logically, that we cannot evaluate the shortages of professionally trained manpower in the mental health field without at the same time contemplating the widespread shortage of highly trained persons in a variety of technical and professional areas. The reason is simple: We all draw on the same pool—namely, young men and women who are graduated from college. Any particularly successful efforts at recruitment in one field must necessarily be made at the expense of another field also reporting a shortage.

Any upward trend in the supply of any and all kinds of professional manpower will depend, then, on the strength of our educational system and the motivation of our youth in greater numbers to seek professional careers. The nature of a profession, with its emphasis on expert knowledge and specialized service to others, presupposes superior mental competence, moral responsibility, and advanced educational achievement.

At present, our system of education at both high school and college levels apparently fails to inspire students fully to utilize their brain power in ways that would prepare them for professional careers. There is, Dr. Albee states, a fundamental lack of appreciation and interest in intellectual achievement in our society and its schools and colleges.

Now suddenly we have been forced to the realization that the quality of our educational system has been on the downgrade for some years, Albee asserts. The trend in our high schools has been away from teaching the more difficult subjects involving mathe-

matics and a basic understanding of science and toward teaching life adjustment and immediate vocational skills. The same trend persists in college, where students poorly prepared in high school drift into courses that do not require extensive backgrounds in mathematics and the sciences. In short, some types of intellectual discipline have been sacrificed and science requirements softened.

Paralleling this deterioration of scholarly interest and lack of rewards for outstanding scholastic achievement in mathematics and science, we have witnessed the exodus of many of the best qualified secondary and college teachers to take higher paid jobs, usually in industry.

Our schools and colleges are shockingly underfinanced and our teachers vastly underpaid. These facts have been dinned into the public's ear and are so well documented by so many different sources that they need no review here.

THE CRISIS IN EDUCATION

The crisis that we face in education—and therefore in the training of professional manpower, and therefore mental health manpower—will become more acute, Albee points out, when the students who have swollen the enrollments of the public school system (with results, we should say, now made obvious to all who will listen) go on to our institutions of higher education.

But on the whole, the American public appears incapable of recognizing the full implications of its educational problem and of becoming sufficiently alarmed to take the necessary degree of effective action. Educators have expressed alarm. Political statesmen have expressed alarm. Military leaders have expressed alarm. Industrial statesmen have expressed alarm.

What is the nature of this apathy?

Albee believes it arises as a consequence of our industrial success and the abundant increase in consumer goods for a large majority of our people, with an attendant shift of emphasis to the importance of merchandising and the objective of a life of comparative ease.

Though high quality education is crucial to the maintenance of

technological and scientific progress, both in our consumer society and in military competition, it does not seem too important to most citizens. Our system of public schooling, Albee continues, has been responsive to—indeed, is dependent on—people who are not at all impressed with the importance of intellectual achievement. Mediocrity is all too evident.

In the end, the student's education must be financed by his parents, by himself, or by society if he is deemed worthy. At present, higher education has become so expensive—the minimum cost of a college education is $6000 to $8000—that it has been priced out of reach of many parents and their children. Only a part of this cost is tuition and it, in turn, covers only a fraction of the operating expenses of a college or university which then must make up the difference from other sources.

As matters now stand, college faculty members indirectly subsidize a part of the cost of their students' education out of the deficiency in their salaries as compared to those of persons of equal training in private enterprise. Albee reports that college teachers' salaries need to be raised at least 50 per cent in the next five years. Only in this way can competent faculty members be prevented from continuing to seek more remunerative jobs elsewhere, abandoning higher education as a sinking ship.

Dr. Albee distributes responsibility for the decerebrate trend in the American value system so broadly—both educators and businessmen share some of the burden of his criticisms—that we might better acknowledge that we all participate in the responsibility for the anti-intellectual and anti-educational attitudes he documents. At least one member of the Joint Commission feels that one group which Albee did not scrutinize must share in the responsibility—the liberal arts professors. As this one critic states:

> [The liberal arts professors] have simply been socially irresponsible . . . aloof from all concerns of public education, and even have allowed the colleges to become centers for the entertainment of the public. An assumption that liberal arts professors are brighter than the education specialists only makes more reprehensible their irresponsibility and their willingness now wildly to flail everyone but themselves. . . .

Albee does make this telling charge: those who go to Washington to fight Federal aid to education on the basis that public schooling is a prerogative of State and local governments often are the same ones who go back home and oppose increased State educational aid or bigger local school budgets. The problem seems to be one of a dislike for taxation coupled with a dislike for education. Through selfishness and ignorance, the education of our youth suffers.

Presuming lawyers, teachers, chemists, physicists, psychiatrists, psychologists, and other members of learned professions to be desirable members of our society, and also presuming that it is not wholly disgraceful to cultivate the brains God gave us, Dr. Albee cites a dramatic measurement of the amount of brainpower that is being wasted in the United States today:

Of 10,000 youngsters, 7880 enter high school, 5755 graduate from high school, 2016 enter college, and 1190 graduate from college.

Only about one in ten will enter the professional manpower pool, in other words. The above calculations take the students as they come, without respect to intelligence. The data reveal that this, contrary to widespread opinion, is in large measure the way our colleges take them.

Here is the situation when mental ability is taken into account:

Of 10,000 youngsters in a given age group, 2000 are in the top fifth with respect to intelligence; 1963 of these enter high school, 1857 graduate from high school, 864 enter college, and 692 graduate from college.

The manpower pool of the mental health professions, as of other professions, depends (to a great extent) on the number of youths of superior mental competence who graduate from college and go on to graduate school. From the above figures, it would appear that only one in three of our brightest students enters the professional manpower pool.

The explanation for the number of students who, after entering high school, fail to obtain a college education lies in a complex of factors, including lack of interest, lack of inspiration, lack of self-discipline, poor study habits, lack of money. Both motivation and money are important, in that order.

Motivation usually comes either from one's parents or from a singularly good teacher. Professional parents produce a large percentage of children who enter professions. Many scientists report that their curiosity was originally stimulated by one teacher or another, in high school or college.

THE MOTIVATION PROBLEM

It is of special interest to a national mental health study that our culture does not manifest a great respect for the mind. This conclusion certainly follows not only from the deficiencies in our educational system that Dr. Albee demonstrates but from our lack of sufficient concern for those who are mentally sick. Our minds seem to be a small matter to us. What sounds merely ironic may prove massively tragic if we are unable to use our imaginations and creative energies in ways that will improve our value system and reverse the present trend.

What can we do to reduce the mental health manpower shortage now or in the near future? We can hope wholeheartedly for the first possibility that Albee entertains—a great change in the public's attitude—without really counting on it if we are guided by experience.

The second possibility he mentions, a major breakthrough in prevention or treatment methods, could greatly reduce the demand for professional services for the custody and continuous care of patients with schizophrenia or cerebral arteriosclerosis. These two classes of patients fill the great majority of our mental hospital beds. The care of such patients would be greatly simplified by the development of a biochemical or other technique that could be administered to large numbers by a single therapist.

However, we can also agree with Dr. Albee that it would be unrealistic to pin all our hopes on such a research breakthrough. Certainly, both basic and clinical research should be supported to the maximum, but even with such support, we cannot count on increased purchasing power to produce the desired result.

A characteristic of scientific research is that it ultimately produces

results of potential benefit to us all, but we cannot predict when such results will come or even that they will be the ones we were looking for. The time element is uncontrollable. There was a lag of forty years between the time Karl Landsteiner discovered the cause of poliomyelitis and the time John Enders and his associates found the way of cultivating the virus for effective vaccine production, although scientists worked on the problem of prevention regularly in the intervening years. The breakthrough often comes by chance. Sir Alexander Fleming was not looking for penicillin when he observed its effects, and yet this antibiotic has made more difference in the control of infectious diseases than any other drug in medical history.

The development of the tranquilizing drugs and their helpfulness in the management of disturbed and agitated mental patients has been a source of encouragement in the care of the mentally ill. But one point is often overlooked: Although the drugs and the hopefulness they inspire make mental hospital employment more interesting and therefore more attractive, they do not relieve the need for professional experience and skills but increase it. These are not harmless drugs. Their effects must be closely watched and evaluated. In addition, they render persons hitherto out of contact with their surroundings accessible to psychotherapy, re-education, and rehabilitation. Thus, they actually increase the need for trained therapists.

This brings us back to the need—so obvious that it is banal to repeat it—of training more professional personnel. Albee notes that States and regions making an extensive effort to establish, strengthen, and support mental health training programs of one sort or another are at once in a more favorable position than those that do not. Training programs attract teaching talent and teaching talent attracts students. Students tend to stay in the area where they are trained. To be effective, of course, such programs need financial support and recruitment devices.

Dr. Albee entertains the idea, as others have originated and discussed it, of creating a new helping profession in mental health. The training of a fully qualified psychiatrist requires 13 or 14 years beyond high school. The proposal is to create a new person carefully trained

in psychotherapy but without the lengthy basic medical, general clinical, and advanced specialty training—a person to be trained in a maximum of 4 college years. Presumably, such a person would work under adequate supervision and in a publicly accepted mental health agency.

The dynamics of personality and behavior present a complex problem, and depend on an intricate interplay of multiple factors; even the physician and psychiatrist must evoke the utmost in knowledge and art to achieve a desired result. Many psychiatrists, knowing this, would view the proposal of a doctor-substitute or "junior psychiatrist" with instant dismay.

As Dr. Albee points out, the creation of a new profession begs the underlying question of how its members will be recruited and trained, and thus returns us to the numbers treadmill. Such people would have to come from the same shallow professional manpower pool as do all others.

As a principle, we can state, with Albee, that every professional person should do those things which most help the largest number of persons needing help. The crucial questions are *how,* and *for whom.* The possibilities for experiments in what methods provide the most help are often foreclosed by the mental hospital's sheer lack of personnel to cope with the hundreds and thousands of patients to be admitted and managed. The professional staff's first responsibility is to carry out treatment along generally accepted lines. For small staffs, this becomes more than a full-time job.

Yet we need to engage in an intensive exploration of methods of obtaining better staff utilization. The maximum benefits for the patient appear to be secured through individual attention in a "friendly but firm" environment. We have a great deal of practical information about the psychotherapeutic and re-educational process in the long-term, face-to-face uncovering and examination of the patient's problem, conscious or unconscious. We also have explored how the patient sees his problem against the perspective of how the psychiatrist and outsiders might see it. Psychoanalysis has provided us with much basic information, some of which may be modified and adapted to group therapy and environmental manipu-

lation. All this knowledge, plus information from the field of sociology on the nature of emotional forces among people in groups, provides further opportunity for the refinement of group therapy. It calls for further research with the goal of dividing the task of treatment into distinct but interrelated jobs that might be handled by skilled technicians or subprofessionals.

Such an approach would necessitate the presence of a highly skilled therapist to organize, guide, and support such workers. The analogy of treating the patient by assembly line techniques is tempting, but inexact. At present, the complex steps involved in the treatment and cure of a large variety of mental or emotional illnesses are not sharply enough defined to permit this separation of a total process into separate but integrative units. Because the realization of such a goal would go a long way toward more efficient use of our professionals and a large number of attendants, aides, or their equivalents at the community level, this area deserves intensive research.

Dr. Nicholas Hobbs, a member of the Joint Commission, proposes experimentation with professionally trained but nonmedical persons similar to the *educateurs* employed by France in the care of emotionally disturbed or maladjusted children. The *educateur,* as set forth in the writings of Dr. Robert Lafon, French neuropsychiatrist, and personally observed by Dr. Hobbs (1959), is a blend of group therapist and teacher, and perhaps may best be described as a professionally trained substitute parent. He lives with the children in several different classes of residential treatment center on a round-the-clock basis. His role is reminiscent of the medical superintendent of the small, nineteenth-century moral treatment hospital (see Chapter II) who lived, dined, worked, and played with his patients as a benevolent father figure.

Educateurs are largely selected from among young teachers who have stable personalities, have led full lives, and have already demonstrated an intuitive capacity for work with children. Following a one-week orientation and testing period, in which about half the candidates eliminate themselves, the individual undergoes two years of training aimed at providing him with some of the skills of the psychologist, social group worker, special teacher, and recreation

leader. He is taught to work in consultation with the psychiatrist, social worker, psychologist, and court officer, who are normally consultants to the residential treatment center.

The center's objective for the child is not individual psychotherapy so much as providing a therapeutic environment with all essential educational, medical, and welfare services by qualified persons, the emphasis being shifted from a hospital-and-clinical to a home-and-school frame of reference; as Dr. Hobbs points out: "In America, we tend often to put the school experience in a position secondary to formal psychotherapy. In doing so, we not only miss an opportunity to use the child's main job (next to effecting an adequate adjustment to his family) for therapeutic purposes, but we often send the child back to school behind his classmates and thus handicapped . . . as an effectively functioning person."

The director of a residential treatment center may be a teacher, *educateur,* social worker, psychiatrist, or psychologist. Dr. Hobbs was struck by "a tendency to choose among people rather than professions" in the operation of the center, "willingness to give people responsibility commensurate with their ability and training, the absence of aides, attendants, and other marginal professional people, the absence of phony directorships," and lack of "concern for professional prerogatives in appointing directors." Typically, the ratio in a French boarding school for maladjusted children is one *educateur* per group of ten children. He receives a teacher's salary while in training and about 15 per cent more after graduation.

The chief intent and value of *Mental Health Manpower Trends* has been to give us a bedrock statement of the nature, breadth, depth, and overall significance of the manpower problem. From this bedrock it becomes the task of all interested persons to devise a program that will help us locate, build, and fill our professional manpower pool.

One might find some cause for regret that Dr. Albee did not dwell at greater length on the subject of career motivation, which includes inspiration, emulation, example-setting, a good press, good will, and other factors lumped under the somewhat disreputable but highly

significant term, "image-making." He does successfully demonstrate how important to a profession's recruitment it is for the public to have a favorable mental image of the person in the profession.

He makes it clear that our potential reservoir of professional manpower—untapped manpower—lies in the able-minded high school students who are either not motivated or not financially able to go to college and pursue a professional career. Two-thirds of this reservoir now leaks away.

Any general solution of the professional manpower shortage must of course depend on new, greater, and more successful efforts to support our educational system from the elementary school all the way through the graduate school, but it is questionable how much of the needed support will be forthcoming without important changes in public attitudes toward teaching, toward study, and toward people who try to use their minds in a rational manner. This, as far as the general professional shortage is concerned, is the keystone in the nonintellectual façade our culture presents.

We have seen various studies of what high school students and the general public think of scientists and of their teachers. The images are far from favorable, and often distorted or uninformed. The better studies indicate that our youth are not being encouraged to choose professional careers, or adequately informed of career opportunities in public service pursuits. Yet we know full well that children are imitative, and that what they become is determined to a great extent by what we provide for them to imitate.

The public attitude toward scientific and teaching careers has improved since the rise of Sputnik I. Russian competition has done more to focus public attention on the deficiencies of our cultural values and to stimulate interest in our professional manpower shortage than all the eloquent exhortations of educators, scientists, and their few staunch friends in the legislatures for some years previously. The appeal of the conquest of outer space offers at the most only indirect benefits in attracting youth to attempt the conquest of inner man, however. Whereas the general intellectual climate would seem much improved in the last three years, the student showing interest

and aptitude in the physical sciences is much favored in the inducements offered him to pursue an education and career in this direction as opposed to the youth who would prefer to "work with people."

Some efforts are being made to attract youngsters to mental health careers. One notable example is the Health Careers Program sponsored by the National Health Council. The Council published a *Health Careers Guidebook* (1955), of which more than 115,000 copies have been distributed in the nation's 30,000 high schools. The brochure describes the various opportunities available in the health field, including certain mental health positions. The Council created a Commission on Health Careers, and out of this effort 300 state and local health career committees sprang up throughout the country. As Philip E. Ryan, executive director of the National Health Council, points out, "It is difficult to evaluate the effectiveness of such efforts, designed to underpin the recruitment activities of the various professional groups, to help create a climate conducive to more effective recruitment of health personnel, and to stimulate thinking and experimentation regarding the effective utilization of available personnel." Undoubtedly, considerable interest has been stimulated.

The problem of creating favorable public images of mental health workers, particularly as viewed by high school students, requires more intensive pursuit. Dr. Albee gives us a cue to one course of action in citing the importance of contact between students and the representative of a given subject in the case of psychology and psychologists. Few subjects are of more interest to people than how and why they behave, and the task of the expert is simply to exploit natural interest through adequate exposition of his subject.

If this same platform for favorable image-making were moved back to the high school level and perhaps somewhat broadened to involve teaching in the area of the behavioral sciences—psychology, sociology, anthropology, mental health—in time it ought to make a difference in the number of high school graduates interested in seeking mental health careers or careers in basic research in human behavior. The task is one of creating more interest in working with people than with things.

This prompts the question of who would provide such stimula-

tion or models for imitation. We already are shockingly short of competent teachers in the sciences. Here we must allow our imaginations to run and improvisations to creep in.

What young psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker would not be persuaded, if such a cooperative program were undertaken under joint educational and mental health auspices, to spend some time working with the local school system in developing courses through which some of the simpler elements of human behavior (individual, social, and cultural) could be taught to pupils and to adults? Dr. Ralph H. Ojemann, a member of the Joint Commission, points out how an obstacle that has discouraged such an approach in the past can be overcome. The obstacle is the strong tendency in our culture to make superficial and arbitrary judgments of a person's behavior rather than see it, in keeping with scientific evidence, as a matter of cause and effect. For example, the teacher lacking training and understanding in the behavioral sciences may see the pupil who causes her trouble in the classroom as a "problem child" rather than as a child with a problem to be solved. Dr. Ojemann and his associates (1955) show that the approach based on arbitrary judgments can be changed by proper attention to training of teachers and alteration of course content. Not all mental health professionals would want to assist the school system in such a program, and not all would be suited to this task, but with sufficient stimulation and willingness to overcome obstacles it could be done.

The volunteer teacher proposal would have to be tried and proved. But when we contemplate the number of highly trained, competent, and successful professional people who can be found in most communities, and the capacity of Americans for community spirit and voluntary work, we must admit that we have approached the question of teacher shortages and bob-tailed curricula rather unimaginatively. Unless people who consider themselves intelligent and educated—even "eggheads"—take action of a sort that will win them respect and emulation in their communities, they will lose the battle against professional manpower shortages by default. And all of us, the nonintellectuals as well as the so-called intellectuals, will be the losers.

NEW PERSPECTIVES ON MENTAL PATIENT CARE

Exploration of existing deficiencies in the care of the mentally ill has consumed a considerable part of this report, together with our thesis as to why these deficiencies exist and some indication of how the untreated mentally ill could benefit from what is known. Members of the Joint Commission, as well as other mental health authorities, were, of course, well aware of the inadequacies in mental health services at the time the Commission was formed and the Mental Health Study Act passed.

Dr. Morris S. Schwartz, director of our study of mental patient care, chose not to make a quantitative statement of existing conditions but to concentrate on a qualitative analysis of new approaches to treatment of the mentally ill, to explore the assumptions upon which treatment proceeds, and to indicate the basic problems and issues that have to be faced if a solution is to be found to the adequate treatment of mental illness. The outcome of Dr. Schwartz's assignment, undertaken together with seven associates (whose names may be found in Appendix IV), is a forthcoming monograph, *New Perspectives on Mental Patient Care.* Its general aim is to increase the therapeutic effectiveness of our resources for helping the mentally ill. Three classes of patients were taken into account, "outpatients," "inpatients," and "ex-patients," which is to say (1) those remaining in the community but treated by private practitioners or in psychiatric clinics, (2) those hospitalized, and (3) those discharged or on leave from mental hospitals but in need of rehabilitation and aftercare.

Issues Involved in the Treatment of the Mentally Ill

The Schwartz group begins with a statement of the magnitude of the problem and an examination of some of the social values and attitudes that come to bear in identification and treatment of the mentally ill. These have already been covered to a considerable extent in the first three chapters of this final report. It would appear, from the gross inadequacies that exist in the care of mental hospital pa-

tients, that society has not put a high value on restoration of their mental health.

The kind of care received by mental patients is affected by a number of characteristics tending to differentiate it from medical care in physical illness. One is the lack of a clear demarcation between psychological "treatment" as a medical and as an educational process; another is the fact that mental patients are mainly cared for in a public institutional system but pursuant to professional patterns laid down in the private practice of medicine. The authors report:

> Many professional groups are involved in helping the mental patients as a primary component of their professional activities. Psychiatrists, social workers, clinical psychologists, nurses, occupational and recreational therapists, and ward attendants are the most prominent although not the only groups engaged in this. Depending in part on their professional competence and in part on what they actually do, their intervention may be labeled as therapy, counseling, rehabilitation, training or re-education. . . .
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> There is no doubt that the medical profession as represented by psychiatry plays the dominant role in the treatment of the mental patient. Even where physicians are not themselves participants in the therapeutic process, the treatment tends to proceed according to medical ideals and values. . . .

The Schwartz group further points out that "the limitations and inadequacies in theory and knowledge that presently characterize the field of mental illness and health will be reflected in the effectiveness of practitioners in providing successful care and treatment." They continue:

> The mental illnesses manifest themselves at all levels of the human personality —biological, psychological and social. They involve disturbances in many spheres of the individual's life affecting his feelings about himself, his relations with others, and his ability to work productively. There are also a variety of ways people get into trouble and come to be seen as emotionally or mentally disturbed, and a variety of conditions are defined as mental illness. In a parallel fashion professionals hold varying perspectives, assumptions, and interpretations about mental illness and its treatment. Thus, they differ on what persons "are" when they are emotionally disturbed or mentally ill, on how they get that way, on what is wrong with them, on who should be placed in the category, on why they stay that way, and on what should be done about it. . . .
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> If we add to these conceptual difficulties the difficulties in determining the

efficacy of any particular treatment mode in comparison with another, one can understand why so much controversy can persist and so many problems remain unresolved; why therapeutic practice remains uncertain and groping; why practitioners retain their partiality to their own point of view; why ambiguity might attend the treatment choices to be made for any particular person or for categories of patients; why various therapies can continue to compete with each other; and why at regular intervals "the answer" to schizophrenia is found and why the problem is still with us.

Since no one theory or method of diagnosis or treatment can as yet conclusively be called superior, we can all agree that dogmatism and rigid adherence to a particular system have no place in the immediate future of services to the mentally ill. We must maintain an open-door policy not only in our hospitals but in our minds. New ideas may come from practitioners trained in social work, clinical psychology, psychiatric nursing, or internal medicine; from academic research scientists in biochemistry, neurophysiology, or experimental psychology. At this stage of knowledge, it is important that new ideas not be rejected automatically because their proponents do not wear the conventional garb of workers who have traditionally been involved with mental health problems. Regardless of their source, serious proposals and efforts deserve serious scrutiny and evaluation.

New Trends in Treatment

In accord with its main objective of taking a "new look" at the problem of patient care, the Schwartz group's report emphasizes new and promising lines of attack on the problem rather than typical and traditional approaches. Staff members interviewed mental health experts and visited facilities where new and interesting patient care and treatment programs had been or were in process of being introduced. In all, well over 150 experts were interviewed and visits were made to over 100 clinical installations where programs were observed and staff persons interviewed regarding their objectives and problems.

There is great variety in these new programs and each of them is influenced by the special characteristics of its own particular setting. However, Dr. Schwartz and his colleagues found that all these pro-

grams tend to reflect a small number of general trends in the field. They refer to these predominant trends as *themes,* and suggest that they are the issues of central concern to students and practitioners dealing with problems of care and treatment of mental patients.

These *themes,* each discussed in a separate chapter in the Schwartz monograph, are as follows:

In the outpatient system: providing immediate help for the emotionally disturbed, extending the outpatient system in the community, and broadening the conception of help.

In the inpatient system: individualizing care and treatment, breaking down the barriers between the hospital and the community, and developing a therapeutic milieu.

In the ex-patient system: tailoring care to ex-patients' needs, grading stress, and providing continuity of care.

In analyzing the significance of these trends and their implications for developing more adequate care and treatment programs—a task which forms the core of *New Perspectives on Mental Patient Care* and constitutes its major contribution to thought in this field—many specific programs are described and examined. These include emergency psychiatric services, mental health consultation, psychiatric sections in general hospitals, open hospitals, interaction "prescriptions," member-employee work programs, volunteer services, therapeutic communities, halfway houses, sheltered workshops, and foster family care programs. A great deal of attention is given to the problems encountered in introducing these programs, which often require new ways of thinking about patients and treating them, into traditional institutions. Energetically pursued, any of these programs may set off a chain reaction in which hardly any of the accepted prerogatives of the different professions or the rationales behind traditional approaches escape questioning. Thus, the new programs provoke anxiety and insecurity as well as excitement and hope.

The Outpatient System

The complex of treatment facilities for outpatients is a mixture of both public and private services. Both the number of public and voluntary clinics and the private practice of psychiatry and psycho-

therapy have grown rapidly, but there is general agreement that the supply of outpatient services is still insufficient. As soon as a mental health clinic opens in a community, it is overwhelmed with applications for help and soon has a waiting list; many private practitioners turn patients away. Because the pressures for treatment are so great, most professional time is spent in direct treatment of patients, although many psychiatrists carry on a mixed activity including teaching and consultation as well as treatment.

Some current idea of the professional pursuits of psychiatrists may be obtained from a 1960 survey by the American Psychiatric Association of a 10 per cent sample of its members. Some 63 per cent treat private patients. Of this number, 14 per cent list no other professional activity, but 40 per cent who say they are in full-time private practice do hold teaching, clinic, or consultant appointments of a public service nature. Of the total membership 16 per cent work solely in hospitals, 13 per cent engaging exclusively in public hospital work. One-third of the membership hold academic appointments. A total of 25 per cent work in outpatient clinics or social agencies, but only 3 per cent do so on a full-time basis (American Psychiatric Association, 1960).

The demand for private treatment of mental illness and psychological problems has been so strong that some clinical psychologists (estimated to be less than 5 per cent of the American Psychological Association's 18,215 members) have gone into full-time private practice. An additional unknown number of the 35 to 40 per cent who are employed by Federal, State or local governments or by nonprofit organizations have engaged in part-time private practice.

Psychiatrists generally have defined psychotherapy as a medical function, therefore placing it within the areas of responsibility covered by a State license to practice medicine. Psychologists have sought State accreditation of qualified practitioners. They emphasize the educational and learning aspects of psychotherapy and their own knowledge of behavior and background of qualifications in scientific research and the teaching field. The differing viewpoints about who should do psychotherapy have led to strained relations between the American Psychiatric Association and the American Psycho-

logical Association, despite the fact both professions are recognized members of the mental health team and, in the hospital or clinic setting, work together and enjoy considerable mutual respect.

As the Joint Report on Relations between Psychology and Psychiatry (American Psychiatric Association, 1960) observed: "The public need is such and the professional manpower problem is such that both parent groups cannot fail to recognize the legitimate interests of society as a third party. . . ."

With no intent either to fan or to dampen the flames of this controversy, we can note two facts that are incontrovertible. A significant portion of the treatment being made available to mental patients today, both in hospitals and in clinics, is personally provided by psychologists, by psychiatric social workers, by psychiatric nurses, and by occupational therapy workers, as well as others. In seeking a solution to the core problem of humane and healing treatment for patients with major mental illness, the question of whether or not psychologists go into private practice and do psychotherapy is a side issue. Private practice is not mainly directed to a solution of the core problem of major mental illness.

The trends in the outpatient system observed by the Schwartz group have developed in response to existing inadequacies which now make it difficult for persons with emotional difficulties to secure appropriate help. Overspecialization of agencies and practitioners, competition and lack of coordination among different facilities, and lengthy waiting lists are all important parts of the current situation. The Schwartz report describes a number of these problems:

> These professionals vary widely in their backgrounds, orientation and treatment methods. Persons suffering from such diverse ailments as psychosis, neurosis and alcoholism; manifesting criminal or suicidal behavior; or having problems in school or in marriage are treated by a range of therapies from psychoanalysis to drug therapy, including group therapy and electric shock treatment. Practitioners tend to specialize in one type of therapy and hold out different goals for their patients on the basis of their orientation and specialization.
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> Although there is still considerable stigma attached to the idea of "going to a head-shrinker," there has been increasing public acceptance of psychiatric treatment. This acceptance often is accompanied by unrealistic expectations and the assumption that practitioners can produce cures easily and quickly. When

miracles are not forthcoming, the person may become skeptical about the ability of the psychiatrist to perform as effectively as other doctors. Among some physicians there is still considerable coolness, misunderstanding, and rejection of psychiatry and psychiatrists. However, many physicians feel that closer cooperation and increased acceptance of psychiatry as a respectable branch of medicine is both desirable and inevitable.

The various agents and agencies offering help to emotionally disturbed persons such as clinics and private practitioners tend to function in isolation from each other. Furthermore they have little formal connection with inpatient and ex-patient facilities. Because of the pressure of treatment demands, many agencies tend to concentrate on and devote themselves exclusively to the immediate problems of their patients. However, under the influence of new programs such as emergency psychiatric services and day and night hospitals, this isolation is breaking down. The present tendency to see the unit of treatment as broader than a particular patient also is forcing practitioners to pay greater attention to the community and the social environment.

Since World War II clinics have proliferated and expanded in urban centers. The emphasis placed on the treatment of children recently has been supplemented by the recognition of the importance of treating the child's family. But admission to treatment ordinarily is slow, with processing consuming anywhere from three months to a year—a time and procedure that are discouraging to persons who need immediate help.

Among mental hygiene clinics there tends to be considerable specialization. Each clinic erects various criteria for admission, with a subsequent selection of the type of patients who fit in and rejection of those who do not. Thus, patients tend to be accepted or rejected on the basis of . . . age, diagnosis or type of problem, education, "readiness" for treatment. Clinics also vary according to the type of treatment they emphasize, its frequency and intensity, and the social class of patients admitted.

In reference to their internal operations, clinics are ordinarily under medical direction with the psychiatrist having the responsibility for the clinic. However, psychiatrists are frequently only part-time employees and the bulk of the work is carried on by social workers under the direction and supervision of a psychiatrist. Of late, psychologists have taken a more active role in clinics and the concept of the clinical team has included the psychiatrist, psychologist, and social worker. . . .

The private practice of psychiatry, psychotherapy, and especially psychoanalysis, have also developed rapidly since World War II. The private practice of psychiatry tends to polarize around either psychotherapy or somatic treatment. Somatic outpatient treatment primarily consists of pharmacologic or electric shock therapy. While various kinds of psychotherapy are practiced with different degrees of intensity and types of theoretical orientation, psycho-

analytically oriented therapy is a dominant mode. Fees are sufficiently high to prohibit lower income persons seeking or continuing treatment as private patients. Thus, private practitioners serve primarily middle and upper class persons, with lower class persons having their primary treatment opportunity in the State mental hospital. But even those able to pay the fees of the private practitioner frequently experience difficulty getting help when they want it because psychiatric time is so scarce.

There are a number of persistent problems in the field of out-patient care that have caused practitioners concern and have led them to develop new concepts and programs of treatment. The inadequate coverage of patients who need help, the difficulties in providing clinic patients with long-term help, and the long waiting period have motivated practitioners to search for more effective treatment approaches. Furthermore, doubts about the effectiveness of present treatment methods and difficulties in evaluating treatment procedures have raised questions about the appropriateness of present treatment techniques for the various kinds of patients needing help.

In attempting to meet these problems by providing emergency help, extending treatment services into natural community settings, and generally broadening the conception of care—the three prominent trends discussed in the monograph prepared by Schwartz and his associates—the changing outpatient system raises a flood of new questions. For example, if treatment pursues the patient rather than vice versa, how can we protect the individual's right to privacy, or his right to live with his emotional burdens and refuse help? When the unit of treatment expands to the family group as a whole, what effects does this have on the traditional doctor-patient relationship where the well-being of the individual patient was the physician's only concern and the basis of his prescription? These and other similar issues are explored in the Schwartz monograph.

The Inpatient System

The four predominant types of mental hospitals are the large State mental hospitals (270), the Veterans Administration mental hospitals (41), the small private psychiatric hospitals (310), and the psychiatric sections of the general hospitals (789). The State hospitals alone account for 80 per cent of all hospitalized mental patients at any given time. The vast majority of these hospitals have more than 1000 beds, and some are equal in size to towns of 10,000 to 15,000.

New Perspectives on Mental Patient Care points out that superintendents of these mental hospitals are still hopefully contemplating the concepts that concerned their predecessors in the era of moral treatment in the early nineteenth century—individualizing care, breaking down the barriers between hospital and community, and developing a therapeutic environment for the patients. The obstacles to these objectives are towering, with the result that relatively few State hospitals—probably no more than 20 per cent, we estimate—have been able to institute therapeutic reforms in keeping with the modern trend. The Schwartz report surveys the typical scene as follows:

> The responsibility of the State-supported institution to the community is much more . . . direct than that of hospitals under other auspices. Its mandate requires it to accept as patients all legally qualified residents who need inservice psychiatric treatment—both those who come voluntarily as well as those who are legally committed to the hospital. A court officer or a policeman is the patient's usual escort to the hospital, and most often he is unaccompanied by either friends or family members. Although the hospital is in a general state of readiness to receive and admit patients, it is not specifically prepared for any particular patient.
>
> With this relative lack of control over the flow and characteristics of admissions, the superintendent of a State mental hospital has little room for administrative maneuver. . . . Anything that affects the incidence of mental illness or the probability that mentally ill persons will seek treatment will have immediate consequences for the hospital administrator and his staff in affecting the pressure for hospital beds. . . .
>
> The administrator's freedom to release patients to the community is also more apparent than real. For, whereas only he has the formal and legal authority to determine whether a patient has recovered sufficiently to be discharged, his policy on these matters may reflect in part his judgment of the community's receptiveness to ex-patients. By and large, the patient receives as little preparation for his return to the community as he had received for his entrance into the hospital.
>
> The State hospital is accountable to the political administration of the State. It is more likely than other hospitals to be subjected to and responsive to local political, social, and economic pressures. "Incidents" involving patients or ex-patients might cost an administrator his job, might affect his budget or the hospital's reputation, or might be exploited by one of the parties to the political power struggle in the State. The easiest solution to these problems is to develop "safe" programs of patient care and treatment that pose little risk of incidents. Apparently, administrators in the past have preferred to have custodially-

oriented institutions with safe programs rather than active treatment centers since the latter presuppose and entail larger risks.

About 40 per cent of the resident patient population in State mental hospitals has been hospitalized continuously for ten or more years. Almost 30 per cent are sixty-five years of age or over. As a result of the generally unrestricted admission policy and the lack of specialization among these hospitals, the patient population tends to be . . . heterogeneous with regard to type and severity of illness. . . . To some extent, the State hospital has also been used as a "dumping ground" for a variety of problem persons, particularly certain kinds of troubled and troublesome individuals in the lowest socio-economic classes. The presence of these socially "undesirable" persons combined with the high proportions of aged and chronic patients seems to be particularly conducive to the custodial and apathetic atmosphere that is a striking feature of our State hospitals, including the better ones. Achieving perceptible "movement" in chronic patients or rehabilitating antisocial individuals requires a great deal more in time, energy, and skill than is necessary for equivalent results with less difficult cases. These resources are in such short supply that the objective of improvement tends to be forgotten and most patients who require maximum efforts to show improvement receive at best the barest minimum of care.

Many observers have commented that the State hospital functions as a self-contained community or subculture. It is often geographically isolated and, in attempting to provide for the total life needs of its patient population out of its own internal activities and resources, it has tended to become functionally isolated from other social institutions. This development further accentuates the . . . other features we have been discussing—the qualities of a mass organization, the atmosphere of apathy, the repressive custodial orientation. . . .

For patients the ward is the primary center of their lives in the hospital. Because of the low salaries and undesirable working conditions, the attendants who dominate ward life have been recruited traditionally from relatively uneducated and socially deprived sectors of the society. In some instances, the jobs have been handed out as political patronage and attendants sometimes come from the population of irresponsible "floaters." It has been difficult to attract and retain a stable group of responsible and well-motivated ward personnel, and most descriptions of the "attendant culture" stress its negative impact on patients. . . .

Nonetheless, despite these thoroughly negative aspects, the State hospital is not, and indeed never has been, quite the end of the road or point of no return that many people believe it to be. The discharge rates vary considerably, but from 40 to 75 per cent of patients are released within one year after admission to State hospitals.

The Schwartz group paints a contrasting picture of V.A. mental hospitals, where, thanks to Federal funds and standards, the average daily expenditure per patient is almost three times that in State hospitals, or $12 as against about $4. The range is from $2 to $6 per patient per day in State hospitals in comparison with $8 to $20 for V.A. mental hospitals.

This difference is reflected directly in the quality of such things as the food, the physical surroundings, and the material and equipment available for various patient activities.

The differences in expenditures and standards are also reflected in the relatively high staff-to-patient ratios, with regard not only to physicians and nurses but also for other professions such as clinical psychology and social work. The special emphases of these latter professions have contributed markedly to both the general atmosphere and the specific features of V.A. hospitals in ways which serve to distinguish them in important ways from hospitals under either State or private auspices.

For example, there is considerably more research activity and interest in a typical V.A. hospital than in the typical private or State hospital. This seems due in large part to the special interests and training of the psychologists and to the official definition of their job which explicitly includes research activity. The relatively greater stress that one finds on the "psychiatric team" and on group therapy as a form of treatment also appears to be related to the more extensive and intensive use of psychologists. On the other hand, both the special emphasis on aftercare programs and the degree of concern about the outside world that one finds in V.A. hospitals seem to reflect the perspective and interest of social workers who take an active part in the over-all hospital program. The prevalence of adult men for whom work would be a major area of interest and activity in their normal lives outside the hospital, and the availability of funds to hire occupational and recreational therapists and vocational counselors, probably account to some degree for the greater interest in work programs and industrial therapy in these institutions.

For a number of reasons—more funds, more professional personnel, more research—V.A. hospitals have been rather receptive to new trends and new ideas. Their programs suggest a greater willingness than has existed in other types of hospitals to experiment with new approaches and new forms of treatment. The increasing homogeneity of the patient population in terms of age and chronicity and the better competitive position of State institutions for recruiting and retaining high quality professional personnel are problems that V.A. hospitals are beginning to face, and their future form and functioning

will depend in no small part on how these problems are managed and resolved.

The small private mental hospitals provide some of the psychiatric leadership in the country and the best of them are models for quality of personnel and intensiveness of treatment. They do not, however, play a significant role in the care of the nation's mental patient population when viewed in numbers of cases cared for. Costs per patient in these hospitals vary from $400–$500 to $1500–$2000 per month, including therapy. A much greater proportion of their patients, necessarily from the upper socioeconomic classes, are diagnosed as neurotic rather than psychotic, and the latter in these hospitals more commonly suffer from depressions than schizophrenia. Patients are usually referred to these institutions by their private physicians.

The psychiatric units of general hospitals have played an increasingly important role in the short-term care of mental patients in recent years, now accounting for about 60 per cent of 315,000 annual admissions to hospitals treating the mentally ill and about 18 per cent of all patients on mental hospital books during the year, although they have only 7000 patients at any given time. The trend has been for general hospitals, particularly the larger ones, to add a psychiatric wing, ward, unit, or building. These psychiatric departments are geared to the active treatment of acute disorders, there being a high rate of patient turnover resembling that in the hospital's medical and surgical departments; the average stay per patient is four weeks. About 25 per cent of the patients are transferred directly to State hospitals; general hospitals could not long function without State hospitals to take the long-term and troublesome cases. The general hospital psychiatric unit is designed to serve the local community and its practitioners.

Even from this brief overview of the inpatient system, some of the major problems are apparent, particularly those that beset our large State mental hospitals. Isolated from their communities and characterized by the negative features of mass-custodial institutions, they tend to compound the basic difficulty of providing effective treatment to their patients. Desocialization adds to the problems the patients

bring with them, and the disabling effects of their illnesses are increased and prolonged.

The new trends and programs being developed in mental hospitals are aimed at these problems. Practitioners hope that the negative consequences of hospitalization associated with traditional institutions will be reduced or eliminated by: breaking down the barriers between the hospital and community through open-door policies and strengthened volunteer activities; individualizing care and treatment by reducing the size of hospitals and orienting personnel to treat each patient as an individual rather than as a case or a number; and developing therapeutic milieus where the therapeutic potential of all persons in the hospital is recognized and used.

Many of the new approaches are experimental insofar as scientific proof of their effect on the recovery rate goes, but there can be little doubt that all are consistent with moral and social values and therefore worthwhile in improving the human condition of the patients. And, unquestionably, all impose stresses on the traditional system of maintaining order since they make work rather than reduce it. As the Schwartz report says: "Working closely with mental patients is hard work, and the more closely one works with them the harder it is. Maintaining these programs on a continuing basis seems to require as an essential ingredient institutional arrangements that provide support and supervision to personnel so that these more intense relationships with patients can be sustained and managed."

Aftercare for Mental Patients

One characteristic of good mental health in our culture is an ability to "take it"—that is, to face life as it comes with some degree of independence as well as some degree of satisfactory social adjustment. Ordinarily, this means doing a job of some kind, living with other people in relative peace, and coping with such troubles as may come along. Implicit in good mental health is a kind of mental resilience, or capacity to undergo various stresses and withstand them. The object of aftercare or rehabilitation programs for mental patients is, insofar as possible, to enable them to meet this definition of good mental health and maintain themselves in the community after

they leave the hospital. Achievement of this objective means earlier release of patients from mental hospitals and reduction of readmissions due to relapse. Ideally, the fullest development of outpatient and ex-patient services would reduce the mental hospital to a temporary phase in a total program of treatment for the mentally ill—a way station as it were rather than an institution at the end of the road. The hospital then would be truly open, in this case, *open-ended* in the process of treatment. So extended—that is, into treatment services short of hospitalization and subsequent to hospitalization—the modern mental hospital might then emerge as the center of an integrated mental health service to the community.

But here we discuss principles far more than practices. As *New Perspectives on Mental Patient Care* makes clear, aftercare presently involves many different kinds of service unevenly developed in various communities:

> Professionals describing this diversity in aftercare service and facilities sometimes leave the impression that large numbers of ex-patients actually receive these services. But this is not the case. In 1958 in the United States, for example, there were only nine halfway houses and less than two dozen day hospitals; we located only eight rehabilitation centers and approximately 70 ex-patient clubs. Less than one-quarter of the States reported foster family care programs. It is difficult to estimate the extent of the aftercare provided by States through mental hospitals, aftercare clinics or field offices of State agencies. But experts in the field maintain that few States provide adequate aftercare. This seems to be the case even in communities with better than average mental health programs.

Many ex-patients appear to need some form of continuing help even though they no longer require hospitalization. The general purpose of aftercare programs is the prevention of relapse and rehospitalization. Accordingly, these programs aim minimally at maintaining the level of recovery reached at the point of discharge and hopefully at fostering further improvement. Many of them are directed at reducing the ex-patient's vulnerability to stress and providing immediate help in crises so as to prevent the recurrence of severe symptoms.

The themes that appear to be of major concern to workers in the

aftercare field reflect the problems they have encountered in trying to reach these objectives. They are: tailoring care to ex-patient needs, grading stress, and providing continuity of care. Specific programs and aftercare services reflect one or another of these general trends. Many different types of aftercare services have developed recently. Because of their relative newness, their characteristics are not widely known and brief descriptions are provided here of the most important of them.

Aftercare clinics are an extension of mental hospital service. They are set up mainly to give treatment and casework service to patients on convalescent leave. Some clinics are located at a mental hospital or general hospital and run by its staff for its own ex-patients. These patients return for posthospital help, often continuing with the same physician or social worker they knew as inpatients. To provide for ex-patients living at some distance from hospitals, some permanent or traveling clinics are organized. Some aftercare clinics are independent units, administratively separate from hospitals. They have their own full-time staff and serve ex-patients from a number of hospitals.

The first *day hospital* began operation in Moscow in 1932; fourteen years later, in 1946, a day hospital was started in Montreal by Dr. D. Ewen Cameron. At present, the day hospital is regarded by many psychiatrists as one of the most significant innovations in clinical care in this century. So great has been the interest in the day hospital that in 1958 an entire conference was devoted to it despite the fact that not more than several hundred patients in the United States were then receiving this form of care.

The day hospital was designed to meet the need for a treatment facility in between the mental hospital and the mental hygiene clinic. Psychiatrists believe the day hospital can provide a unique service for a large number of persons who do not need hospitalization but require more help than that given by most mental hygiene clinics. Cameron makes it clear that three assumptions underlie day hospitals: patients do not need to stay in bed; they do not need to stay in the hospital until they are well and should not remain in the hospital when they are able to leave; and treatment should not

be limited to the patient but must include his family and home and his social setting. He and other psychiatrists cite the many advantages connected with providing help *at* a treatment facility rather than *in* a mental hospital. The day hospital encourages patients to develop relationships outside the hospital and decreases dependency on the mental hospital; it avoids the desocialization associated with long-term hospitalization; it permits the patient's family to participate in treatment; it relieves the family of the burden of caring for a disturbed person for an entire day; and it is more economical than hospital treatment.

Present day hospitals have developed along two distinct lines, the Schwartz group notes. At one extreme are the treatment-oriented day hospitals. These are modeled after the psychiatric service of a general hospital, giving full hospital treatment to persons who return to their homes or accommodations each night. Some treatment-oriented day hospitals emphasize organic therapies; others, individual or group psychotherapy. Less attention is given to vocational training, recreational or occupational therapy, and there tends to be little systematic use of the day hospital setting as a therapeutic environment. Patients spend an average of four hours a day at such a center.

At the other extreme are the rehabilitation-oriented day hospitals modeled after the school or workshop. While these centers give a range of therapies, they emphasize prevocational, recreational, and social activities designed to help patients live more adequately in the community. They secure jobs for patients and help them to cultivate hobbies, develop satisfying relationships and behave in ways appropriate in normal social settings. Patients are expected to attend a full day, five days a week.

The *night hospital* is the converse of the day hospital. It has been described as a psychiatric unit offering treatment to patients after working hours. Its main function is to make treatment possible for persons who work, without interrupting their employment or interfering with their daytime responsibilities. Several advantages of the night hospital are cited: Since persons receiving treatment at night need not disclose their patient status except to their intimates, more disturbed persons might seek help. Treatment does not interfere with

work or social life. Emotional support can be provided ex-patients in the early stages of employment. Night hospitals are economical in that the same facilities may be used for day hospital patients. Finally, the night hospital provides an overnight service for psychiatric emergency cases.

Rehabilitation services on the whole are concerned with helping ex-patients perform better in their social roles, particularly in three life areas: family living, work, and social life or recreation. Family living services are concerned with the ex-patient's housing, his life routines, and family relationships. Work services are provided in connection with helping the ex-patient prepare for, find, and hold a job.

Public health nursing services have traditionally been concerned with such problems as the management of communicable diseases, help to expectant mothers, and disease prevention in school children.

The idea of the public health nurse working with the mentally ill is not new. What is new is the idea that she can offer supportive services to ex-patients and their families. In many States, this idea has led to the reappraisal of the role of the public health nurse in the field of mental health and to experimental programs of service to ex-patients and families. Public health nurses involved in these programs are attached either to a State, county or city Health Department or to a Visiting Nurse Association, and work under medical supervision. Many hospitals are working closely with public health nurses who follow up ex-patients. Sometimes, this follow up is mainly to gather information about the ex-patient's adjustment on furlough so that the hospital can decide whether he should be discharged. Sometimes public health nurses provide more direct help to the former patient and his family. In rural areas particularly, the nurse may be the only person available to provide such help.

It appears that the public health nurse's special contribution in the mental illness field lies in the supportive services she can give families of the mentally ill through her psychiatric understanding and its use in conjunction with her generalized skill in human relations. The public health nurse is becoming increasingly important in administering and supervising ex-patients' tranquilizing drugs. She also plays an important role in the home care of aged ex-patients and

other ex-patients with medical problems who need continued medical care and supervision.

Foster family care for ex-patients is probably the oldest form of aftercare in this country. Placing a mental hospital patient with a foster family makes it possible to maintain in the community persons who do not need to be in hospitals but who cannot return to their families or live on their own. Many mental hospital patients seem to make further improvement only when living outside the hospital in a normal social setting. Thus, family care is considered as a way of rehabilitating former patients and returning to normal living many who otherwise would remain hospitalized. Family care relieves overcrowding of mental hospitals, it is less expensive than hospitalization, and it often convinces patients' families they should take them back.

Foster family care programs have been operating for a number of years and generally are held to be successful in keeping in the community most of the patients placed. Nevertheless, there has been but a small yearly increment in the number of patients placed in family care.

The *halfway house* is one of the most recent of the specialized aftercare services.

Present halfway houses show considerable uniformity in aims, with some basic differences in practices and structure. In general, the halfway house is a transitional residence, based on the assumption that experience in a protected setting can significantly increase the ex-patient's chances of remaining out of the mental hospital, as well as prepare him for more independent living. These temporary residences for ex-patients are of three types.

1. The cooperative urban house—with residents limited to a small number of ex-patients of the same sex, with good enough remission to get along with minimum supervision, and potentially or immediately employable.

2. The rural work-oriented halfway house—often referred to as a farm, ranch, or homestead—and larger than the urban type. It accepts ex-patients of both sexes as well as persons never hospitalized for mental illness.

3. The treatment-oriented halfway facility—a residential treatment center standing halfway between the patient's home and the mental hospital. Residents are still patients and are not required to assume any large degree of personal or domestic responsibility or to participate in community life.

The halfway house is the center of a mild controversy in the aftercare field. Critics point out that extensive planning and considerable capital outlay are needed before a halfway house can come into being. They argue that segregation of residents perpetuates separation from the community, and comment unfavorably on the tendency of former residents to return to the house for their social life. They fear the halfway house will become a static "little mental hospital ward" and maintain that foster family care can accommodate ex-patients in the community without these disadvantages.

Proponents point out that the halfway house offers more freedom and privacy than foster family care and that many ex-patients need this experience to become independent. Residents may feel it is their home in a way that a foster home can never be. Professionals operating halfway houses state that dependency, like other problems of the ex-patient, needs to be handled in any setting and that no properly managed setting need become a little mental hospital.

Convalescent nursing homes have long been a facility for caring for the elderly infirm. Only recently has the idea become prominent that nursing homes can be a better solution than the mental hospital for the care and treatment of the aged and aging mentally ill. Some States, such as California, have instituted the practice of placing mentally disturbed older persons needing special care in geriatric facilities or in nursing homes instead of mental institutions. The logical next step, releasing the aged mentally ill from mental hospitals to such units, has just begun.

At present there is a general absence of nursing homes willing to take elderly disturbed patients. Moreover, those that do accept such patients rarely see rehabilitation or the prevention of further deterioration as their major goal. Generally little attention is given to the psychological and social needs of these patients. Often, too, both psychiatrists and social workers take a dim view of the rehabilitation and

treatment potential of these patients. This pessimism is generally hedged by the statement that it is more expedient to use scarce personnel in service to those whose life is ahead of them.

Work services are those facilities available for helping ex-patients prepare for a job, find it and hold on to it. Preparing for a job means not only training for a marketable skill but learning how to handle oneself on the job. This includes acquiring habits of punctuality, regularity, and personal neatness, following instructions, observing work rituals, and getting along with fellow workers and supervisors. The services of the State Vocational Rehabilitation agencies, rehabilitation centers, sheltered workshops, and employment services are the most important of the work services to ex-mental patients.

While some vocational rehabilitation divisions have pioneered in developing programs for ex-mental patients, these agencies face major problems in providing service for ex-patients. One problem arises from the fact that in some agencies the workers have interests and skills aimed at service to a different population—the physically disabled. Consequently, the agency must seek consultation and further training for counselors who are to serve ex-mental patients in ways appropriate to their varied needs. Pressure for closure and the limitation on time available for adequate counseling are two immediate factors that shape counselors' problems in work with ex-patients. And some counselors are not trained to serve persons whose disability, in contrast to the physically disabled, is intangible and involves emotions and motivations. (See Appendix V, Footnote 4–2).

Sheltered workshops are factory-like establishments primarily operated to provide remunerative employment to handicapped persons. Some shops concentrate on returning their workers to outside employment, functioning as training centers to assess and develop their clients' capacities for competitive work. Though there are about 600 workshops, only a small number express willingness to accept ex-mental patients. To their knowledge, Schwartz and his associates remark, no shop serves only ex-mental patients. Furthermore, workshops arbitrarily set a quota on the number of such patients they accept at any one time. Most rehabilitation workers assert that there is a serious shortage of workshops suitable for rehabilitating ex-

mental patients. According to at least one theory, this is because ex-patients unable to work in competitive industry require more than a sheltered work situation if they are to achieve or regain the capacity to work in conventional ways. They need a work situation in which they are given both emotional support and protection from excessive demands and work tasks that are graduated according to their ability at a particular time. The ex-patient's capacities for work need to be carefully evaluated, and other services, such as vocational counseling, and psychiatric and medical treatment, may be required before work progress can be made.

Combinations of services are found, however, in *rehabilitation centers* where vocational evaluation and counseling, vocational training, sheltered employment, competitive placement, psychological counseling, and social casework may all be available to clients. Some such centers are connected with medical units and have both medical and nonmedical staff; some are independent social agencies; others are part of State Vocational Rehabilitation agencies. It might be assumed that compared with sheltered workshops, rehabilitation centers more often provide for ex-mental patients. However, a 1958 survey of 78 leading rehabilitation centers reported that only 27 per cent (23 centers) actually had ex-patients in their programs. The reluctance of many sheltered workshops and rehabilitation centers to accept ex-patients is, of course, related to their inability to provide adequately for them.

Ex-mental patient organizations, according to a 1958 Joint Commission study, are found in 26 States, with perhaps the largest concentration in California (14 groups). At the time of the study, at least 70 such organizations existed. Recovery, Inc., claimed 250 groups in 20 States with 1810 paying members, and a total membership of over 4000 persons (Wechsler, 1960). These organizations tend to be small groups, primarily concerned with providing satisfactory social relationships and experiences through group participation. Ordinarily groups meet on designated evenings—weekly, fortnightly, or monthly—in donated or rented quarters.

Though over 80 per cent of these organizations have started since 1950, we cannot conclude that they are increasing in number. Many

observers have noted that these organizations are remarkably unstable and short-lived, especially when no professional direction or consultation is involved. (It is interesting that a good majority of organizations in our study had a professional consultant or leader and were affiliated with a professional organization—a mental hospital or clinic, State or community agency, or some combination. A relatively large number were affiliated with mental health associations.)

The majority of these ex-patient organizations reported that they were concerned with integrating the ex-patient into the community, though they followed three different means to attain this end.

1. The largest number of the independent ex-patient groups are *social clubs* whose activities are social and recreational. Ex-patient social clubs are about equally divided between those in which membership is limited to persons hospitalized for a mental illness and those in which ex-patients, friends, relatives, and others may become members.

2. A small number of organizations in our study are *mental patient aid societies* that aim to serve ex-patients and persons still hospitalized through projects such as Christmas parties, clothing collection, or arousing public interest in the plight of the mental hospital patient. Generally the membership is larger than in the social club and includes interested community members as well as ex-patients and their relatives. Recreation is secondary as it is believed that the ex-patient's social adjustment can be furthered by helping him participate in a community effort to aid others like himself.

3. A third type of ex-patient organization is the *therapy group.* Such groups are generally smaller than either social clubs or patient aid societies. Their main activity is group discussion of the problems of living in the community, with the goal of helping members establish meaningful relations with each other. Some groups are led by professionals, affiliated with a clinical setting, and only accept ex-patients from that institution. Others are more like Recovery, Inc., in that they have no affiliation with a professional group or institution, no professional leader or consultant, are largely inspirational, and accept any community member who has emotional problems. Fre-

quently, both kinds of groups have social-recreational programs as a secondary activity.

To meet the ex-patient's need for a rehabilitation program in a protected setting, a few *social rehabilitation centers* for ex-mental patients have been developed. These differ in orientation from rehabilitation centers for the physically handicapped in that social relationships are the major emphasis.

The Joint Commission learned of eight social rehabilitation centers in operation in North America in 1958. The best known and most developed is Fountain House, Inc., in New York City. Starting as an ex-patient club in 1948, it was reorganized in 1955 to include professional direction and an enlarged program. In 1958, it had seven full-time professionals on its staff, a part-time psychiatric consultant, a professional advisory board, and 70 volunteers. Its quarters were a large house in midtown Manhattan, providing space for a patient lounge, a dining room, staff offices, and a variety of classes and activities. It had both an evening program for ex-patients who worked full-time and a day prevocational program for those not yet able to work. These persons were involved in real work that contributed to the organization, such as making charts, typing, and mimeographing, and some were helped to move into a job in the community. In addition, the Fountain House operated six ex-patient club groups that met once a week in the neighborhoods of their members. In format, they were similar to other ex-patient clubs that had a professional leader.

Summarizing aftercare, the Schwartz group states that the ex-patient is a latecomer to the help scene. Many agencies that potentially might be able to offer him help do not do so. Much of the service he does receive is given by organizations specifically set up to serve him. A number of discrete services appear to have little in common. However, each service reflects one or the other of two prevalent orientations in aftercare. Work with ex-patients—as perhaps with both inpatients and outpatients—proceeds either from an individual or from a group orientation. Services focus either on the ex-patient as an individual (whether the particular concern is with his physiology, personality dynamics, or social behavior) or on the

ex-patient as a member of a group (whether of a family, ex-patient club, or rehabilitation center group). While a few services make use of both orientations, the majority appear to have adopted one or the other approach. This split has resulted in difficulties in thinking about the problem of returning inpatients to the community. First, to a large degree, inpatient, outpatient, and ex-patient care are handled separately. Second, the ex-patient's problems themselves are dealt with in a piecemeal fashion—family problems by family services, work problems by work services, and so forth. Both kinds of fragmentation fit the current pattern of community organization, but many students of aftercare question whether this organization fits the needs of ex-patients.

SUMMARY OF FINDINGS ON MENTAL PATIENT CARE

We have reported on some recent trends in the care and treatment of outpatients, inpatients, and ex-patients. The practitioners who are developing the various new programs believe in them and hope that they will result in better care and more effective treatment of mental patients. However, we know that this is a field where fads and fancies flourish. Hardly a year passes without some new claim, for example, that the cause or cure of schizophrenia has been found. The early promises of each of these discoveries are uniformly unfulfilled. Successive waves of patients habitually appear to become more resistant to the newest "miracle" cure than was the group on which the first experiments were made. The one constant in each new method of psychiatric treatment appears to be the enthusiasm of its proponents, and most probably such enthusiasm transmits itself to patients in beneficial ways. Even when some small success is gained, however, the major problems in the field still seem to remain as insoluble and obdurate as before.

We have observed the lack of definitive research findings with regard to any of these new programs. Hunches, guesses, and uncontrolled observations are the major sources of information on their operations and degrees of effectiveness.

With little definitive data and with the knowledge of many earlier abortive and abandoned efforts, what can be recommended for the future? This is a critical problem posed by the work of Dr. Schwartz and his associates.

In developing policies and recommendations, certain aspects of the field of patient care at the present time should be taken into account. In focusing on new developments, this portion of the Mental Health Study documents the problems of a rapidly changing field. The advanced programs are relatively rare and unevenly distributed with the large majority of State hospitals still custodial and punitive. *The thesis of this final report, that the lag in the treatment of the mentally ill reflects a fundamental pattern of social rejection, is nowhere better evidenced than by the continued existence of these "hospitals" that seem to have no defenders but endure despite all attacks.* How to begin and nurture new programs in the institutions that need them most but want them least, and how to prepare for the tensions and insecurities that accompany these changes, are serious and difficult problems.

It is evident that the boundaries of responsibility among different treatment agencies and professionals are unclear and confused. The specialization of services and the relative isolation of different mental health workers from each other often means that the patient receives fragmented and discontinuous treatment or does not find his way to an appropriate treatment resource.

Above all, the field may be characterized as suffering from two major lacks: verifiable knowledge and competent manpower. These points need not be labored here. It is worth noting, however, that the new programs do nothing to solve the manpower problems, at least in the short-term view, since they require more and better trained personnel than are found typically in our treatment institutions.

To achieve better care of patients, the mental hospital needs to be integrated into the community where it is geographically situated (by community is meant, in various senses, the town, city, county, or State). This means keeping the hospital and its staff in closer touch

with all the community's public and private service agencies. It means an end to the hospital's isolation from the community; in isolation, the backward, custodial system may thrive, whereas in the mainstream of community activity, a hospital's shortcomings of service may come to attention.

The hospital must cease to be treated as a target for political exploitation. Patronage must end; appointments to jobs in State hospitals must not be made on a political basis if we have any intention of improving these hospitals. The hospitals and their logical community extensions—clinics and aftercare programs—must be manned in all cases by properly motivated career workers and not, as in so many instances in mental hospitals, by hacks, professional or lay. Too many persons who are alcoholics, addicts, social misfits, or otherwise mentally ill themselves have been given mental hospital positions ranging all the way from attendant to superintendent. Happily, there is now apparently a shift toward greater competence. There is no cheap, quick method by which we can raise the level of care for mental patients, any more than there are short cuts to high-class care in general hospitals. The personnel must be well paid and well trained, professionally or vocationally.

The salient characteristic of treatment of the mentally ill, the Schwartz group concludes, is that some kind of relationship is formed between the patient and the helping person. These relationships can be formed by laymen working individually or in groups under the guidance of psychiatrists, clinical psychologists, or psychiatric social workers. Helping the mentally ill person is a process of discovering how to work with the particular person at hand. The discovery may be made by selected, trained, nonmedical mental health workers as well as by psychiatrists. Under our present laws, the responsibility of running mental hospitals rests with the physician. Whether medical or psychiatric training equips one to run a social institution such as a mental hospital in the most effective and therapeutic manner should be a question to be explored rather than an assumption that is taken for granted. Even if the psychiatrist should continue to play the controlling role in the mental hospital,

the public should not permit him to restrict other professions from making their maximum contribution to the restoration of the human condition of mental patients.

It is difficult to see how the large-scale effort that is needed can be launched without more active community support than has been available in the past. The "preconditions" of adequate patient care programs must first be established if we are to look forward to real breakthroughs. *These necessary preconditions are funds for personnel, training, and research; the replacement of political by professional control of mental health programs and agencies; and the development of a community atmosphere that is receptive to new ideas for the treatment of mental patients.*

At this time, we must depend for progress on the informed guesses of the mental health practitioners. Their hunches should not only be tried but tested, and evaluation procedures should form an integral part of proposals for new treatment programs.

Most importantly, we must constantly remind ourselves that the final test is the welfare of the mental patient.

V

Research Resources in Mental Health

The enormous patient care task the mental health professions face today is matched only by the enormous research lag in the study of human behavior. As is true of deficiencies in mental patient services, the inadequacies in the support of scientific research in this field have no quick and easy remedies. This is a central thesis of Dr. William F. Soskin's study for the Joint Commission, *Research Resources in Mental Health.*

The present chapter draws from Dr. Soskin's work and findings and also reflects and includes suggestions made by Commission staff members and the Committee on the Studies.

The mental health sciences address themselves to the alleviation of a complex of biological, psychological, and social problems that have plagued man throughout his history; mental health scientists face this task with an incredibly small fund of knowledge about causes and cures. It is a field where much-qualified guesses abound and the few hard facts achieve prominence by their very scarcity.

What we mean by a lag in the research effort is that our total national investment in mental health research—in time, money, men, and research and training facilities—simply does not measure up to the desperate need for useful and reliable knowledge.

Many useful proposals have been put forth in recent years as solutions to one or another of the difficulties confronting the mental health research enterprise. The problem to which we address ourselves in this chapter is to frame a general strategy for intensifying the research effort in the field of mental health as a whole.

While substantive research areas will be touched upon and used

illustratively, our primary concern is with the more formal characteristics of the research enterprise—with where and how mental health research is carried on, organized, and supported. From an examination of the characteristics of the present research enterprise and on the basis of an analysis of problems and deficiencies associated with it, we shall propose some guide lines for a planned major increase in the total research effort. While these proposals are realistic and take into account the limitations as well as the possibilities of the present situation, they are challenging in their requirement of a much heavier commitment of resources than the society has to this point been willing to give to this problem.

As Dr. Soskin notes in his report to the Commission, the budgetary needs of the people who offer direct service to patients are the ones most easily comprehended by both legislators and the general public. However, he states:

> Less well understood is that research is an even more vital level of service, but a service to the profession itself rather than to the patient. Only through research can we hope to discover and pass on to the practitioner the means that will improve his own effectiveness. It is the practitioners' primary source of new knowledge, new theories, and new techniques without which we continue out of habit, convenience, and tradition to labor in the clutches of our own ignorance.
>
> The mounting of a solid research attack on problems of mental illness and health, furthermore, is no short-term commitment. It is a pretty safe bet amply supported by experiences in other areas of science and medicine, that the achievement of many of our goals lies thirty to fifty or more years ahead.

It is with this awareness of "girding for the long haul," rather than attempting a host of specific and detailed recommendations, that both Dr. Soskin's report and the present chapter focus on a number of broad issues and considerations that must be taken into account in planning a comprehensive research effort.

CHARACTERISTICS OF THE RESEARCH ENTERPRISE

Two important and pervasive aspects of the overall research effort in mental health are reflected in our discussion of many specific issues.

For this reason they warrant brief mention at this point. The first is the wide diversity of types of inquiries viewed as mental health research; the second is the distinction that is found in the field between basic and applied research.

The persons engaged in "mental health research," the procedures followed, the objectives sought, and the settings worked in are so varied as to defy adequate classification. In addition, there are studies not so labeled whose findings are found to be relevant to mental health problems. Any description of research in this area and any attempt to formulate a general program for research support must take this fact of diversity as a first principle.

This diversity expresses itself, for one thing, in a cleavage between basic and applied research. This distinction is a common one but imprecise, and criteria for deciding whether a study is of one or the other type are vague and subjective. Usually, basic research is defined as any scientific inquiry for the purpose of discovering and generalizing truths about the essence of nature, including man. Applied or clinical research refers to studies directed primarily toward the practical problems of the prevention and treatment of illness and the care and management of patients. While the latter often undertakes to apply knowledge developed in basic research studies, it equally often may proceed in the absence of basic theoretical knowledge.

This cleavage between basic and applied research has been crystallized and is perpetuated by differences in the institutions in which research is conducted and the disciplines that engage in it. That is, the notion of basic research is associated in the minds of professionals and laymen with work in universities carried out by academic research scientists, and that of applied research with the investigations of practitioners in medical institutions. We believe that the distinction between basic and applied research may be less troublesome and less fundamental than is sometimes assumed. As we shall try to make clear in our discussion, many of the problems attributed to it appear to derive more from the different requirements of the institutional settings and disciplines associated respectively with basic and applied research than from the different qualities of these research approaches themselves.

Both the general diversity of research efforts and this split between two kinds of research foster a wide range of differing points of view regarding the objectives and needs of mental health research. The implications of these differences on research policy and their bearing on the possibilities of implementing proposals for expanding our research efforts will be noted wherever relevant in the following sections.

The Institutional Settings

The research output in mental health has been highly concentrated in a relatively small number of major universities. The State mental hospital system accounts for an extremely small proportion of the total research effort. Even less research emanates from the community-sponsored and private agency clinics and other outpatient treatment facilities than from the State hospitals.

Figures compiled by Dr. Soskin show that, although there are more than 175 public and private universities in the United States, 25 per cent of all research grants awarded by the National Institute of Mental Health during the period 1948–1957 went to 6 of these institutions; and 25 universities together accounted for over 50 per cent of all such grants.

There is no mystery behind this heavy concentration of funds and the consequent research efforts in the major universities. They have large and active programs of postgraduate study and research training; they have the stature and facilities to attract the best minds and the most productive scientists from all over the world; their research scientists are experts at conceiving, planning, and executing good research; their staffs are encouraged to seek research support. Although these characteristics of the large universities would lead us to expect what we do find in the way of research support and activity, Dr. Soskin provides some historical perspective by reminding us:

> The promotion of science is so pre-eminently the responsibility of the modern university that we tend to lose sight of the fact that it has not always been so and may not continue to be exclusively so in the future. The methodologies and substantive core of modern science evolved not in universities but in the private studies and laboratories of gifted individuals who supported themselves by

private means or through the beneficences of wealthy patrons. Only slowly did science move into the universities of Europe and America. Indeed, the first university scientific laboratories were established less than a century ago. In universities scientists found a nurturant climate and in turn so nurtured the university that, until recent times, the majority of newly trained scientists were quickly recruited for the teaching staff in still other universities.

It is generally recognized that the universities' historic and primary mission and responsibility in our society is to preserve, transmit, and advance knowledge. Some of the implications of carrying out this broad social function are commented on by Dr. Soskin:

In discharging this responsibility, universities are obliged to train young investigators and to promote research, and today a major determinant of the stature of a university is the character and quality of the research and research workers it produces. Traditionally, too, university research has been carried on in the service of science rather than of technology and the applied arts. Its objective has been to add to our fund of knowledge about man and nature without concern for the immediate utility of such knowledge in solving current "practical" problems. To this end, universities have been highly selective in the kinds of men invited to join their faculties. On the whole, they tend to be men of exceptional intellectual caliber, who hold high expectations of themselves and of others. . . . Having developed methods of inquiry that reduce the influence of personal bias and opinion in their investigation, they tend to be impatient with fuzzy formulations, appeals to authority, and assertions which cannot be substantiated. Unrelenting critics of each other's work, they are likely to apply the same criteria to nonscientists whose unfamiliarity with such severe intragroup appraisal leads them to regard such reactions merely as "hostile" attacks. . . . The university scientist is a man who enjoys and therefore divides his time between teaching and research, who demands the freedom to determine for himself to which problems he will address his capacity and for how long, who regards himself as a responsible and competent worker, and therefore resents supervision or subordination. An alien to the concept of the 40-hour week, he may devote endless week ends and holidays to his research, but he also reserves the right to be accountable primarily to himself.

When university scientists and administrators advise on mental health policies, their advice naturally tends to represent the requirements and needs of the university and the value system of the university community whose main features we have sketched in the preceding paragraph. Their viewpoint differs markedly from that of

persons whose major responsibility is within the service and treatment institutions for the mentally ill. The Soskin report characterizes the latter:

> Just as the university has responsibility for advancing knowledge, the hospital has responsibility for alleviating suffering, and although these responsibilities are related they affect a different ordering of priorities where personnel and budget are concerned. In many State hospitals, the long-standing domiciliary orientation dictates that maintenance and improvement of the physical plant, support of a minimally adequate service staff, and similar considerations be given first priority. There are also the self-concepts of individual staff members as practitioners rather than researchers which account for the fact that shockingly few State mental hospitals spend any money on research or retain research personnel.
>
> Many administrators in these hospital systems do not clearly appreciate what research is about and, not understanding it, they give it little support. The feeling that the physician already knows what to do if he only had more help often coexists with a deep feeling of personal frustration, but the former attitude is not easily relinquished nor the latter readily acknowledged to an outsider. . . . Furthermore, and understandably, in many a hospital pitiably understaffed, the assignment of even one full-time salaried position to a person who does nothing to contribute to care and treatment sometimes seems an unconscionable waste of funds.
>
> It seems unavoidable to conclude that the failure of State mental hospital systems generally to develop any substantial research enterprise in past decades was at least in part a failure on the part of administrators to appreciate the need for such research. Money was a problem to be sure, but not the only one.

A similar orientation to research may be found in typical outpatient clinics and social service agencies where for many workers in these settings "research is merely a laudable responsibility of scientists in far-away universities who report their findings in esoteric articles published in somewhat inaccessible journals."

Professional Backgrounds of Researchers

Research workers in mental health come from the many disciplines concerned with understanding human behavior—from the life sciences, the social sciences, psychology, and psychiatry. It is difficult to specify with any accuracy the number of persons engaged in mental health research since the process of gathering good statistics on scien-

tific personnel has barely begun. The membership figures from scientific societies do not provide good indices of the number of individuals engaged in research since the majority of scientific publications in a given field appears to be the work of a small group among those trained to do research. Within these limitations, it is possible to discuss the rough orders of magnitude of different types of research scientists.

Currently, the major share of systematic investigation on mental health problems is being conducted by psychologists. Dr. Soskin reports that over 50 per cent of all N.I.M.H. grants go to investigators from this discipline. This figure undoubtedly reflects the heavy stress placed on research competence in graduate training in psychology, and the fact that a majority of psychologists are employed in universities where there is, as we have noted, a heavy commitment and pressure to engage in research. Whereas many of the fundamental concepts and hypotheses of modern psychiatry derive originally from clinical observations *and from what now appear to have been* poorly designed studies, emphasis today is placed increasingly on sophisticated research designs, on highly specialized research techniques and instruments, and on complex statistical procedures for data analysis. Psychologists are likely to have had the requisite training and experience for this type of research and this fact helps to account for their prominent position in this field.

Nevertheless, considering the research manpower potential in the field of psychology it is clear that relatively few of the total available man-years are devoted to research directly concerned with mental illness and health. There are 18,000 members of the American Psychological Association of whom some 11,000 hold a Ph.D.; a majority of the latter are employed in colleges and universities where they typically report about 25 per cent of their time allotted to research. Although psychology has produced a very large number of Ph.D.'s since World War II, and in the past decade has enjoyed one of the most rapid growth rates in any scientific field, a substantial part of this effort has gone into the training of clinical psychologists whose primary post-training function has been service in hospitals and clinics. In these settings, their responsibility tends exclusively to be

a service function and little or no time is allowed for research. In this connection, Dr. Soskin reports:

> Indeed there is a continuing concern in many of the larger psychology training centers whether it is wise, considering long-term objectives in the mental health effort, to pour so much time and money and brain power into meeting service needs of the moment. Psychology, it is argued, could offer far more in the long run if its major efforts now were directed to the training of research workers and the conduct of research.
>
> In psychology then, as far as research is concerned, the present manpower problem is less one of numbers than of the effective use of available resources. Far more psychologists are trained to do research than are allowed by their employing institutions to do so, and considerable numbers are obliged to accept employment in technological research centers for lack of adequate, attractive opportunities in the field of mental health research.

The field of psychiatry presents a quite different picture. To quote again from the Soskin report, "Problems of definition, the absence of systematically gathered statistics, and similar considerations make it difficult to know how many psychiatrists today engage in formal systematic research. Both within and without the medical professions, in scientific circles, among foundation officials, and in agencies that support research, the impression is widespread that an extremely small proportion of psychiatrists engage in research." Further, compared with other fields, it seems that a disproportionately small number of younger psychiatrists enter research careers and this situation seems likely to continue until more of the training institutions themselves become research oriented.

Dr. Soskin underlines a serious problem that may develop out of the present situation where the mental health enterprise including its research aspects tends to be identified with psychiatry in the eyes of the legislator and the public, but where there is a desperate scarcity of psychiatrists sufficiently trained and experienced in research to direct the many new training-research facilities that are needed.

> In view of this long-standing underproduction [of research psychiatrists], psychiatry itself is in no position to undertake an immediate and rapid expansion of its research enterprise, at least not one staffed and manned by members of its own profession. Herein lies a source of danger, it would seem, for the profession as well as for science. As a medical discipline, psychiatry commands

more public prestige than the nonmedical disciplines concerned with mental health and, in nonscientific circles at least, it is easier to raise funds under the rubric of "psychiatric" research than of neurophysiology, pharmacology, sociology, or psychology, as examples. Certainly State legislators, who associate mental illness directly with the profession of psychiatry, and whose contact with problems of mental illness may be exclusively through the psychiatrists representing State departments of mental health, will have only a marginal appreciation of the relation of psychiatry to the mental health research enterprise. . . .

Except in the area of the clinical study of individual cases in psychotherapy—where control of training opportunities and other restrictions necessarily limit the research participation of other groups—the lead in mental health research has clearly passed from the hands of psychiatry to other groups: notably to physiologists, psychologists, anatomists, biochemists, and social scientists who easily constitute 90 per cent or more of the investigators working in mental health research today. . . .

Psychiatry in brief seems due for an "agonizing reappraisal" of its present recruitment and training procedures. The so-called "young Turks" of the immediate postwar years performed an edifying service for psychiatry and for the nation through the founding of G.A.P. (Group for the Advancement of Psychiatry), by dramatically challenging public attitudes about mental illness, by drawing national attention to the plight of the mental hospitals, and by attracting a high caliber of young students into training. But the almost exclusive concern with the training of practitioners at the expense of a solid research endeavor, laying psychiatry open to more and more criticism as a scientific discipline, poses the great challenge for today's young Turks wherever they are.

This picture would be incomplete and somewhat misleading if we did not add to it the fact that the clinical and administrative psychiatrists, whose own major interests and preoccupations are in training and practice, have played the major role in bringing nonpsychiatric research scientists into the field. Sometimes the psychiatrists have been guided by a belief in the value of a multidisciplined attack on their problems; sometimes their need for competent and skilled researchers has forced them to look beyond the boundaries of their own discipline. The fact remains, however, that the actual work of planning and executing research now falls almost entirely to the nonpsychiatric disciplines. The lack of research training and experience on the part of most psychiatrists reduces the possibility either of effective collabo-

ration with their newly recruited colleagues or of knowledgeable administration of a research organization.

In order to make up for this record of gross underproduction of research psychiatrists and to accelerate the "tooling up" stage, Dr. Soskin suggests that it may be necessary for psychiatry "to sacrifice a few of its already proven young investigators by drawing them into research-administrator roles—for the sake of expansion losing a few investigators, just as psychology was obliged to do when it 'tooled up' to train a vast number of clinical psychologists following the last war."

Compared to the work in other fields, there is a greater fluidity in the types of problems undertaken by investigators in the life sciences. A comprehensive brain research laboratory, for example, may include research workers in neurophysiology, anatomy, biochemistry, histology, physiological psychology, and pharmacology—all working on different aspects of the same central problem.

Dr. Soskin reports that the latest figures on which to base an estimate of the number of biological scientists engaged in research relevant to mental illness are nearly ten years old. In the light of the past decade's developments, estimates to the present are likely to be risky and unreliable. He comments:

> Fortunately, support for this work is as good as are recruitment and training resources. The major effort required at the moment seems to lie in the organization of additional and larger work facilities—institutes or large laboratories where scientists from different disciplines can pursue their work in close relation to other specialists whose advice or collaboration they may need. . . . One thing is clear, however; there will be a very substantial increase in the number of medical and nonmedical investigators from the life sciences moving into mental health research over the next decade. The brain is coming back into its own as a subject of scientific interest and the potential excitement is bound to attract large numbers of young scientists.

While the total numbers of social scientists—sociologists, social anthropologists, and social psychologists—engaged in mental health research is still small, they have had an important impact in the past fifteen to twenty years on the mental health field in terms of theory and actual practice. The support available to these fields is relatively

modest. Until recently, for example, the National Science Foundation, a major scientific instrumentality of the Federal Government, has felt obliged to withhold or give only sparing support to these fields. Even now, such support is extended on an extremely limited basis. This restrictive policy reflects the attitude that these are not "proper" sciences.

The membership in the scientific societies of anthropology and sociology numbers 5000 to 6000 combined and there are less than 2000 members of those divisions of the American Psychological Association to which social psychologists are likely to belong. When we eliminate those with less than Ph.D. training and take into account diverse research interests and college teaching loads the total man-years of research time available for mental health problems from investigators in these fields appears to be severely limited.

The large private foundations have consistently provided support to these fields. In addition, the N.I.M.H. has recently extended its training grant program to include them and the Veterans Administration has opened up similar opportunities in its own traineeship program.

These new sources of support are encouraging, as is the more widespread acceptance and respect for the social sciences that has grown in recent years. However, as the Soskin report reminds us, "One critical factor in the increased production of social scientists is the number and size of potential training departments in universities. For the decade ahead it is additional university positions for which support must be found, if the output of scientific investigators in these fields is to be substantially increased."

In concluding his review of the various disciplines concerned with research in mental health, Dr. Soskin calls attention to an outstanding need:

> There is need for an immediate strengthening of the research effort in the field of social work. Largely through the effort of the Russell Sage Foundation, some research positions for social scientists have been created in several schools of social work; but the need is vastly greater than the resources of one or two foundations can provide for, and—as with psychiatry—special conditions in present training practices make it especially difficult to draw competent and

creative young people into research early enough. The research corps among social workers is today a group of negligible size, yet the cost to society of providing social service to various patient and client groups runs into the multimillions.

Areas of Mental Health Research

Earlier we noted that the focus in our discussion would be on the organization of the research effort rather than on substantive areas of investigation. It seems useful, however, to acquaint the reader with some of the more prominent concerns and emphases of the current research effort, even though we shall not be able to explore the implications of these areas of interest in any detail. This section is intended neither to be exhaustive nor to suggest priorities among the range of topics pursued by research workers in mental health. The limited purpose should be kept clearly in mind.

There are many different ways to classify research—by the type of methodology, the degree of rigor of the design, the definitiveness of the hypothesis tested, the particular theory or conceptual model involved, or by the specific organ or behavior system under investigation. None of these is entirely satisfactory for all purposes. While we have already suggested that there are problems connected with the conventional distinction between basic and applied research, we shall follow it in this brief exposition.

Basic Research

Research in the *life sciences* offers much of importance to mental health work. Research on the structure and function of the brain, and the relationship of brain activity to psychological processes and behavior is an area of increasing interest and exciting discovery. We noted earlier that a good brain laboratory will count members from many different disciplines among its research scientists. Representatives of the newer multilabeled disciplines—neurophysiology, neuroanatomy, neurochemistry, neuropsychology—are much less rare today than they were only a short time ago.

The complexity of the problems, our still-rudimentary knowledge

of the brain, and the variety of disciplines involved all suggest the wide range of topics under investigation. In the area of brain metabolism, for example, techniques are in the process of development for studying individual brain cells and their supporting cells in test tube cultures of living cells. This permits the close examination of the part played in brain nutrition by the supporting cells and the effects on this process of drugs and other agents. Studies of the energy exchange between the circulating blood and brain cells, which admit no blood, and investigation of the effects of various chemical agents such as drugs on nervous system activity have produced a number of significant findings in recent years.

Techniques that allow for the stimulation of specific areas of the brain through the implantation of deep electrodes and other electrophysiological methods are producing much needed knowledge about the structure and functioning of the brain as a total organ.

A considerable amount of systematic work is underway on the biochemistry of mental illness. Here, the attempt is to isolate biochemical processes in the brain and nervous system that are associated with the specific mental illnesses. Most attention has been given to schizophrenia and many investigators are engaged in the search for abnormal compounds in the blood, urine, or other bodily fluids of psychiatric patients. Progress could be made in our understanding of the ways in which other organs of the body affect the functioning of the central nervous system, through such studies as those concerned with the mental symptoms accompanying liver malfunctions and various abnormalities of blood composition such as pernicious anemia.

Modern genetics also offers much of theoretical importance to psychiatry. Such discoveries as that of an abnormal chromosome in the germ cells of mongoloid children, for example, increase our understanding of the role of genes and heredity in various types of malformation and malfunctioning of the brain. Studies in "chemical" genetics are beginning to point to relationships between the arrangements and combinations of the deoxyribonucleic acid (DNA) molecule, patterns of chemical functioning, and the activity of certain

transmitting substances in the nervous system that are in turn affected by stress.

Present research in *psychology* is of particular relevance for mental health problems. There has been an increase of interest among psychologists in research on cognitive and perceptual processes, and on language and communication. Experimental studies of the effects of subliminally perceived stimuli are underway in several research centers; highly sophisticated techniques of linguistic analysis have been applied to the verbal productions of psychiatric patients and to the interactions of therapists and patients; studies have been made of the relationship of thought processes and language structure to educational and socioeconomic backgrounds. Studies of nonverbal communication—gestures, facial expressions, repetitive bodily movements, posture, gait, activity rate—through which individuals may symbolize and express their attitudes and feelings have also received attention.

Through the use of drugs, special techniques such as hypnosis, and artificially produced conditions of sensory deprivation it has been possible to "simulate" certain psychological processes and states that accompany and characterize mental illness. This has permitted more controlled experimental study of these phenomena than was possible before. New techniques for determining learning patterns and developmental stages are also permitting a more detailed and accurate picture of differences between the mentally ill and normal populations.

Studies of normal personality development have begun to supply a corrective to our theories that have been developed largely from clinical experience with troubled children and adults. "Longitudinal studies" that follow the same persons from infancy into adulthood, measuring and recording a multitude of factors, are providing more adequate knowledge on the origins of our drives and ambitions, our morals and loyalties, as well as of the factors that promote or hinder the healthy realization of potential in the course of development. Comparative studies of child-rearing practices in the various subcultures within our society are providing a clearer picture of the wide range of variation in normal development that provides a more

adequate context for assessing the case histories of our psychiatric patients.

There have been energetic attempts in recent years by *social scientists* to give greater weight in their theories and studies of group behavior to variations among individuals—i.e., to personality differences. Our general theoretical understanding of deviant behavior and of the relation of mental illness to other forms of deviation has also gained in depth and precision. Combined with a continued interest in "microsociology," i.e., small group processes and interpersonal relations, these trends in theory have fostered new developments in method and technique which have permitted a more extensive research attack than was heretofore possible on mental health problems.

Illustratively, we may mention studies of the effects of group membership and participation on individual behavior; of the "shaping" effect that social position, socioeconomic class, and institutional setting have on individual motivation and orientation; and of relationships that have been discovered between basic personality structure, attitude toward authority, and prejudicial opinions about minority groups.

Studies in the sociology of the professions, the sociology of organizations, and the social epidemiology of mental disorders are adding to our understanding of the role played by mental health practitioners in influencing attitudes toward mental illness and the use of treatment facilities, of how the hospital milieu operates as a factor in treatment, and of the etiology of mental illness.

The orientation of social science is in large measure responsible for the recent spurt of interest in the family's role in mental illness—as the setting in which the illness emerges and manifests itself, as the buffer and transmitter of wider social pressures, as the social unit to which the psychiatric patient returns for final recovery and rehabilitation.

Applied Research

In applied, or clinical, research the method, approaches, and concepts used in any one study may be drawn from several different

disciplines. The concern is with the prevention and treatment of mental illness and with the development of more effective services for patients.

Primary prevention is an important area for applied research. Many of the specific studies in this area reflect our growing interest in and understanding of the effects of social forces. It must be said that systematic studies are still infrequent but topics such as the following are now among the serious interests of applied researchers: the evaluation of mental health education programs, particularly those directed at parents; the influence of various school curricula, different educational policies, and teaching procedures on the adjustment and mental health of children; the effects of large-scale readjustments and changes in the society such as the introduction of automation in industry, the desegregation of our schools, and the relocation through urban renewal projects of large numbers of persons.

Modern trends in psychiatry suggest that increasingly larger proportions of a patient's time while he is in treatment will be spent outside of hospital walls within the family setting or in other natural community groups. Interest in studies of the interaction of the ill person with others in this natural environment has also been increasing.

Care and treatment of the mentally ill comes under scrutiny in studies of psychotherapeutic processes and of the effectiveness of different types of psychotherapy for different subject populations with different presenting problems. These areas are receiving growing attention. Concepts and methods for evaluating the effectiveness of treatment are barely in their infancy. The general impact and the specific and differential effects of the large and rapidly growing store of psychopharmacological agents is a large and busy area of investigation. Methods developed here for evaluating drugs are also applicable to the study of other forms of treatment.

Findings have accumulated in recent years that demonstrate the value of efforts to rehabilitate chronic mental patients. However, methods in this area remain crude and imprecise. On the related topic of alternative treatments to hospitalization, there is evidence that the nearer the patient's home treatment is given, the greater the

prospect of recovery and successful rehabilitation. This, of course, has implications for research evaluating such units as day hospitals and night hospitals, halfway houses, emergency care services, and other similar units.

Administrative patterns in treatment institutions for the mentally ill have been dominated by the idea of the hospital under medical-psychiatric control. There has been much argument and discussion in recent years, however, about other forms of administration. Research on this topic has barely begun but the need for bold experimentation in administrative patterns seems apparent. The evaluation of different forms of administrative organization is likely to develop into an area of major interest.

In this brief excursion into the content of mental health research, we have tried merely to illustrate the range of interests and topics under investigation and have highlighted those that have in recent years received increasing attention. At this point, we turn again to the organization of the research enterprise as a whole and will examine the sources of and mechanisms for providing funds for research.

Support of Mental Health Research

It is difficult to determine with high accuracy the total amount of money currently being spent on mental health research. Table 5, from Dr. Soskin's report, represents an estimate of total expenditures

Table 5—Estimated Expenditures for Research Related to Mental Illness and Health, 1958

Source		Amount in Millions
Federal agencies		$40
N.I.H.	$32	
Military agencies	6	
Other Federal agencies	2	
State governments		14
Pharmaceutical industry		12
Foundations and other sources		4
Total		$70

Source: Soskin W. F., *Research Resources in Mental Health.* Joint Commission monograph (unpublished).

for both basic and applied research in those areas of the biological, psychological, and social sciences, and psychiatry having a central bearing on problems affecting mental health. During the year 1958 the total expenditures came to about $70 million per year from all sources. Soskin comments that "the annual outlay of $70 million for our research is about equal to the cost of constructing and firing two Atlas missiles."

More than half of the total outlay comes from the Federal Government, mainly from the National Institute of Mental Health. More modest support comes from other government civilian agencies and the military services. Soskin reports:

> At the peak period of interest in the development of the new market for psychotherapeutic drugs the pharmaceutical industry in 1957–1959 invested about $12 million per year on psychotherapeutic drugs, about $10 million of which was for research within the industry's own laboratories and the remainder for drug testing and free research grants to investigators in universities, State hospitals, and similar settings. State governments appropriated about $14 million in 1958; but 75 per cent of this represented the expenditure of four states: Illinois, Michigan, New York, and Pennsylvania, while more than 20 other states made no appropriation whatsoever for research.
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> Based on a study by Dr. Rashi Fein, the Joint Commission on Mental Illness and Health estimates conservatively that mental illness is costing the nation at least $3 billion annually. Our $70 million, then, is barely 2 per cent of this total cost, a shockingly small investment. The pharmaceutical industry, whose 1958 sale of psychotherapeutic drugs was estimated to be around $185 million, invested about 6.5 per cent of net sales that year for further research on these drugs, but State governments which spend over $800 million annually on the maintenance of mental hospitals invest a bare 1.7 per cent in research. If we subtract the appropriations of the four States mentioned above, the remaining States collectively allocate less than 0.5 per cent of their total mental hospital budgets for research. Table 6 shows the approximate amounts of regional investments of State funds in mental health research for 1958 both in dollars and as a per cent of total regional expenditures for the operation of State mental hospitals. . . .
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> While Congress and the State legislators are subject to similar budgetary pressures and the competition of various services and facilities for funds, it is clear from an examination of the monies they allocate to mental health research that they have responded quite differently to these pressures. On the whole, State legislatures have displayed a singular imperviousness to pleas for addi-

Table 6—Regional Expenditures for Mental Health Research as a Per Cent of Expenditures for Operation of State Mental Hospital Systems

Region	Research Expenditure (thousands)	Research Expenditure as Per Cent of Hospital Appropriations [a]
New England	$ 300	—[b]
Middle Atlantic	6,400	2.8
East North Central	5,100	3.1
West North Central	200	—
South Atlantic	200	—
East South Central	300	1.3
West South Central	600	1.7
Mountain	20	—
Pacific	700	0.9

Source: Soskin, W. F., *Research Resources in Mental Health.* Joint Commission monograph (unpublished).

[a] Per cent based on estimated expenditures for 1958.

[b] Less than .01 per cent.

tional research funds; Congress, on the other hand, has poured millions of dollars into mental health research.

Many State legislators fail to see why they should spend any money at all on research and do not appear to appreciate the possibility that investing tax dollars in research may sometimes be a wiser legislative policy than holding the line on State budgets. It would appear that the failure of many State legislatures to appropriate funds for mental health research reflects a failure in public education since the arguments for stronger research programs are so compelling that these officials could not fail to be responsive if the facts were well presented.

Even where legislatures have appropriated research funds, the Soskin Report notes:

The program envisaged has quite distinctive features. Often it is urged on the legislature by physician-administrators who themselves have little direct experience with the conduct or direction of a research enterprise. By contrast with Federal funds, State appropriations are likely to be virtually "captive" grants, intended for specific individuals or specific laboratories. No suitable mechanism exists by which other scientists can apply for funds; and again, in contrast with Federal policy, the allocation of funds or the evaluation of projects for which they are spent only occasionally comes under the scrutiny of impartial panels of scientists. Furthermore, State appropriations for the conduct of research are highly vulnerable to local political pressures unless a formal mechanism is established to insure the stability of such funds.

In describing the fund-granting activities of N.I.M.H., the largest single supporter of mental health research in the country, Dr. Soskin comments:

As has often been pointed out by Philip Sapir, Chief of its Research Grants and Fellowships Section, the Institute's policies and practices have been criticized by one group or another as being "pro-psychiatry" and "anti-psychiatry," "pro-biology" and "anti-biology," too rigid in its research standards and too lenient, biased in favor of "big name" investigators and wasteful in supporting poorly designed research by "unproven" men. Yet very few of these criticisms hold up under careful, objective scrutiny.

N.I.M.H. is charged by Congress to promote research in mental health and to promote the training of research and service personnel. With others of the National Institutes of Health, its objective is to achieve the highest quality of research output and the best-trained personnel consonant with the multiple needs and objectives of the various groups and institutions it serves. It is not primarily a grant-in-aid program for States. It is not charged with responsibility to solve the financial problems of universities. It dare not become the instrumentality of a particular professional or scientific group or be dominated by a particular theoretical persuasion at the expense of others if it is to serve the total scientific community and be of maximal use to all the professions concerned.

In implementing its broad responsibilities, inevitably N.I.M.H. will pursue policies which on casual inspection seem inconsistent. Under its long-standing practice, recommendations as to which research proposals shall receive Federal support are made not by Institute staff members but by advisory panels of scientists drawn from the country's leading research centers. These scientific advisory panels hold high standards for most research grants, yet they are quite lenient about appraising truly creative exploratory studies. As compared with small universities, a disproportionately heavy flow of research funds goes to the major universities where there is a high concentration of good research men, but the major determinant of favorable recommendations is not the institutional affiliation of the investigator but the promise of outcome of the research proposal itself. In making individual research awards the Institute is not limited by considerations about equitable distribution of funds among the several States, and yet it will occasionally support a marginal project primarily to foster a stronger research attitude among professional workers in a particular region.

In his analysis of the sources of funds for mental health research, Dr. Soskin isolated several elements that he felt constitute together an "implicit policy" in the granting of research funds.

The first of these elements is that the formation of research policy, at least at the Federal level, is predominantly influenced by people trained in research as contrasted to the practitioners of medicine who control treatment institutions.

A second characteristic, again, especially of Federal policy, is that the prime criterion for awarding a grant is the scientific competence of the investigator and minimal consideration is given to the official position, particular role, or prestige of the researcher.

A third and particularly important additional element of this implicit policy is that the research funds are to be used only for the production of knowledge and are not to be diverted to meet other needs, however important the latter may be in themselves. Associated with and reflecting this feature are several familiar practices to which we will return in our later discussion: the tendency to allocate funds on a project-grant basis; the limited and only nominal control over the expenditure of funds allowed to the administrating institution; the allocation of funds on a directly competitive basis with minimal consideration of regional distribution or spread throughout the various disciplines.

A fourth and final characteristic of this implicit policy is that it encourages the development of multiple sources of support for research. It is felt to be of critical importance that investigators have available to them several alternative sources of support so that a project whose merits are not evident to one source might be sponsored through the decision of another panel of judges in a different agency.

We shall return to some of the implications of this implicit policy in the following sections where we discuss the problems associated with the current research effort and offer suggestions for increasing this effort in the future.

PROBLEMS AND ISSUES OF THE CURRENT RESEARCH ENTERPRISE

We turn from inspection of the major features of the current research enterprise in mental health to a discussion of problems and

issues that are associated with the present overall effort in this area.

The administrative problems concerning us here refer to the organization and support of research. These are clearly different from the difficulties in theory and method which concern professionals and scientists in these fields. We have emphasized in this report the complexity of the mental health problem and the inherent difficulties of carrying out good research and producing reliable and useful knowledge. These problems are properly the concern of the research scientists themselves.

All of us, however, recognize that the way in which the research effort is organized affects directly the research activity itself. Poor administration frustrates investigators in their attempts to secure funds, equipment, and personnel; it disrupts the continuity that is necessary in many research areas or activities where they do not have to face the extra hazards and frustrations; and, in its most serious form, it leads to the neglect of important research areas. On the whole, it is clear that administrative problems of the kind we shall discuss can make the entire research undertaking more difficult. Unless research policy is developed with an awareness of these problems and their sources, our hopes and expectations for advances in this field will be difficult to fulfill.

In addition to this distinction between administrative and "technical" problems, a second distinction is important in examining problems and considering policy with regard to mental health research. This is the difference between the research enterprise seen as a whole and any research area or particular project. An example will indicate the nature and importance of this difference. In thinking about the enterprise as a whole, the problem of recruiting and training young researchers for the future life of the overall effort is a prominent consideration. In thinking about a concerted effort to solve a particular problem, we are more concerned with guaranteeing and underwriting the efforts of the mature investigator whose lifetime of work may now be reaching fruition. A responsible and comprehensive research policy must recognize that the requirements of the whole are neither the same as, nor always consistent with, the requirements of individual areas or research projects.

The Distribution of Research Settings

Research in mental health is largely carried on in our major universities, which dominate the field. What are some of the implications of this fact?

Here the distinction we have made between the overall research effort and specific projects is particularly germane. The above pattern appears to reflect more concern with specific research products and a research attack on specific problems than with the development of a broader-based research enterprise.

Pouring funds into a small number of the major universities may also pose problems for these institutions themselves. Their functions are, after all, much broader than the pursuit of mental health research; they include teaching, research training, and scholarly and research work in the other areas of human knowledge. Discussing the problems that may accompany current research policy, Dr. Soskin cautions, "It is more than a matter of passing interest, then, that today in the major universities science is taking on the aspect of big business. In our hunger for new knowledge we pour more and more money into university research and thereby run the risk of altering markedly the position of the scientific enterprise in relation to other legitimate functions of the university."

A number of other problems associated with the concentration of mental health research in the major university centers may be listed briefly. First, as universities have become more and more dependent on research grants as a source of new income—particularly in the private universities, where the changing tax structure over the past few decades has reduced their potential sources of endowment funds —heavy pressure comes to be placed on investigators to be continually in the business of seeking new grants. However, as Dr. Soskin points out, few grant sources presently pay the full cost of a project to the university, and the differential must be made up from other institutional resources. Thus, universities seem to be forced into committing more and more of their own resources as they continue to actively seek additional outside research support. Finally, universities, be-

cause of their departmental structures and traditional academic hierarchies, have practical limits on tolerable rates of expansion in any specific department, which may affect the growth possibilities of the research enterprise.

Regional differences in research support and output are well known. The New England and Middle Atlantic States with a number of pre-eminent "national" universities are especially productive of persons with advanced degrees and of research in mental health areas; the Midwest and Pacific States have strengthened their efforts in these directions in recent years. Southern States tend to underproduce Ph.D.'s and, as Soskin observes with respect to our own specific interests, "Relative to other areas of medically related research, then, a smaller proportion of southern research workers were engaged in mental health research than was true in other sections of the country." Perhaps the most serious implication of this uneven regional distribution is its effect on the recruitment of future research scientists. Where local and regional colleges and universities offer little that is exciting and challenging in the area of mental health research, the brightest students are likely to be drawn into other fields. By the time they are ready for graduate training and prepared to travel to the large distant centers, many potential contributors to the mental health field may already have become committed to other careers.

One last general point may be made. The concentration of support in the established universities with strong and specific intellectual traditions may, while it assures a high quality of research output on many important problems, also have the effect that certain problems are neglected. One might mention as an example the long neglect of research on the types of patients that fill our large State mental hospitals. In particular, new ideas that do not seem to fall easily within the framework of established disciplines and doctrines—ideas which one might anticipate as emerging in universities with idiosyncratic traditions or in research centers that may be insulated from the dominant trends—may receive less of a hearing than might be the case if the research effort was more widely distributed.

The Split between Researchers and Practitioners

The major point emerging from our review of research manpower in the mental health field is the clear dominance of research scientists in the academic disciplines, and the scarcity of researchers from psychiatry or the other service professions. This is consistent, of course, with the concentration of research funds in universities and the two patterns are interdependent and mutually reinforcing.

The problems engendered by the split between researchers and practitioners is one of the main themes of the Soskin report:

> Many professional workers and large segments of the general public think of the field of mental health as the special province of the psychiatrist, the clinical psychologist, and the social worker, admirably aided by the teacher, the nurse, the clergyman, and related professional groups. It is true that insofar as therapeutic services are concerned, these professional groups are pre-eminent in the mental health endeavor. This is no longer the case, however, when we talk about mental health research. For although a large middle ground exists in which the sciences and professions co-mingle, where sometimes the same individual engages in both research and service, on the whole quite different groups and up to now even quite different institutions are involved in these respective functions.
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> What is more, the general public long familiar with the service role of the psychiatrist or the social worker, often has never heard of the scientists responsible for most mental health research—the research psychologist, the biochemist, the neurophysiologist, the pharmacologist, the geneticist, the sociologist, and the cultural anthropologist. Even less is it understood how these men work or why it is that good research requires specialized working conditions.
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> But the layman who lacks information is not the only one at a disadvantage in discussing research policy. Professional and scientific workers carry their own impediments. For quite understandable reasons each of these groups is saturated with its own peculiar biases, saddled with its own responsibilities, striving toward its own goals, and hence views the problem of mental health research from a highly particularistic vantage point.

Discussing some of the problems that arise from the different positions, perspectives, and interests of the traditional scientific researcher and practitioner, Soskin reports:

Between professional people engaged in offering a vital service and research groups there exists a greater estrangement than is often acknowledged or recognized. The practitioner is constantly faced with the enormous demand for his service—a demand that usually far exceeds both manpower and budgetary resources. Given more money, he would tend to try solving the problem by expanding present services in order to offer immediate help to patients not now being adequately treated. To a great many of those engaged in professional practice, research is seen as a slow-moving, long-term operation whose practical outcomes, at best, lie years in the future.

This attitude grows quite naturally out of the circumstances and requirements of the practitioner's daily work. . . . [The practitioner] knows that research might yield some useful clues and he even might try to do a little himself, but he often finds that his time is too limited or worse, because he is not trained in the research methods, his research product is likely to be criticized as incompetent by more experienced researchers. Thus, he finds himself esteemed by patients for what he seems to know and tries to do, and regarded skeptically by research people who have reasons to doubt the efficacy of many of his practices.

The research worker, on the other hand, usually is protected from these enormous service demands precisely so that he may be free to engage in research without coercive and interfering pressure. His rewards derive not from the gratitude of patients but from the approval of colleagues. Because his work demands it, he is often much better informed about latest developments in his field than is the practitioner. . . . More than that, since discovery and invention are rare accomplishments, often his work takes the form of studying the inadequacies of existing techniques so that he is an expert in the deficiencies of current treatment practice.

Ideally, the research worker is a professional skeptic. In the face of a staggering service burden he is disinclined to plead for more practitioners, but might ask instead, "With more research couldn't we find a more effective method of treatment?" Because there is a high degree of specialized technical skill involved in good research, just as there is in good professional practice, the trained research worker is likely to disparage the amateurish research effort of the practitioner as merely compounding confusion. Thus, in many settings, these two groups regard each other with mutual circumspection.

These problems are reflected in the serious gap that exists between the knowledge generated by research and its conversion into practice. Practitioners find that they cannot understand the research reports nor see their relevance to their daily problems. Research workers, on the other hand, when they are interested in investigating

mental health questions, cannot understand the resistance of the practitioner to such elementary and necessary principles of good research as experimental controls and adequate sampling procedures.

Even when they work together on the same problem, as has been increasingly the case in large-scale projects undertaken in recent years, they often seem unable to arrive at an adequate level of mutual understanding. The hospital administrator or clinical practitioner complains at the end of the study that he received little help for his practical work and knows little more than he did at the start. The research worker complains that much time was wasted trying to convert the problem with which the practitioner began into a "respectable" one. The scientist sees himself as a contributor to general and abstract human knowledge, but he is viewed by the practitioner as simply a gatherer of useful information or as a technician who knows how to organize and marshal information so that the practitioner's theory will find vindication. It should be noted, parenthetically, that these problems between practitioners and researchers are not specific to the mental health field but seem to arise in other areas as well.

Public Misconception of Research Areas

In our bird's-eye view of current research areas in mental health we suggested that perhaps the most prominent feature was the diversity of the effort. Work on many levels from many different approaches and by investigators from a variety of specialties is actively underway.

It seems to us that such diversity should be encouraged and supported. Whatever problems exist flow not from the diversity itself but from the lack of public understanding of research needs and resources. This sometimes leads to a sudden outpouring of funds centered on a particular topic which the scientific community may not be able to use in an effective way. On this question Dr. Soskin comments:

> Periodically in Washington there is talk of mounting a single "crash" program attack on this or that illness and, as was mentioned earlier, Congress and the general public have become accustomed to thinking of research support in terms of specific illnesses, thanks largely to the promotional efforts of the large

volunteer health organizations. Although such strategies reflect the urgent need and apprehensions of the social community, they bear little relation either to the realities of the process of discovery or to the realities of our research resources in the mental health field. Past experience with research in other areas makes it abundantly clear that we cannot predict where or how soon a significant advance will occur in our attack on mental illness.

We already have cited, in the manpower section of Chapter IV, the lapse of 40 years between the 1908 discovery of the cause of polio and the discovery at Children's Hospital in Boston making a polio vaccine practicable. It merits telling, too, that the Enders team was not the least interested in polio at the time of the discovery. The group was working on a trio of common children's diseases when it discovered the technique which finally paved the way for Jonas Salk's development of a successful polio vaccine five years later.

Soskin observes:

By comparison with polio, we are not even in the 1908 stage in the sense of having discovered causes. We believe that some forms of mental illness arise from as yet unidentified biological disturbances and we believe that others result from prolonged exposure to deleterious psychosocial experiences, but our firm positive leads are few indeed. In the area of mental illness and health we face not only biological problems, but psychological and social ones. In addition to a far greater understanding of brain processes, we need a profoundly more sophisticated grasp of the nature of human learning, the nature of language and communication, the idiosyncrasies of human cultures, and so on. The key to much of what we need to know lies buried in bits and fragments in the area of inquiry being investigated by a dozen scientific disciplines; of the basic research required in each discipline, some surely enough will resemble proper medical research by involving burettes and microtomes and tissue stains and hospital wards; but the rest may well involve electronic computers, sound movies, children's play groups, and street-corner gangs. We must recognize that our concerns for the several target populations whether in mental hospital or clinic, in social agency or school or prison, are closely linked and that we are dependent on a common core of basic and clinical research for understanding their problems.

Forms of Research Support

Earlier in this chapter, we pointed out that the dominant features of mental health research in source and form are (1) the major role

played by the Federal government, particularly through N.I.M.H.; and (2) the strong tendency to supply funds on a project basis.

In discussing the problems of overdependence on Federal support and the situation that researchers themselves often talk of as "projectitis," the Soskin report comments as follows on the character of the funds presently available:

> These funds do not meet other vital needs of the research enterprise . . . if still more research is needed we cannot get it merely by doubling or trebling the money available for such grants, because these men (the recipients of research grants) cannot increase the amount of time they have available for research. Instead of more grant money then, we must have more research workers and since such men have to be trained we next need to invest money in the training of scientists. This the Federal Government has already undertaken to do. But once these men are trained, we need stable, salaried positions for them. Of these, few can be expected to be provided by universities themselves, given their present resources. For the Federal Government to provide the necessary funds, on the other hand, immediately raises not unfounded concerns about steadily encroaching Federal control of our universities. As has been implied in preceding sections, research grants themselves are already a thinly disguised Federal subsidy on which many of the largest institutions have come to depend; direct subsidization of faculty positions by influencing faculty size could only increase this dependence.
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> Presently, under an extremely flexible policy designed to take every advantage of available resources, Federal grants in some instances make it possible for some investigators to support themselves completely for one or two or three years through research grant funds, but no competent investigator enjoys the prospect of a career that involves precariously scrambling for new grants every two or three years. The whole process of doing original creative work is difficult enough without imposing the additional requirement that those investigators not on regular institutional payrolls be obliged to live uncertainly from grant to grant at the mercy of the vagaries of Congressional appropriations or the uncertain decision of study panels.

AIMS AND STRATEGY FOR A RESEARCH EFFORT IN MENTAL HEALTH

Our primary intent in this chapter has been to examine the conditions under which research in mental health is organized, supported, and conducted. We have been concerned with the overall re-

search effort rather than with any particular area or direction of inquiry. We hoped to bring into sharper focus certain administrative issues and problems that might be minimized by changes in existing policies and procedures.

The most important principle that emerges from our consideration of various problems is the need for breadth and diversity of research. This principle is applicable whether we are concerned with the institutional settings for research, the professional disciplines involved, the sources of financial support, the substantive areas for study, or the basic or applied nature of the research.

Dr. Soskin emphasizes this point in his discussion of research objectives:

> Unglamorous as it may sound, the only realistic approach seems to lie in a long-term program of basic and clinical research equally well supported in the broad spectrum of medical, biological, psychological, and social science disciplines and conducted in universities, in hospitals, in clinics, and in a variety of other settings. . . .

We wish it clearly understood that this principle does not derive from a cautionary attitude toward research in mental health, that is, we are not arguing for a policy of "hedging bets" where, being unsure of where the answers may come from, we put a little money on every chance in sight. Rather, the need for a broad and varied program of research is dictated by the nature of the mental illnesses themselves. They have their source in the interaction of biological, psychological, and social factors; they are manifested in somatic disorders, in emotional and psychic distress, and in unhappy interpersonal and social relationships; they are treated with drugs and other physical therapies, by individual and group psychotherapy, and by methods of social rehabilitation. There is no one direction that promises *the* answer. Most simply, there is no one answer.

With breadth and diversity as the overall aim, the following proposals outline a general strategy for expanding and strengthening the research effort on mental health problems.

First, with regard to research settings *there should be support for flexible and experimental programs of stimulating research in many different areas and settings.*

Reasons for expanding and diversifying the settings and locales within which mental health research is conducted were discussed earlier. There are many different ways such a recommendation might be implemented, and these ways deserve exploration. For example, research in small, poorly-staffed, or outlying institutions could be encouraged, and quality standards maintained at the same time, by the active use of research consultants from central agencies or research centers. This is not a new proposal and some activity of this kind now goes on. It would not be too difficult to expand these efforts. One approach would be to encourage granting agencies, such as N.I.M.H., to place less emphasis on their function of evaluating research applications and more emphasis on providing research advice and consultation.

Several administrative arrangements for research have been tried that serve this general purpose and may merit more general use. The Veterans Administration uses central coordinating and data analysis facilities that permit research on the same problems to be carried out simultaneously in several hospitals scattered across the country. The Psychopharmacology Service Center provides another useful model in its work of setting out guide lines for drug research, holding conferences, and rapidly summarizing and circulating findings from drug studies.

The administrative devices we have described involve new uses of or new arrangements among existing facilities. In addition, there is a fundamental and universally recognized need for more large, well-staffed research centers.

Second, *efforts should be made to increase contacts between researchers and practitioners so as to increase mutual understanding of each other's problems and approaches.*

In discussing scientific manpower, we referred to the cleavage between academic researchers concerned with theoretical issues and clinical practitioners concerned with concrete and useful knowledge. This is a complex problem and we do not believe in the possibility of a simple rapprochement between theory and practice. The differences between practitioners and researchers develop out of the realities of the different jobs they each must do, and their respective points

of view are useful to them in their work: The objective of policy should not be eliminating or obscuring the differences, but recognizing them in order to find ways through which research can contribute to practice and vice versa.

More opportunities for communication and collaboration between researchers and practitioners would seem a useful first step. To pursue research on clinical problems so that findings have meaning and applicability to practice, the researcher may have to know a great deal about how the problems appear to the practitioner and this may suggest that he carry out his work in a clinical setting. Inservice training institutes, on the other hand, may provide an effective mechanism for practitioners to learn about research problems and procedures. Departments of Behavioral Sciences in Medical Schools or appointments of social scientists to Psychiatry Department staffs would be still other forms through which to increase the possibilities for practitioners and researchers to learn from each other.

Third, *there is a general need for long-term research support.*

We have made the point that current support programs emphasize short-term projects. We wish only to stress that new efforts should involve both the financing of broad research programs and the establishing of tenure research positions in universities, clinical institutions, and other research centers.

Finally, *there is an urgent need to expand and intensify basic research in mental health.*

We have explored some of the differences between basic and applied research. One additional distinction is worth noting. The quality and strength of the basic research effort in any one area depends on the health and vitality of the entire scientific and intellectual enterprise. While basic research requires a broader base of support than is needed for applied research, its findings ultimately spread more widely and more deeply through society.

VI

The Second Question: How Can We Catch Up?

DISPARITIES OF MEANS AND ENDS

The Joint Commission on Mental Illness and Health now faces the responsibility that we accepted from Congress to recommend a national program for the control of mental illness.

We have revealed the hope of dedicated mental health workers that they can—through scientific knowledge, general experience, social conscience, or the sheer force of tender feelings—help the mentally sick to regain their social balance and build up individual strength of mind. We have analyzed the towering obstacles that lie in the path of such therapeutic efforts.

The obstacles, in outline, are these: A main characteristic of psychosis or any severe mental illness is disordered behavior of some kind. Such behavior tends to alienate the person from his fellow men. They commonly fail to recognize him as sick, and his plight stimulates disapproval rather than a desire to help him. Aware of this rejecting attitude but themselves not entirely immune to it, psychiatrists and others who work with the mentally ill can help them through humane, healing care. But medical science presently lacks the kind of knowledge that would make it possible to treat the mentally ill quickly, certainly, and cheaply. Psychotics can be treated individually and privately with good results, but most patients and their families lack money for the prolonged treatment or hospitalization that is

frequently necessary. As a consequence, the responsibility and burden of care fall on the States rather than private citizens and private enterprise. This outcome places the major mentally ill at the mercy of both politics and public resistance to increased taxes. In effect, chronic mental patients acquire the liability of poverty while losing the right to be treated as sick. Since they are lacking in the qualities that arouse sympathy and do not appeal for help, are liable to be treated as discredited witnesses when they protest the treatment they receive, and have the further handicap of not being able to work together effectively, the mentally ill lack the leverage available to other pressure groups in the promotion of their own interests.

Under the democratic and medical traditions of free choice and mutual trust, the situation of the major mentally ill is a strange one and society has treated it accordingly—by avoiding or casting out mental patients and refusing to accept full responsibility for them.

We have described the resultant lag between mental health and other public health or medical care programs, while at the same time not overlooking the gains that have been made—in improved public attitudes, in intensive psychotherapy, in sociological systemization of the values of moral treatment, in funds expended.

We have taken long looks at psychiatric treatment and its results, at the need for a foundation of "hard science" and superstructure of therapeutic technology; instead, much of our knowledge comes from common experience and subjective conviction. We have surveyed the psychological, social, educational, and welfare scenes. We have discovered that a sense of material prosperity and comfort, a main source of happiness, does not extend vertically through all classes of our population. Nor does it appear that our total efforts to relieve or improve conditions at the lower socioeconomic levels are deep and far-reaching, alarmists who see a welfare State impending or upon us to the contrary. We also note the analogy between the state of public services in behalf of the mentally ill, and those for dependent children, broken homes, working mothers, the dependent aged, slum tenants, displaced national groups, deprived minority groups, and the unfortunate or ill-starred in general. Compared to the size of each prob-

lem, the social efforts to solve it are impressive in their pretensions but feeble in actuality.

Thus, as we come to the problem of recommendations, we see at once that the question is not simply, "How can we catch up?" but really, "Can we catch up?" To answer affirmatively we must rely to a large measure on hope and subjective conviction as well as on various pieces of evidence that show progress where the necessary effort has been made.

The evidence from which we derive hope and conviction is of several sorts: Mental health information, whatever its vehicle, has had positive effects on the educated public's ability to recognize and seek help for psychological problems. The public demand for the services of mental health experts is clear-cut, and has not been met. Congress and some of the State Governors and legislatures have assumed leadership in providing increased support. Many communities have evinced eagerness to establish and pursue mental health programs. All signs over the past fifteen years indicate that a trend has been established, which, if wisely and boldly fostered, could continue. Innovations and experiments are sufficiently numerous to make us believe that old retrogressive directions, prejudices, and resistances can be reversed if frontally assaulted. In the name of patient care and despite personal rivalry and honest differences of opinion, psychiatrists, psychologists, social workers, nurses, occupational therapists, volunteers, and others are learning to work together, and may become more disposed to do so as time passes. A good many psychiatrists concede the desirability of broadening the base of therapeutic manpower as the evidence accumulates that this can be done without harm to the patient—or to the profession of psychiatry. It remains for organized psychiatry and medicine as a whole to accept this reality and implement it.

We can reach one of two decisions:

1. A national mental health program *can* be developed and, through effective effort, overtake the problems of untreated mental illness itself. *But* this course only will be possible if we—the interested and involved public and the mental health professions—make

a tremendous, imaginative effort that transcends anything yet contemplated by those who accept the primary professional responsibility for the mentally ill or by those with social responsibility who provide the financial means.

2. We *cannot* do more than we are presently doing, taking account of present knowledge, past experience, and projected costs.

Those who will legislate a national mental health program have this decision to make. We shall return to the final consideration—the cost of making one decision or another—in the concluding section of this chapter.

How can we catch up?

Within the context of prevention and treatment of mental illness, we would say that the need in its largest, theoretical dimension is to provide every person with the chance to develop a personality or character of sufficient strength to cope with the stresses life imposes upon him, or, to provide those persons who find the stress too great with the benefits of proper diagnosis, adequate treatment, and rehabilitation. But, as we have said before, it is easy to state the need; simply to state it is to endow it with overtones of grandiose ambition.

What are our resources for meeting the need? Whether we define need in terms of the average citizen's effective psychological functioning or limit it to adequate professional care for mentally ill patients, disparities exist between present resources and the need. Each of our monographs has presented such a disparity.

One study suggests a disparity between what we now do and what we could do if we did as much for most patients as we do for some. Indeed, the majority of the mentally ill do not receive the benefits of present knowledge.

Another well-documented disparity involves the contrast between the professional manpower now available and what would be needed if we were in fact to do for all what we can do for some. We are tragically shorthanded.

Still another disparity emerges in the matter of costs. What we are now spending is only one-third to one-half what it would cost to provide modern mental hospital treatment to all the mentally ill.

Finally, there is the disparity between what we know scientifically

and what we need to know in order to achieve mass prevention or control of mental illness, in the manner by which certain organic diseases have been brought under control through correction of physical deficiencies, or in the manner by which infectious diseases have been controlled through personal hygiene, public sanitation, mass immunization, and specific drugs.

The Mental Health Study Act directed us to analyze and evaluate available facts, and through this investigation to stimulate desirable action. Only the briefest compilation of the factors operating at the action level or the supporting level is needed to reveal one obvious fact: Any progress depends on the solution of the same three problems. They are (1) manpower, (2) facilities, and (3) costs.

With this clarification of ends and means, we can now proceed to our recommendations for a program, both at the action and support levels. We can proceed with less optimism, perhaps, but with more appreciation of the complex nature of the problem and no expectation that there are simple answers. The answers themselves are complex and in no way resemble the prefabricated health miracles offered by some propaganda.

PURSUIT OF NEW KNOWLEDGE

Because of the difficulty reasonable men have in reaching conclusions in the field of mental health, one of our consultants, John R. Seeley, has labeled the mental health movement "a continuous conversation." It is. It must continue. The maintenance of one's mental health itself is a continuous process, like breathing; likewise the search for knowledge about mental health must continue, because excellent answers to our questions, let alone final answers, are not yet at hand. On this basis, some of our more scientific associates have deplored "action for action's sake." On the other hand, mental illness being a personal, social, and administrative reality and some good results being possible, we cannot stand still for the sake of being still. Our actions need not be considered rash if we have calculated the value and cost of taking them.

We have demonstrated in the pages of this final report that all

progress in the control of mental illness need not wait scientific explanations of cause and effect; a patient care program can proceed and be accelerated on moral, social, and humanitarian grounds. But meanwhile scientists—the professional skeptics—must continue the conversation and the final triumphs will come only when we can prove what we know subjectively by producing conclusive evidence through objective methods and measurable results that will "stop the talk."

Our present effectiveness is seriously limited by the large gaps in our scientific knowledge about the fundamentals of mental illness and mental health. Our research recommendations will concern themselves with the particular kinds of support we believe are needed to fill the gaps as fast as possible.

It has been frequently said that there is now more money available for mental health research than we can wisely spend; in fact, Presidential opposition to N.I.H. appropriation increases in 1959 was in part based on this contention. The argument, as indicated in Chapter V, appears related to the character of the funds available; while admirably suited to the support of project research, the funds do not meet other vital needs of mental health research.

Whereas the Federal government has recognized the need of training research workers and the need to support individual projects conforming to standards for competence and facilitation as applied by N.I.H. advisory panels, it has not as yet sufficiently recognized certain realities of scientific life in America, though progressive beginning steps have been taken. For example, the scientist, once trained, needs stable, salaried appointments to hold him in research. Congress has begun to accept this reality. His institution needs greater support in the indirect, or overhead, costs of maintaining the setting where research can be carried out. This truth has not been fully accepted. There is a need for greater support of program research and of research institutes. A good start has been made here. There is need for development of research settings and programs in colleges and universities other than the few major centers now carrying out the bulk of research. There is an equally great need for the development of research in service institutions, such as mental hospitals and

clinics, where little or no research is now being done. These items do not cover the full extent of unmet needs, but serve to illustrate here the theme and direction of the recommendations we shall make. In sum, *what we seek is a balanced portfolio in mental health research.* The content of this portfolio can be visualized by outlining and briefly discussing a series of strategies which we recommend be adopted as the basis for a well-rounded national mental health research program.

RECOMMENDATION ONE: *A much larger proportion of total funds for mental health research should be invested in basic research as contrasted with applied research. Only through a large investment in basic research can we hope ultimately to specify the causes and characteristics sufficiently so that we can predict and therefore possibly prevent various forms of mental illness or disordered behavior through specific knowledge of the defects and their remedies. This research must be concerned with the entire range of mental health problems, including the care and treatment of the mentally ill, the causes of various forms of mental illness, the role of various factors in preventing emotional disturbances, and the development of good mental health.*

At present, there is comparatively little support of research in the basic sciences as they apply to man. Specific projects offering some hope for application of a practical sort receive much more support, although they seldom increase our basic knowledge.

The principal handicap in carrying out more fundamental research lies in the unfortunate tendency of many private and public agencies to feel that somehow money is wasted if spent on research of other than a practical or applied sort—that is, on "useless knowledge," to quote a former Secretary of Defense whose corporation was born out of the "useless knowledge" of internal combustion that powered a contraption first called a horseless carriage. This attitude, regarded as anti-intellectualism by some, may be due in part to the failure of money raisers and executives to understand how knowledge grows, expands, and becomes useful.

We can cite as an example the "Presidential Criteria" for review of research and training grant applications made to the National Insti-

tutes of Health. These criteria were laid down by the Administration in November 1959, as a reaction to Congress's fourfold increase in appropriations for N.I.H. activities over a four-year period. The Presidential statement pointed out, correctly, that there is a limit to the rate at which research can grow and grow soundly. It then stated the following fallacy as its first test for approval of a grant: "That the proposed new research project is of such high priority and great promise that its deferment would be likely to delay progress in medical discovery."

Most of the great medical discoveries of our time would not have occurred had they depended for their support on such a judgment. The original investigations of the drugs now known as tranquilizers, taking place in the fields of anesthesia and motion sickness, could not have been regarded at that time as of high priority or great promise—or even connected with the field of mental illness, where they have made their major impact. The novel experiments with cross-circulation of blood in dogs seemed of no great urgency at the time they were proposed, and in fact the report lay for some years unnoticed in a British scientific journal until an American surgeon came across it and, with this starting point, developed open-heart surgery as a practical lifesaving measure. Albert Einstein's original thoughts would have gone begging under the 1959 Criteria, and so would Sigmund Freud's, but one man's theory led to atomic energy and the second man's to a revolution of our understanding of human behavior and its meanings.

The second point in the Presidential Criteria would appear equally ill-advised: "That the new research project would not result in harmful diversion of manpower and other resources needed for teaching and medical care services." The sentence pivots on "harmful," to be sure, but it overlooks a fundamental of medical service: clinical care, clinical teaching, and clinical research move together and, indeed, are logically inseparable. Much of medical teaching—originally a master-and-apprentice relationship—*is* practical care of patients. And, as we pointed out in Chapter V, *research is service to the profession.* Both the practitioner and the teacher depend on it for their knowledge. If the Joint Commission were forced to make a choice between

Federal expenditures for patient care and for medical research, it would recommend the opposite of this second criterion and say, spend the money on research. But we would hope that there will be enough money both for service to patients and for research *as well as* for teaching.

The third and last test imposed by the Presidential Criteria was this: "That the new research grant project would not bring about the substitution of Federal for non-Federal sources of support for medical research and training." The statement ignores what has been happening in the last two decades. The substitution already has occurred, but without the balance for which we now plead. Since World War II, the Federal government has replaced private philanthropy as the leading source of research and other funds in many of our greatest medical schools, schools that lead in the production of teachers, scientists, and knowledge. As Table 6 in Chapter V showed, the Federal government is the source of four-sevenths of all funds available for mental health research; private foundations, two-thirty-fifths. While private foundations and private funds are now giving more dollar support to research than ever before, this support represents a small portion of the total money available.

The philosophy that the Federal government needs to develop and crystallize is that science and education are resources—like natural resources—and that they desire conservation through intelligent use and protection and adequate support—period. They can meet an ends test, but not a means test and not a timetable or appeal for a specified result. Science and education operate not for profit but profit everybody; hence, they must have adequate support from human society, whether this support comes from wise public philanthropy or private.

The actions of a number of enlightened members of Congress and of some State legislatures and Governors, plus the understanding of a few wealthy individuals and foundations willing to subsidize research as a national resource, are responsible for most of the progress that we have made in support of the advancement of knowledge. Continued, intensive collaborative work at all levels is necessary if we are to cope with the expanding needs.

RECOMMENDATION TWO: *Congress and the State legislatures should increasingly favor long-term research in mental health and mental illness as contrasted with short-term projects.*

As emphasized and well illustrated in the Soskin report, public concern with major disease problems, plus the fact that public appeals can be more easily made if they have a dramatic focus, have introduced a "crash" program philosophy that bears little relation either to the realities of the process of scientific discovery or of our research resources. We cannot predict where or how soon significant advances will occur in our attack on mental illness.

Research concentrating on specific projects is expanding rapidly under Federal subsidies. This is a desirable program, but would be more desirable if it encompassed a greater opportunity for work on fundamental problems (basic research) over a long period of time. At the moment, it would appear that people who are capable of doing project research are reasonably well supported. However, as projects gain support, they tend to breed more projects, not only by raising new questions but also by developing more people who can design and carry out such projects. Therefore, the expanding scale may be expected to continue. To appropriate the same amount for one year as for the previous year means a loss of ground rather than a gain in expanding the potentials for advancing knowledge through project research.

Project research means that the investigator sets out the hypothesis or question to be pursued in the research project, outlines the method to be used, and estimates the time, staff, and money required to answer the question positively or negatively in a given period, usually a short one. This type of research is the one most commonly in use in the mental health professions in the United States today. Project research has the advantage of allowing the granting agency to exercise a certain amount of control. The agency commits itself to a specific project directed by a particular individual in a particular institution. If, for personal or other reasons, the individual fails to produce, the agency has "lost" only the amount of money spent in this project. It is not committed to a long-term investment inasmuch as most research grants are annual and renewable for about three years. Excep-

tional ones may run as long as five years, but in each instance renewal is to some extent conditioned on progress reports made during the previous year.

This project type of financing has shortcomings for supporting basic research. Original ideas are often a matter of individual curiosity and not easily formalized at the outset. Some individuals with original ideas are not of established reputation. It would be impossible for them honestly and convincingly to describe a project, and if they did it would be in such vague and general terms that it would take an imaginative agency and institution, indeed, to agree to support it. Thus, project research may be considered one of our most important devices for stimulating and supporting research; but alone it does not cover the potential field and appears more apt to encourage "safe bets" than brilliant and revolutionary discoveries.

Possible methods of achieving greater continuity and originality of effort in mental health research will be elaborated in the discussion of further strategies of a balanced portfolio.

RECOMMENDATION THREE: *Increased emphasis should be placed on, and greater allocations of money be made for, venture, or risk, capital in the support both of persons and of ideas in the mental health research area.*

Granting agencies, both private and public, may be too conservative, too prone to ask a "return on their investment." It is indeed laudable for the legislator to try to obtain for the taxpayer, or the foundation director to obtain for his board of trustees, the best value for each dollar; yet it is quite possible that the progress of knowledge in the field of mental health is impeded by this desire to support only "sound" research. Sound research usually means research done by persons with a stipulated amount of formal training and predictable behavior who have a reasonable chance of producing some type of results that meet professional standards for publication.

Much needed is a small proportion of research funds for what James Miller has described as a "crackpot pot"—that is, funds available to back unorthodox ideas in the hope that perhaps a few of these may produce results in ways not at the moment predictable. Certainly, in view of the primitive state of our knowledge about the

cause and treatment of mental illness, all avenues of inquiry should be explored even at the risk of wasting some money.

We already have made clear in discussing Recommendation Two that, in addition, lack of appreciation of risk gain works against the unknown or untried investigator, although it is sometimes this person who discovers something entirely new and of fundamental importance. The importance of some support for the pursuit of unorthodox ideas may be better appreciated when we realize that advocates of revolutionary scientific concepts nearly always must overcome great opposition on the part of established authorities in the field involved.

RECOMMENDATION FOUR: *The National Institute of Mental Health should make new efforts to invest in, provide for, and hold the young scientist in his career choice.*

It is almost axiomatic in science that it is the young man who has the novel ideas and heeds random impulses that lead to new discoveries. It is equally axiomatic that this young investigator works in a research setting established by a senior scientist, and often in close collaboration with the latter, who may be his teacher or director.

In order to keep the young man freshly trained in research working in research, we propose, as a part of Recommendation Four, *that the Federal government must provide, on a stable base, more salary support for mental health career investigators, that more full-time positions be established for ten-year periods as well as some on the basis of lifetime appointments, and that, in the case of medical schools and universities, these latter positions be awarded on condition that the scientist receive a faculty appointment with tenure.* The "ten-year tenure" men should be permitted to teach and, where their work would require it, attend patients so long as their main interest and the major portion of their time is devoted to research and so long as they do not engage in private practice. It would be permissible, even desirable perhaps, that the man's institution supplement his Federal salary, possibly on a matching basis.

Certainly many budding scientists in the medical field are now devoting themselves to private practice because of the meager pay available to them in research coupled with the economic demands

made upon them by the American way of life. Future satisfaction and future greatness in the research field will not compensate for shabby clothes, poor food, poor housing, or a lack of educational opportunities for one's children.

A society that believes in its own mental health and its future development should be as freely willing to support persons in this area as it is to support persons in the defense or labor fields.

RECOMMENDATION FIVE: *Support of program research in established scientific and educational institutions, as initiated by the National Institutes of Health, should be continued and considerably expanded in the field of mental health.*

Program differs from project research in that while monies are appropriated for a study in a particular area, the granting agencies do not always require the details of its implementation, principally because of confidence in the knowledge and competence of the institution and the persons carrying on the program. This type of research has one principal advantage over project research: It is more flexible and, while it tends to be operated by established research workers, the programs often are so large that newcomers are brought into the system. Graduate students or medical students serving as aides or technicians in early parts of the program may have worked their way into fairly responsible spots on the research staff before the program's completion. This training of new personnel is an additional dividend that comes from program research. The program functions as a recruiting and training device.

RECOMMENDATION SIX: *The Federal government should support the establishment of mental health research centers, or research institutes. These centers or institutes may operate in collaboration with educational institutions and training centers, or may be established independently.*

The chief characteristics of a research center or institute are that (1) research is its primary business, (2) its staff engages in investigation and the training of investigators as its major or exclusive effort, (3) the organization can determine the directions in which it will move within a given field, and (4) the organization has some degree of independence from educational institutions.

A research institute may carry on project research and/or program research, but in addition usually has, or at least ideally should have, a substantial amount of free money for the development of new ideas, permitting a worker to pursue ideas about which he is curious. Most research being done in teaching and educational institutions involves many research workers with either administrative or teaching duties. Except for fund raising, the staff in an institute research often has no other commitment of time. It is yet to be proved whether such arrangements are more or less productive; we suspect that if a study were made, it would show this type of surrounding is best for some types of persons but not as good for others who require the stimulus of students and the change of pace provided by pedagogical or public service activities.

On the other hand, the training of young scientists is a logical function of a mental health research institute; one reason is that it offers continuity of effort, or a permanent base for long-term and deeply searching investigations. It is not necessary that the research person have specific assignments as a teacher within the school; rather, he may serve as an image and inspiration for the young person in training. As such a model, he may entice more individuals into the field, and he can offer advice, consultation, and encouragement for the youngster who wishes to devote his life to basic research.

Certain research institutes might well have research training built into them as part of their fundamental role with research productivity being equated somewhat with the patient care part of teaching hospitals—that is, no research training institute would be worthy of the name unless the research done there was of high caliber and its workers productive. On the other hand, a research institute set up with a training objective would, like the university, have a responsibility for turning out a reasonable volume of highly skilled research workers.

As our techniques develop and our search for knowledge delves into the mysteries of human behavior and mental sickness, we can predict that the cost of research will increase both in the expense for equipment and material and in the amount of manpower required. There is also a requirement for more administrative skills to be

brought into the research areas as these projects and the number of persons operating them grow larger. As a small example, the research workers and projects in many areas are not covered by any type of insurance or retirement policy because they are hired for the duration of a short-term project. Most of the people skilled in research work have no facilities or skills in personnel and management matters. Administrative skills should be incorporated into a research organization and probably could be if the matter of communication and comprehension of objectives were better worked out between the research and administrative staffs than is commonly the case.

A committee chaired by Boisfeuillet Jones has recommended the establishment of certain research institutes and has suggested sums that seem adequate and fair for today. No specific sums will be mentioned here, in our research recommendations, as it is felt that the needs, advances, and areas of interest will alter the sums required from year to year, but one may fairly anticipate that the sums in general will tend to increase. The document we refer to is *Federal Support of Medical Research* (Report of the Committee of Consultants on Medical Research to the Subcommittee on Department of Labor and Health, Education, and Welfare of the Committee on Appropriations, United States Senate, May 1960). We endorse and support the entire program envisaged by the Jones Report.

RECOMMENDATION SEVEN: *Some reasonable portion of total mental health research support should be designated as capital investment in building up facilities for research in States or regions where scientific institutions are lacking or less well developed.*

Such support should not be given in competition with or at the expense of the major research centers, now the main sources of new knowledge in both basic and applied research. On the other hand, legislation is needed to achieve a better geographical and institutional distribution of our research resources through the promotion of interest, competence, and effort in underdeveloped areas—for example, the South, to name one region, and State mental hospitals and local mental health clinics, to name two types of institutions. As discussed in Chapter V, serious consideration needs to be given the possibility of using the scientists who make up the advisory panels of the Na-

tional Institutes of Health more as regional consultants in the development of new research programs and centers than as a mechanism for screening and evaluating research grant applications. Such a proposal would have to be weighed, however, against the consequences of disturbing what has proved to be a valuable instrument for apportionment of Federal research grant monies on an objective, fair, and equitable basis.

The Jones Committee recommended establishment of regional clinical research institutes. We would concur in this recommendation as applied to mental health, as we have indicated in Recommendations Six and Seven. We would further suggest that it might be helpful to the total research enterprise to view institute development in two categories: 1. *Major centers* associated with great universities, themselves in great need of further financial resources. 2. *Minor centers,* where new development of both educational and research facilities are required before a return in terms of new scientific knowledge may be expected.

RECOMMENDATION EIGHT: *Diversification should be recognized as the guiding principle in the distribution of Federal research project, program, or institute grants from the standpoint of categories of interest, subject matter of research, and the branches of science involved.*

Such a principle is of particular importance in the field of mental health research, where, as we saw in Chapter V, investigations proceed in many directions, on many topics, and under the banners of many scientific disciplines. We are tempted, for example, to respond to current enthusiasms or needs and advise the Federal government to place its biggest bets on biochemical studies and child studies, but we are not at all sure that this is a wise course. (Biochemistry at present happens to be an exciting and popular field of mental health research. The growth and development of children and their relationships to mental health or mental illness happens to be a somewhat neglected area.) Rather, we would recommend a balanced effort insofar as topics of interest and scientific methods are concerned. To achieve balance would require investments of large sums of money in basic research in the fields of psychology, sociology, and anthro-

pology as well as in some branches of biology per se, such as chemical genetics. Whatever the content or the direction, the diversification of interest and support should be linked with the recognition that, for the greatest possible progress, a mental health research program, project, or institute must be so operated that the competent scientist can spend long periods of time in pursuit of the elements of a phenomenon which interest him, with a relative degree of independence and security. (See Appendix V, Footnote 6-3 for further mental health survey recommendations.)

In general, what we propose is an extension and expansion, combined with certain shifts of emphasis, in the research grant program ably administered by the National Institute of Mental Health through the wisdom of Congress. While substantially supported in the 1960 summer session of Congress, the recommendations of the Jones Report unfortunately were not fully carried out, particularly as they applied to more realistic support of the indirect costs of medical research to the institutions which make the research available. We would memorialize Congress on the urgent need of reviewing this now notoriously sore point. Too many business-minded governing boards of deficit-ridden universities and teaching hospitals now conceive of research as being operated at a direct loss to the institution and therefore are reluctant to approve of further expansion of research efforts.

BETTER USE OF PRESENT KNOWLEDGE AND EXPERIENCE

To overcome the attitude of the public and its institutions that mental hospital patients are beyond help, we must publicly demonstrate that the mentally ill can be helped through wider application of present knowledge regarding the benefits of humane and healing care. This is our conviction. In this section, therefore, we shall emphasize various dimensions of service to troubled persons and to mental patients. We must not repeat the mistake, made in the 1909 founding of the National Committee for Mental Hygiene, of diverting attention to the more appealing and stimulating but as yet visionary pros-

pect of true, or primary, prevention of mental illness—that is, the building of "healthy minds in healthy bodies." More precisely, we construe primary prevention of mental illness to mean the elimination of causes, either by eliminating exposure to them or by building resistance.

The primary prevention of mental illness presents a twofold problem. First, no program of prevention through public education or other means should be undertaken without a thorough assessment of the available scientific knowledge and a grounding of the program in such knowledge. The importance of such a grounding has often been overlooked in the past. Second, advances in prevention of mental illness, as in its cure, depend on the development of the extensive research program proposed above.

On the other hand, there is general agreement, as the National Assembly on Mental Health Education brought out in its published findings (1960, p. 4), that "some mental illnesses are controllable with early and effective treatment; that there is or should be no disgrace about being or having been mentally ill; that a recovered patient might be ready to take his full share in the work and life of the community; that sometimes treatment of mental illness is difficult and recovery slow."

Here, of course, we reveal the bias of this report—and give a little discomfort to some of our colleagues who have a strong commitment toward practices and programs aimed at the promotion of positive mental health in children and adults. Indeed, a few members of the Joint Commission have found themselves in the position of affirming this final report as it relates to the treatment of the mentally ill and to research, but of rejecting the view that achievement of maximum effort in behalf of the mentally ill would require the minimizing of emphasis on the mental health of persons who are not ill or in immediate danger of becoming so. We have assumed that the mental hygiene movement has diverted attention from the core problem of major mental illness. It is our purpose to redirect attention to the possibilities of improving the mental health of the mentally ill. It is not our purpose, however, to dismiss the many measures of public information, mental health education, and child and adult guidance

that may enhance an understanding of one's own and others' behavior and so build self-confidence, reduce anxiety, and result in better social adjustment and greater personal satisfaction. But our main concern here, in recommendations for a program attacking mental illness, is with various levels of service beginning with secondary prevention—early treatment of beginning disturbances to ward off more serious illness, if possible—and continuing through intensive and protracted treatment of the acutely and chronically ill.

As pointed out, it is easier to specify ends than means in our attempt to make better use of our knowledge and experience to help the mentally ill. The great stumbling blocks are manpower and money; they are intimately associated. But, of the two, need for manpower is probably the greater obstacle because it is not reasonable to ask for or insist on vastly increased sums of money for the public care of the mentally ill if we cannot indicate the sources of manpower for the mental health services we should like the nation to undertake. As matters stand, *American psychiatry has found itself in the awkward position of revealing the unmet need of the mentally ill for its services while, almost in the same breath, stating it lacks the manpower to render these services. It would seem that this economy of scarcity, so different from the mass production ways of our culture and, indeed, of medical science itself, may be responsible for an undercurrent of futility and confusion that characterizes the mental health movement, an operational expression of frustration coinciding with the more fundamental phenomenon of society's rejection of the mentally ill and a basic need for more knowledge of causes and cures.* The only alternative has been to lean on mental health education, which is to say a psychiatrically sponsored increased human understanding of emotional tensions and their relief. As indicated in this final report we have leaned on a weak reed.

Any proposal we make will require a multiplication of mental health workers. Therefore, our first recommendations must deal with sources of manpower and, more importantly, with a policy of manpower utilization that may serve as a point of departure from past futility and frustration.

Certain policy decisions need to be made by mental health leaders,

both professional and lay, before they can achieve maximum utilization of manpower resources in help for the mentally ill, much less stimulate a greater influx of young people into the mental health field. We need no survey to note that some persons successful in other fields have been challenged by the mental health problem and then, after brief or extensive exposure, have succumbed to the rejection phenomenon and turned away. Another facet of the same problem, it would appear, is the rapid turnover in mental health personnel, including turnover at the top as well as at the bottom. The "lost leadership" difficulty of the National Association for Mental Health is a case in point. During the life of the Joint Commission, the N.A.M.H. has had four executive heads. Such managerial instability is scarcely a basis for effective action.

Manpower, Its Training and Utilization

It is impossible to make an intelligent analysis of mental health manpower in 1960, and from this analysis make recommendations, without taking into account modern trends in professional care of the mentally ill. One trend, in close harmony with the understanding of medicine that disease denotes a defect or loss in structure or function of an organ, has featured various efforts to arrest the sick-mind process through physical shock, surgery, or drugs. A second and ascendant trend, inspired by medical psychology and psychoanalysis, has been the refinement and intensification of individual psychological treatment on a one-to-one, therapist-patient basis. A third, more recent trend combining sociology and psychology with psychiatry has been the systemization of "moral treatment," or social treatment, based on interactions of groups living, working, and playing in a "therapeutic milieu," or beneficial environment. The second (psychotherapeutic) trend gains great strength from the mutual satisfaction practitioner and patient derive from the doctor-patient relationship, but both the first (somatic) and the third (social) trends have the advantage of better adaptation to mass application.

These trends have run parallel to certain directions and aspirations in professional organizations. One such direction is the longtime and recently more successful effort to integrate psychiatry into the med-

ical profession as a whole, thus ending the isolation of the psychiatrist and the institution in which he works from the mainstream of medical science and clinical medicine. While some psychoanalysts remain backward in this integration, possibly due to criticism of their theories and the different character of their practice, which concentrates on a small, select number of patients, their own standards of professional competence are similar in philosophy to, and as high as, those for other medical and surgical specialties. These standards have the primary purpose of excluding the untrained and inept, but have the secondary effect of holding down the total number of practitioners available to patients.

Meanwhile the growing interest in medicine and in mental health displayed by behavioral and social scientists—psychologists, sociologists, and anthropologists—leads in another direction, about which organized medicine and organized psychiatry have strong feelings of opposition inasmuch as questions of medical practice by nonmedical persons and, of course, the laws of medical licensure become involved. In the hospital and clinic setting, and recently in private practice, such professionals—mainly clinical psychologists and social workers —treat patients by psychotherapy, sometimes including the deep probing and long-continued process of psychoanalysis. As dictated by the social treatment concept, such persons, plus nurses and occupational therapists or other gifted nonmedical persons with no basic medical education or formal clinical training, also work with mental hospital patients on wards or in groups, often with a competency recognized to be equal or, in some instances, superior to that of the psychiatrist, who lacks the time to live with his patients.

Questions of official pronouncement or legal responsibility aside, many psychiatrists have no objection to members of these other mental health professions working with patients in institutional, group, or even certain individual relationships, if the psychiatrist maintains nominal control, which is to say the nonmedical worker remains subordinate and the physician's final authority is recognized. The situation is much the same throughout medicine. Physicians permit laymen—i.e., other professional, subprofessional, or paramedical personnel—to treat patients as long as the service is under a physi-

cian's direction and according to his prescription. But most psychiatrists, as would most other physicians, frown on permitting "laymen" to use techniques requiring a high degree of clinical experience and judgment.

The rub comes in a mixture of facts—that persons associated with doctors may envy them and try to "play doctor"; that physicians undergo long education and training to attain their status and are understandably jealous of their license to practice medicine; that some psychologists consider themselves as skilled as psychoanalysts in the administration of psychotherapy (and furthermore can quote a physician named Sigmund Freud in approval of "lay analysts"); and that, most of all, the domain of troubled human behavior lacks bench marks and boundary lines (anybody may think he is an expert). Since the broadest meaning of psychotherapy is simply that of forming a doctor-patient, or counselor-client, relationship with an emotionally troubled person and, through verbal or nonverbal communication, seeking to ascertain his problem, work it through and resolve it, a narrow enforcement of a psychiatric conviction that "nobody should do psychotherapy except psychiatrists" would effectively deny its benefits to patients now receiving it from nonmedical therapists with or without the supervision of psychiatrists. Such enforcement would also raise questions regarding the psychotherapeutic nature of other interactions of patient and therapist carried out in the name of "group therapy," "drama therapy," and so on.

Conversely, however, to deny the patient access to a doctor trained in medicine opens up the possibility that a physiological, as opposed to a psychological or social, basis for his illness may be overlooked—unless the psychotherapist has ready access to and uses medical consultation.

We believe that for adequate treatment of the mentally ill, and in the absence of more specific knowledge of causes and cures, proper attention to certain facts and principles will clarify the therapeutic dilemma and permit mental health workers of all kinds to work together with a minimum of impediment to progress. At the outset of this report and throughout it, we have stressed that we could only succeed in our purpose through full recognition that the primary

object is to bring to the mentally ill help that hitherto has been denied them. We also took the position that such an object was far more important than the preservation of any tradition, institution, procedure, alignment of professional responsibility, or set of theoretical assumptions. Such a position is not only sound from the standpoint of patient care but in answering the question of what persons will provide this care. Intelligent recruitment and training of mental health manpower would dictate that the recruit and trainee have a clear idea of what their job is and what they are being trained to do.

One fact that we must accept is that many different kinds of efforts, acts, processes, and approaches have been shown to be beneficial to mental patients. Some of these are definitely medical. Some are definitely professional in character. Some are well founded in theory and are scientific. Some derive their support from experience with "what works" and therefore appear to be of practical benefit. But many of the pieces that make up the mosaic of mental patient care simply are human or social in their benefits, and not peculiarly medical or professional.

The first principle of medical therapeutics is to do nothing that will *harm* a patient (a principle that, as we have seen, rapidly got lost in the rise of State hospitals despite the presence of *medical* superintendents). High professional standards must be rigorously enforced insofar as they pursue this "harm-not" objective and the further object of *healing*. In the name of helping patients, on the other hand, we must guard against employing high professional standards simply to maintain a guild or monopoly. This point is particularly compelling in view of the imprecise state of our knowledge of functional mental illness, its diagnosis and treatment, and the fact that the typical mental patient is different in certain fundamental aspects from those seeking help from the physical branches of medicine—that is, he may not cooperate in efforts to get him well and must be approached through whatever avenue suggests itself as a healing device.

The therapeutic truth as it applies to psychotics and other forms of major mental illness appears to boil down, then, to what the public action slogan suggests. Mental illness is "everybody's business." This

is the potentiality we must exploit as a means of resolving the manpower problem. It has been commonly observed that certain therapists, both medical and lay, have an *x* factor, as some have called it, a "healing touch" or a "winning way," that enables them to achieve a therapeutic relationship and good results with certain patients where others may fail. We do not know the precise extent to which this is true, what the touch or way is, or what the variations are from one type of patient and therapist to another. Indeed, research is needed here in the hope that positive findings might be quickly applied in an aptitude test or tests for psychological capacity to heal. But most of us in the mental health professions would agree that there is "something to this," and also might concede that the *something* is not necessarily measured by doctoral degrees, board certificates, or licenses to practice.

The principle that must guide us in questions of authority, professional prerogatives, and qualifications involved in treatment of the mentally ill now readily emerges. The only principle that can satisfy all interested parties, including the public, is one of *individual competence* to undertake a given approach to a patient. The matter of competence applies equally to the psychiatrist, the psychologist who also possesses a doctoral degree, the social worker and occupational therapist who are college graduates, the nurse who may or may not have a college degree, and to the ward attendant who may not have finished high school.

We can guard against the individual exceeding his competence (1) by insistence that he understand and respect the limits of his learning and experience, and (2) by provision of a system for consultation with those more expert than he in the problem at hand.

We may now offer our No. 1 recommendation for better use of present knowledge and experience; it concerns policy:

Recommendation: In the absence of more specific and definitive scientific evidence of the causes of mental illness, psychiatry and the allied mental health professions should adopt and practice a broad, liberal philosophy of what constitutes and who can do treatment within the framework of their hospitals and other professional service agencies, particularly in relation to persons with psychoses or

severe personality or character disorders that incapacitate them for work, family life, and everyday activity. And, all mental health professions should recognize:

A. *That certain kinds of medical, psychiatric, and neurological examinations and treatments must be carried out by or under the immediate direction of psychiatrists, neurologists, or other physicians specially trained for these procedures.*

B. *That psychoanalysis and allied forms of deeply searching and probing "depth psychotherapy" must be practiced only by those with special training, experience, and competence in handling these techniques without harm to the patient—namely, by physicians trained in psychoanalysis or intensive psychotherapy plus those psychologists or other professional persons who lack a medical education but have an aptitude for, training in, and demonstrable competence in such techniques of psychotherapy.*

C. *That nonmedical mental health workers with aptitude, sound training, practical experience, and demonstrable competence should be permitted to do general, short-term psychotherapy—namely, treating persons by objective, permissive, nondirective techniques of listening to their troubles and helping them resolve these troubles in an individually insightful and socially useful way. Such therapy, combining some elements of psychiatric treatment, client counseling, "someone to tell one's troubles to," and love for one's fellow man, obviously can be carried out in a variety of settings by institutions, groups, and individuals, but in all cases should be undertaken under the auspices of recognized mental health agencies.*

Far from losing any high ground of professionalism, the psychiatrist members of the Joint Commission see that there is much to be gained in professional effectiveness and satisfaction by such a broad, liberal application of "treatment" or "help" as conceived within the present state of our knowledge. We can obtain some useful instruction in formulating a new attitude from other branches of medicine, where, with the elaboration of technology, the doctor has divided his labors and delegated the delivery of his knowledge and skills to a host of intermediaries. Each delegation of an act formerly construed as "the practice of medicine" has given rise to jealous concern for loss

of authority and lay interference, fears that habitually have proved groundless. Today, it is frequently the technician who takes the blood sample and tests it, the nurse who gives the intravenous injection and other medication, the social worker who investigates the family's history and financial circumstances, and the medical secretary who records the medical history and issues and collects the bills. All these were considered at one time or another to be duties of the doctor himself and, in many situations, still are.

One aspect of the manpower problem that seems to have received little systematic attention is better utilization of psychiatrists to achieve the greatest good for the greatest number. Our findings have shown that we need many more psychiatrists, particularly those interested in hospital and clinic psychiatry and team and group approaches, just as we need many more persons in each position on the mental health team—psychologists, social workers, nurses, occupational and recreational therapists, attendants, or others. One approach to better utilization of psychiatrists would be to cast the psychiatrist in the role of consultant and "therapeutic overseer" for the efforts of nonmedical therapists working in close cooperation with him. Another approach would be to develop ways of tapping the largest pool of psychiatrists—those in private practice.

Actually, while we emphasized the shortage of psychiatrists in public service and their poor geographical distribution in Chapter IV, we find some cause for cheer when we view the growth of psychiatry, as measured by membership in the American Psychiatric Association. In 1946, there were 4000 members; in the next 14 years, this number tripled, approaching 12,000. It is evident that psychiatrists have increased more rapidly than the population and the medical profession as a whole. This indicates an increase of interest in psychiatry among physicians seeking specialty training. The ratio of psychiatrists to population has risen from 1 in every 18,000 to 1 in 15,000 in the four years since the Joint Commission began its study.

The opportunity for a substantial income and a comfortable way of life in private practice are among psychiatry's attractions. The fact that the young doctor can finance his resident training in psychiatry through a Federal training grant, in contrast with most other spe-

cialties, is also an inducement. The Joint Commission is concerned, however, that so many psychiatrists are trained at public expense and then go into private practice. Greater efforts must be made to persuade these men that they have a moral obligation to pay back time equivalent to the period of their training, by taking positions in either part-time or full-time public service. We recommend that the N.I.M.H. face this problem. We do not, of course, regard the publicly trained private psychiatrist as a total loss from the standpoint of public good; many render part-time public services; some have gone into small communities previously without the services of a psychiatrist, where the community general hospitals have created psychiatric units. The fact remains, nonetheless, that the majority of psychiatrists prefer a full-time private practice in big cities.

With sufficient public support, it would appear possible to accelerate the growing interest of the medical profession in psychiatry and, at the same time, through increased public salaries, divert some of the flow of psychiatrists from private to public practice. Government services probably never will be able to match psychiatric earnings in private practice, but they can afford clear-cut opportunities for service to the community in which the psychiatrist can take civic pride, and also offer opportunities to participate in professional and public educational programs and in clinical research. In sum, this calls for studied efforts to make public mental hospitals and clinics professionally desirable places to work. The recommendations in a subsequent section, The Cost, are essentially addressed to this transformation.

We do not pretend that such an approach will fully meet the need. If the present rate of increase continues, the United States population will rise from 180 million to 200 million in the next ten years. We know that of the additional 20 million, 200,000 will need treatment for major mental illness; the total load in this category will be 2 million—1 per 100 population.

There is every indication that the demand for treatment will increase as facilities become more widely and readily available; therefore, we may anticipate that the ranks of the untreated mentally ill *who seek treatment* will grow even faster than the demand indicated

on the basis of population alone. Without pausing here to examine the pertinent questions of what type of psychiatric services are offered or how the psychiatrist utilizes his time, we can conclude that the United States could quickly absorb the services in the next ten years of two to three times as many psychiatrists as it now has—that is, 24,000 to 36,000. If the rate of growth of the last decade continues through the next, however, we will have no more than 18,000 to 20,000. The American public has no choice, if it wants to improve care of the untreated mentally ill, but to seek and insist upon alternatives to its long-cherished belief that a competent doctor of medicine should personally attend every sick person. This is an ideal impossible of realization in psychiatry. Until now, we have not fully faced this reality.

The only possibility of greatly increasing psychiatrists and meanwhile reducing the equally impressive shortages of workers in the other mental health professions is more effectively to tap the professional manpower pool at its source—high school students who may be induced to seek training as psychiatrists, psychologists, social workers, psychiatric nurses, occupational therapists, or psychiatric aides.

Recommendation: The mental health professions need to launch a national manpower recruitment and training program, expanding on and extending present efforts and seeking to stimulate the interest of American youth in mental health work as a career. This program should include all categories of mental health personnel. The program should emphasize not only professional training but also short courses, and on-the-job training in the subprofessions and upgrading for partially trained persons.

We will not lay down the total specifications for such a program here, but we can suggest certain guide lines. The overriding need would be for a good deal more enthusiasm, energy, and organization of effort than the mental health professions have exhibited heretofore. Finding leverage points, exposing youth to mental health workers, and creating favorable images are factors of crucial importance.

For instance:

Volunteer psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, occupational therapists, and others—selected on

the basis that they can talk to laymen without talking over them or down to them—should be encouraged to speak about mental health and mental health careers in the schools of their own communities. Where feasible, they might provide regular, one-hour-a-week instruction in human relations, human behavior, human emotions, or human understanding as volunteer teachers. Such an endeavor should, of course, be separate from occasional talks falling under the head of vocational guidance; instruction should take into full account the difficulties of making information on human behavior fully understood.

For instance:

We must give careful thought to methods of improving the public impression of the mental health scientist—be he psychiatrist, psychologist, sociologist, anthropologist, pharmacologist, or biochemist—to one more favorable to services in behalf of the mentally ill.

Recommendation: Steps should be taken to create the President's Prizes in the Humane Sciences, large awards to be made each year by the President of the United States to a young scientist and to a science teacher or professor for outstanding scientific and educational contributions in the life sciences, social sciences, or physical sciences of importance to mental health.

Such a pair of prizes would offer a means of obtaining a dramatic focus on mental health careers and of implementing a program of public information. Success would depend on a year-round system of capturing and holding public interest (see Appendix V, Footnote 6-1).

Another approach can be made by combining a service to mental patients with recruitment and public education:

Recommendation: The volunteer work with mental hospital patients done by college students and many others should be encouraged and extended.

These volunteers working closely with mental patients constitute a new resource, different in many respects from traditional volunteer services of less intensive or more peripheral nature. The college student volunteer program (described in the Introduction to Chapter IV) deserves close attention by all in the mental field as a new and

worthwhile contribution to reduction of the manpower problem in the helping professions. The implications of student volunteer service are great. If, for instance, the National Association for Mental Health and State mental health agencies were to foster this movement through the country at points where colleges and mental hospitals are in close proximity (for example, the nation's oldest State hospital and second oldest college are neighbors of long standing in Williamsburg, Virginia), college students could not only have a striking effect on the therapeutic environment of large, understaffed hospitals and themselves develop greater insight and more tolerant attitudes toward the mentally ill but, as has been shown, some would make mental health their career choice.

Inasmuch as all professions draw on the same manpower pool and all therefore have a stake in improving the nation's public system of elementary, secondary, and higher education, we also would make the general recommendation that *leaders of the mental health professions should actively and aggressively participate in support of constructive legislation in the field of education, general as well as medical and scientific education.*

The Joint Commission generally endorses the Federal program of providing student scholarships and loans, and would recommend that this program be extended. We would go further and point out that, as a nation, we cannot reasonably maintain that the various private and public efforts to enhance the college and professional education of our children are constructed on a sound foundation until the Federal government has done all it can to encourage parents insofar as possible to accept the responsibility of educating their own children.

The attitude of the Federal government toward advancement of higher learning must be construed as somewhat negative in spirit until *parents are permitted to treat the direct costs of sending their children to college and graduate schools as a tax-deductible contribution,* in the same way as would be the case if they gave the money to a nonprofit educational institution for the purpose of creating a scholarship fund. We would strongly disagree with opinions that such a proposal constitutes "rich man's relief." A 1958 study by the Bureau of the Census showed that one-tenth of all family

heads were college graduates and their average income was $7600. It is well known that college graduate parents tend to beget college graduate children; thus they should be considered one source of professional manpower and receive consideration accordingly. The task of putting an average of three children through college at a cost of $6000 to $8000 a child, or more, out of an income of $7600 a year, or even twice that, is not an easy one; the need for public action regarding the financial hardship teachers and professors suffer in sending their children to college has been neglected, even by educators themselves.

Recommendation: The Federal government not only should support a student scholarship and loan program but also should foster financial responsibility for education of one's own children wherever possible. The time has come for the Federal government to adopt, and affirm through income tax law amendments permitting deductions from taxable income of direct expenses for higher education, the policy that education is an essential resource of modern life, the same as industrial investment capital, farm products, natural resources, housing, and, of course, medical care. In all these categories, income tax allowances are made, but the demonstrable fact that higher education is a resource and that investment in it increases the future taxable income of the nation's children has been ignored.

The problems of medical education, the need for expansion of present medical schools, and the need for new medical schools have been impressively set forth in two studies by Federally appointed groups conducted independently of the Mental Health Study. These are the Final Report of the Secretary's Consultants on Medical Research and Education (U.S. Department of Health, Education, and Welfare, 1958 [Bayne-Jones report]), and the Report of the Surgeon General's Consultant Group on Medical Education (U.S. Department of Health, Education, and Welfare, 1959 [Bane report]).

The Joint Commission generally endorses these reports and favors the recommendations summarized in Chapter VI of the Bane report.

We can now proceed to an outline of recommendations for expansion of services to the mentally ill.

Our overriding concern here is with new and improved ways

of helping various classes of persons with emotional disturbances, acutely disruptive behavior, acute mental illness, chronic mental illness, and various problems of aftercare and rehabilitation. In approaching the problem of help for each of these classes, we must answer the same three questions: (1) What kinds of persons could help them? (2) What training, supervision, and consultation do these helping persons need? (3) Where can the treatment or care take place? It may be useful to visualize each type of service as a line of defense. Here is the first line:

Services to Mentally Troubled People

Recommendation: Persons who are emotionally disturbed—that is to say, under psychological stress that they cannot tolerate—should have skilled attention and helpful counseling available to them in their community if the development of more serious mental breakdowns is to be prevented. This is known as secondary prevention, and is concerned with the detection of beginning signs and symptoms of mental illness and their relief; in other words, the earliest possible treatment. In the absence of fully trained psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses, such counseling should be done by persons with some psychological orientation and mental health training and access to expert consultation as needed.

Obviously, if persons under disturbing stresses are to be persuaded to seek such a service, the public mental health information program must make some impact on them, and the service must be available to them. As was shown in our nationwide survey, *Americans View Their Mental Health,* many people presently are not able to define their psychological problems in psychological terms. Often, they are conscious only of the physical symptoms or other external aspects of the stressful situation. Many such persons do confide in their spouse, a friend, their family physician, or their clergyman, however. Further education of clergymen and the family physicians, only a small proportion of whom are now interested in dealing with mental health problems, would help persons define their emotional stresses as such, and often enable the minister or doctor to resolve the trouble

in a psychiatrically sound manner or tactfully refer the troubled person to the mental health specialist.

Mental health counselors. A host of persons untrained or partially trained in mental health principles and practices—clergymen, family physicians, teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, county farm agents, and others—are already trying to help and to treat the mentally ill in the absence of professional resources. This was made clear in *Community Resources in Mental Health.* With a moderate amount of training through short courses and consultation on the job, such persons can be fully equipped with an additional skill as mental health counselors; some might go on to become members of the mental health professional team. The first qualification would appear to be essentially the same as that of any mental health worker: an awakened interest in the problem of mental illness and its solution. As a model, we might take the county farm agent who, as Dr. Robinson has pointed out, already is making a considerable contribution in the mental health field as a part of his agricultural extension responsibilities. It is too much to expect every county farm agent to become a mental health counselor in addition—or is it? This is the direction in which the mental health professions must go—inviting and welcoming help wherever they can find it.

In addition to educational programs designed for the postgraduate training of mental health counselors, teaching aid must be provided to teachers colleges, schools of theology, schools of social work, and others so that they may have part-time or full-time faculty members who will integrate mental health information into the training programs of these professions. For this teaching role, we have in mind the public health physician with training in mental health, the clinical psychologist, the psychiatric social worker, or a sociologist with some basic training in mental health.

Mental health consultants. Persons who have obtained training in the mental health field, such as psychologists, social workers, nurses, family physicians, pediatricians, psychiatrists with particular interest in community services, mental health communications, and case-finding—should be available for systematic consultation with mental

health counselors. The mental health consultant should logically be a staff person in a public health or public mental health agency, but could also be a staff member of a voluntary agency, such as a local mental health association, general hospital psychiatric unit, and, in some instances, on the staff of any public or voluntary social service agency. The basic function of this consultant would be threefold: (1) to provide counselors with mental health training at the helping profession level—briefly, on-the-job training—(2) to provide general professional supervision of subprofessional activities, and (3) to provide the moral support and reassurance that has been found essential for most persons working with the emotionally disturbed or mentally ill, whether medically trained or not—a support most important for persons in training. The point here cannot be overemphasized. As we stressed in Chapter III, the disturbed behavior of the mentally troubled person can disturb and trouble the therapist, too. The sympathetic but uninvolved, concerned but objective approach is ordinarily acquired only through long experience.

Few counties in the United States, the Robinson study found, have welfare or health agencies adequately staffed to support and guide emotionally disturbed persons. The study suggests that the workers in this network of agencies could be trained if funds were available. This subsidy of training for persons already working in the field could make a substantial contribution to the more intelligent management of distressed people, and we believe would help reduce the number of mentally ill and delinquent persons.

In working with mental health counseling agencies, psychiatrists are more apt to be satisfied with the consultant role than with taking primary responsibility for operating the agency and making its decisions. It is essential that the personnel of such an agency accept the responsibility for making decisions in their area of professional competence, at the same time recognizing the need of consultation in managing problems of stress in their clients. Psychologists, social workers, properly trained school nurses, and teachers trained as counselors can carry a large part of such a consultation program within the school system and within the general health agencies of the community. Lay organizations with public relations or health education

staff members can, with proper professional consultation and guidance, carry on many of the information activities and in this way help conserve the time of the small number of highly trained professionals.

Pediatricians. The nation's more than 6000 pediatricians offer a considerable potential for helping emotionally disturbed children, but in many cases lack sufficient psychiatric orientation to capitalize on this potential. The National Institute of Mental Health should provide support for resident training programs in pediatrics that make well-designed efforts to incorporate adequate psychiatric information as a part of the pediatrician's graduate training. It also should provide stipends for pediatricians who wish to take postgraduate courses in psychiatry. In neither case is the proposal aimed at converting pediatricians into child psychiatrists, but rather at increasing the mental patient care resources of the community in which the child specialist practices.

Resident schools. We should recommend *pilot studies in the development of centers for the re-education of emotionally disturbed children, using different types of personnel than are customary.* In view of the shortage of manpower in the fields of social work, psychiatry, psychology, and nursing, it is desirable to find alternative patterns of care for large groups of emotionally disturbed children both of normal and retarded intelligence. It is suggested that a system of schools and training programs for re-education of emotionally disturbed children be established on a research basis.

The schools would be operated by carefully selected teachers working with consultants from the mental health disciplines. They would not take the place of psychiatric facilities for seriously disturbed children, nor of special classes in the public schools, but would relieve pressure on hospitals, mental health centers, and public schools by providing care for children not sick enough to be hospitalized but too disturbed to be taken care of on an outpatient basis or to attend classes in the ordinary public school. These centers for re-education might complement the present networks of facilities and offset the manpower shortage; help create a pattern for the effective use of the limited available time of highly trained psychiatrists, social workers,

educators, and psychologists; provide a type of buffer between hospitalization of children, and a facility for speeding their recovery after hospitalization; and perhaps, most importantly, provide a learning experience for disturbed children in a setting with less discontinuity from normal patterns of living. A center would consist of a residential school staffed with 15 specially trained teachers for each 40 children. Five of the teachers would work with the children during the regular school day, with 5 to 8 of them living with the children and serving as substitute parents.

This proposal deserves careful consideration and support, as it might well answer important questions as to the feasibility of treating emotionally disturbed and some mentally ill persons with subprofessional mental health workers, using the professionally trained as consultants rather than the firsthand therapists or educators. This program would be a further development of the French *educateur* system studied for the Joint Commission by Dr. Nicholas Hobbs, and mentioned in the manpower section of Chapter IV. The present proposal contains important additions making it possible to test its applicability to the particular socioeconomic organizations of the United States.

Immediate Care of Acutely Disturbed Mental Patients

Recommendation: Immediate professional attention should be provided in the community for persons at the onset of acutely disturbed, socially disruptive, and sometimes personally catastrophic behavior—that is, for persons suffering a major breakdown. The few pilot programs for immediate, or emergency, psychiatric care presently in existence should be expanded and extended as rapidly as personnel become available.

Persons who become acutely ill require some quick type of care to start them toward recovery and to minimize the disorganization in their families and communities. Experience has demonstrated that a visit to the patient's family by a social worker or by a psychiatrist, if one is available, can often quiet an erupting family situation that, untreated, would result in hospitalization.

Hospitals and clinics that have incorporated an emergency service

into their patient care facilities have found it necessary to augment their staffs. It is particularly advisable to have public health nurses or social workers, or both, backed by psychiatrists where needed to take care of cases of this sort.

It is mandatory that an emergency service be available immediately without putting the patient on a waiting list or through any long, formalized admission procedure if the patient is handled through a community general hospital's emergency room. To be effective, such services must be available irrespective of whether the person can pay, or whether he is a resident of a particular community, and without other restrictions. This means that regulations governing admissions must be liberalized. Some method must be developed to subsidize the patient's care either through a voluntary prepayment plan or a public insurance program similar to Social Security.

The principal complication in the inauguration of such services is the shortage of psychiatrists, social workers, and public health nurses trained for this kind of service.

It also will be necessary to increase the number of psychiatric units in general hospitals, and to indoctrinate general hospital administrators and professional staffs in the need and the feasibility of giving psychiatric care in their hospitals. In order for the patient to be able to go to general hospitals, psychiatrists, attorneys, and many judges must revolutionize their present thinking that hospitalization for the mentally ill requires commitment or coercion. It is obvious that for such a service to operate the mental patient whose condition permits must be able to come and go as freely as any other patient.

We believe that the establishment of emergency and acute treatment services will decrease the number of admissions to hospitals for long-term psychiatric care. We cannot state at this time whether this is actually so; other studies are under way that may answer this question.

As may be seen from the discussion, an immediate care program can be based in a general hospital, a mental health clinic, a mental hospital, or perhaps elsewhere. Immediate care is actually a "battle-front," or "battalion aid" extension of the next dimension of mental patient services—intensive care of acute mental illness—but it is suffi-

ciently important and new in practice that we have treated it separately, as a second line of defense.

Intensive Treatment of Acutely Ill Mental Patients

Recommendation: A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement, and that the intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully trained members of the mental health professions. There is a need for expanding treatment of the acutely ill mental patient in all directions, via community mental health clinics, general hospitals, and mental hospitals, as rapidly as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, and occupational, physical, and other nonmedical therapists become available in the community. There is a related need for revision of commitment laws to ease the movement of patients through the various treatment facilities.

At some point, the experts involved in treating an acutely mentally ill patient reach the decision of whether or not such a patient can get along in the community or requires hospitalization. Too often they make this decision upon the basis of community convenience—the family, the neighborhood, or the employer feels that the patient's behavior is somehow threatening or intolerable. If the anxiety of these people reacts against the patient, his own anxiety and other symptoms may increase, resulting in his admission to a mental hospital, even though he could be more effectively managed as an outpatient in the community. Irrespective of how excellent a community's emergency and clinic services may be, however, some patients require hospitalization for the control of their behavior and the proper protection of themselves and others. Some patients feel more secure in a hospital; at times, this feeling is a realistic one.

Community Mental Health Clinics

Recommendation: Community mental health clinics serving both children and adults, operated as outpatient departments of general or mental hospitals, as part of State or regional systems for mental pa-

tient care, or as independent agencies, should be regarded as a main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization. Therefore, a national mental health program should set as an objective one fully staffed, full-time mental health clinic available to each 50,000 of population. Greater efforts should be made to induce more psychiatrists in private practice to devote a substantial part of their working hours to community clinic services, both as consultants and as therapists.

FOR CHILDREN

Recommendation: Psychiatric clinics providing intensive psychotherapy for children, plus appropriate medical or social treatment procedures, should be fostered and, where they exist, expanded. Of all categories of psychiatrists, child psychiatrists are in shortest supply —children being especially trying to work with and requiring the close cooperation of the parents and infinite patience on the part of the therapist. The present State aid program is insufficient to provide for the needs in this area. It should be expanded.

The first step in management of any child whether he represents an acutely disturbed case from the court or some type of learning problem in school is a *proper evaluation* of the disorder. This requires a complete investigation of the home situation, the school situation, any social situation other than school, and the recreational and other peer group activities of the child. In addition, a complete health inventory must be made, including physical, psychological, and psychiatric examinations.

Treatment of the child will ordinarily involve an intensive type of psychotherapy centered in the child, plus management of the family and environment. In many instances, it is also necessary to bring one or more other members of the family into a psychotherapeutic relationship. Often, the therapy, particularly with the family members and sometimes with the child, can be carried on by a clinical psychologist or psychiatric social worker. In this case, the therapist should have recourse to medical consultation as necessary.

Intelligent planning and guidance from a mental health clinic can

do much in the rehabilitation of some children. Whereas the clinic occupied a pivotal position in the care of emotionally disturbed or mentally ill children, ideally it should be considered a part of a spectrum of community services, including special instruction for classroom teachers in the handling of emotional disturbances, special public school classes for emotionally disturbed children, day care school centers, the mental health clinic, resident schools (not only for the around-the-clock patient but also for day and night care), and children's units in general and mental hospitals.

In the absence of such facilities, makeshift arrangements must be made and the community's available counseling resources used. These may include a pediatrician interested in mental health, a teacher, a clergyman, a county health nurse, or a social worker in the county welfare department.

FOR ADULTS

Recommendation: The principal functions of a mental health clinic serving adults (the majority serve both adults and children) should be (1) to provide treatment by a basic mental health team (usually psychiatrist, psychologist, and social worker) for persons with acute mental illness, (2) to care for incompletely recovered mental patients either short of admission to a hospital or following discharge from the hospital, and (3) to provide a headquarters base for mental health consultants working with mental health counselors. The function of such a clinic as a center of mental health education for the public is of incidental importance, and should preferably be left to other agencies.

The need for an increase in the number of mental health clinics is obviously extreme, inasmuch as less than a fourth of the counties in the nation have them. Where clinics exist, the waiting lists are usually so long that they tend to defeat the clinic's purpose of serving the community. Whereas most operate under the direction of a psychiatrist, he usually functions only as a part-time employee and the bulk of service is rendered by social workers under his general supervision. More recently, clinical psychologists have joined the clinic

team. It is imperative that whoever in the clinic can render competent help to a patient do so. Further steps must be taken to train persons in helping professions now inadequately trained, to provide professional training for additional clinic workers, and to offer financial incentives and opportunities for clinic careers. The question of financing will be considered in a subsequent section on costs.

General Hospital Psychiatric Units

Recommendation: No community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short-term hospitalization and therefore provides a psychiatric unit or psychiatric beds. Every community general hospital of 100 or more beds should make this provision. A hospital with such facilities should be regarded as an integral part of a total system of mental patient services in its region.

It is the consensus of the Mental Health Study that definitive care for patients with major mental illness should be given if possible, or for as long as possible, in a psychiatric unit of a general hospital and then, on a longer-term basis, in a specialized mental hospital organized as an intensive psychiatric treatment center. In the past decade, there has been an impressive increase in the number of general hospitals offering psychiatric treatment facilities, but as yet these still represent less than one-sixth of all general hospitals. The trend should be accelerated in every possible way, for general hospitals commonly have the great advantage of offering high-quality facilities at the onset of acute illness, when opportunities for achieving recovery are at their best. These hospitals offer the further advantage of keeping the mental patient near home and thus often help to eliminate the dehumanizing effects of removing and isolating the patient from his own community. If, as, and when psychiatrists can be further persuaded to move into smaller communities, more general hospital psychiatric units may be expected to come into being. These communities should be encouraged to invest in mental health services by, among other things, offering psychiatrists inducements to serve the community.

Intensive Psychiatric Treatment Centers

Recommendation: Smaller State hospitals, of 1000 beds or less and suitably located for regional service, should be converted as rapidly as possible into intensive treatment centers for those patients with major mental illness in the acute stages or, in the case of a more prolonged illness, those with a good prospect for improvement or recovery. All new State hospital construction should be devoted to these smaller intensive treatment centers.

The most important requirement for an intensive treatment center is a well-trained and competent staff at least as large in number as the patients served. This staff should have a good-sized complement of skilled psychiatrists who know how to work comfortably with a clinical team including a variety of professional and subprofessional persons who can assist them in the treatment of patients. Such workers would include occupational, recreational, and physical therapists as well as psychologists, social workers, nurses, and attendants.

Psychiatric leadership in the executive department of an intensive psychiatric treatment hospital will be necessary, with but few exceptions, if the hospital is to operate as a therapeutic environment for patients. We have been careless in the specifications of this leadership heretofore. The medical superintendent of a mental hospital should be a competent psychiatrist, thoroughly aware of and prepared to use modern psychological and social concepts of treatment as well as physical techniques of treatment, and trained in hospital administration. The American Psychiatric Association's minimum standards for approval of a mental hospital have required only that the superintendent be a physician. A physician untrained in modern psychiatry —perhaps one who has, for example, drifted about in surgery, obstetrics, or general practice, and thence into medical administration —is hardly better qualified to operate a mental hospital than a layman (and, of course, not as well qualified as a layman professionally trained in hospital administration). Given a competent psychiatrist as its professional chief, the administrative work in an intensive treatment hospital should be so organized and delegated that the director can devote the major portion of his attention to the profes-

sional staff and to patients. This is possible only if persons trained in business management make up his administrative staff.

We also believe that the staff of such an intensive treatment hospital, especially the nurses and attendants, must be trained in group or social techniques, also called milieu or environmental therapy. It should be both policy and practice to see that the patient is placed in a unit of this sort only because he needs the therapeutic facilities it affords. The psychological atmosphere of the ward in which the patient is to live during the period of treatment must be carefully scrutinized and properly organized in a way that at once offers the protection he needs and yet provides a gentle but firm stimulus toward resynthesis of his personality and his progress toward independent existence. Well-motivated, psychologically oriented, and closely supported volunteer workers may be assigned to aid in this process.

Many of the large State hospitals do a reasonably good job of treating chronically ill persons but lack the manpower to give the acutely ill the intensive, individualized attention needed. The exceptional ones that have well-developed intensive treatment services only underscore the truth of the statement. Where these first-class facilities are found, they exist because the superintendents, the mental health authorities, and the legislators of the States have recognized the need for such services and have, in an intelligent manner, gone about planning facilities, appropriating money, and putting the services in operation. For a time much progress was made in many States, but in the past two years there has been a leveling off due to the serious burdens imposed by new programs on the tax structure of various States.

It follows from the logic of this final report and the recommendation that State intensive psychiatric treatment centers be operated as separate and distinct hospitals that the Joint Commission finds itself in agreement with Dr. Harry C. Solomon (1958) regarding our vast State mental institutions housing as many as 10,000 or 15,000 patients:

> The large mental hospital is antiquated, outmoded, and rapidly becoming obsolete. We can still build them but we cannot staff them; and therefore we cannot make true hospitals of them. . . . I do not see how any reasonably

objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy. I believe therefore that our large mental hospitals should be liquidated as rapidly as can be done in an orderly and progressive fashion.

Our affirmation of this statement, perhaps regarded as unrealistic at the time it was made before the American Psychiatric Association, leads us to the next recommendation.

Care of Chronic Mental Patients

Recommendation: No further State hospitals of more than 1000 beds should be built, and not one patient should be added to an existing mental hospital already housing 1000 or more patients. It is further recommended that all existing State hospitals of more than 1000 beds be gradually and progressively converted into centers for the long-term and combined care of chronic diseases, including mental illness. This conversion should be undertaken in the next ten years.

Special techniques are available for the care of the chronically ill and these techniques of socialization, relearning, group living, and gradual rehabilitation or social improvement should be expanded and extended to more people, including the aged who are sick and in need of care, through conversion of State mental hospitals into combined chronic disease centers.

Even with our best efforts to treat them in the early stages, some schizophrenic, involutional, geriatric, and senile patients will require continued care. These patients should be transferred from the intensive treatment centers and placed in the proposed separate facilities for long-term chronic patients.

The staffs of these chronic disease hospitals would differ from those engaged in treating the acutely ill; they would have fewer psychiatrists and a larger number of nurses, occupational therapists, and attendants who know how to work with groups and who can create a stimulating day-to-day life for the patient. The evidence indicates that volunteers, such as college students, are particularly suited to helping rehabilitate chronic patients.

Many of the facilities needed for the prolonged care of mental patients are identical with those necessary for the prolonged care of

any type of chronic physical illness. Therefore, communities should find it practical to care for patients with all types of chronic physical and mental disorders in the same chronic disease hospital. Some of the present State hospitals are well equipped with auditoriums, chapels, theaters, recreation rooms, the occasional swimming pool, parks, and picnic grounds needed for proper care of long-term patients.

Many chronic patients get along with minimal supervision if the hospital is properly designed and the staffs are trained in the care of long-term patients.

The chronic disease facilities must have contact with rehabilitation services and clinics. Chronic patients can use sheltered workshops, halfway houses, and other rehabilitation devices that help a person who has lost most of his social skills to reintegrate himself into a community step by step, each step being supervised by a properly trained professional rehabilitation worker who has consultant contacts with psychiatrists skilled in the care of chronically ill patients.

The single, combined chronic disease center may be difficult to set up. At present, chronic disease hospitals may be under State, county, or local Departments of Welfare or Public Health, but many are privately endowed and supported, whereas hospitals treating chronic mental disorders are for the most part supported by State or Federal government.

Implementation of this proposal would require some superintendents to give up exclusive authority; in some cases, these are lay superintendents; in others, medical superintendents.

The fact that our proposal requires reassignment of administrative authority and re-employment of persons who are for the most part working in fields in which there are shortages now would seem to us a minimal objection as compared to the probable greater effectiveness to be gained in the care of patients. The delay will come in getting people to look at the problem realistically and unemotionally, and in inducing them to make constructive suggestions as well as to pick flaws in the proposal.

A chronic disease center could be operated by a trained hospital administrator (layman or physician) with the psychiatrists and other physicians coming in as a visiting staff or functioning as a full-time

medical staff. Precedent for this proposal is found in many nonprofit general hospitals of unquestionably high professional standards. The layman professionally trained in hospital administration could effect a saving in scarce manpower.

It would be necessary to provide the intensive treatment services for the acutely ill, outlined in the preceding section, before these large hospitals could be converted to chronic diseases. It would also be necessary to make certain changes in Federal and State laws.

To utilize fully both private and public institutions now available, substantial flexibility would have to be maintained in requirements for admission. Some prepayment benefits or subsidy programs for the care of these patients over a long term would be necessary. Such payments should be available whether the patients are in institutions basically supported by the State or by private enterprise.

The present cost of operation of large State hospitals is below that required to provide adequate, long-term service for the chronically ill. We believe, however, that the final cost of treatment for the chronic patients would remain substantially below that of caring for the acutely ill patients who require intensive psychiatric treatment. Combined chronic disease hospitals could be operated at a great saving in professional personnel, particularly in skilled psychiatrists, psychologists, and social workers of advanced degree and training who can more effectively work in intensive treatment centers.

Aftercare, Intermediate Care, and Rehabilitation Services

Recommendation: The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all service to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them: day hospitals, night hospitals, aftercare clinics, public health nursing serv-

ices, foster family care, convalescent nursing homes, rehabilitation centers, work services, and ex-patient groups. We recommend that demonstration programs for day and night hospitals and the more flexible use of mental hospital facilities, in the treatment of both the acute and the chronic patient, be encouraged and augmented through institutional, program, and project grants.

It has been commonly observed that many patients are discharged from mental hospitals with no attempt to prepare them psychologically, socially, vocationally, or in other ways for the stresses that they will face and which may bring about their relapse. Many patients remaining in mental hospitals are "ready for release" but are not released because of the lack of staff and time for resocialization procedures, including interviews with the patient, his relatives if any, and the specific determination of where he will live and work and who will look after him. As illustrated by the college student volunteer program and a number of other volunteer services, including the utilization of mature women of a motherly type, such resocialization services can be performed by laymen working under supervision and trained on the job. Thus, the argument that we lack professionally trained manpower sometimes becomes a specious one in the face of uninhibited and imaginative efforts to provide help with anyone who is willing and able to help. There has been perhaps too much emphasis on increased professional training in some directions, as illustrated in general hospitals by the recent addition of practical nurses to render bedside nursing services for which registered nurses were not available. Generally speaking, professionalism serves the purpose of higher training and therefore higher competence, but it also serves the individual's aspirations for higher status; the quest for status must not be permitted to stand in the way of progress in mental patient care.

As the report of the Schwartz group brings out, aftercare services for the mentally ill are in a primitive stage of development almost everywhere, in social service, public welfare, and vocational rehabilitation agencies as well as in mental hospitals and psychiatric clinics. Where they do exist, services and agencies caring for the former patient tend to split off from mental patient services as a whole, and,

further, to approach the patient's problems piecemeal. Rehabilitation agencies should work closely with treatment agencies, and preferably have representatives in institutional settings. There is a further danger in this tendency toward segmentation, as the Joint Commission sees it, that rehabilitation will be treated as a service performed only by rehabilitation specialists rather than as part of a comprehensive program of patient service in which each and every member of the mental health team has a part to play.

We may generally state that we favor the great variety of efforts being made to furnish rehabilitation services before, during, or after hospitalization, so long as they are soundly conceived, well staffed, and operated as part of an integrated system of mental patient services.

The variety of services were described in Chapter IV, and we need only stress here that day hospitals are an effective illustration of new, flexible, and more effective ways of using existing patient care facilities.

The *day hospital* should play an increasingly important role in the care of both acute and chronic mental patients. Research in social aspects of the care of these patients continues to highlight the importance of family relations. Rehabilitation difficulties center around the patient's loss of identification with and support from his family and community. This effect prompts the initiation of experiments with treatment programs which allow the patient to stay at home during the greater portion of his treatment.

The use of the day hospital is ideally suited to bring about such a shift in treatment emphasis. The patient may come to the hospital for participation in physiological, chemical, and group therapy. While there he may also have psychotherapeutic interviews with his physician. Contact with the hospital daily in transporting some of the patients to and from the hospital, and in checking on the progress of the others, keeps the family more intimately involved in the program of the patient as he is involved in the therapeutic situation. At least one hospital is gradually subordinating its inpatient beds to day patient care space in the belief that ultimately the majority of patients can be handled on a day basis. In this system, the family is involved

in the therapeutic program, often with a social worker, or with the nurse in the day hospital. Families in some instances are encouraged to accompany the patient to the hospital for the day care program insofar as this is possible in terms of their own occupations and social responsibilities. As patients further improve and are discharged into the community, they then may return to the day hospital for one or two days a week, and finally become purely clinic patients.

The day hospital is successful particularly if it has some type of industrial or vocational program to condition the patient for work. In such a program, the work conditioning has the primary purpose of teaching the importance of working together in an orderly, efficient way as well as possibly imparting job skills which the patient may use on discharge from the hospital. Work conditioning thus includes subordination to authority; acceptance of responsibility; listening to, comprehending, and carrying out instructions without further guidance or goading; submission to discipline or correction, and getting on equitably and cooperatively with fellow workers.

The day hospital also may be used for patients who are not psychotic, particularly those with various character disorders who do not adapt too well to an institutional environment. These patients tend to become too dependent, seeking within the regular hospital security or other satisfactions that are better provided by the family. Such patients should remain in the hospital only long enough to deal with the immediate social problem that precipitated their entrance. Families of patients with character disorders or chronic psychosis are too prone to want the hospital to take over and become a kind of club for the patient in order that the family may be spared the task and responsibility of managing him. This attitude of the family encourages the patient to feel that he is dependent on the hospital, and that it will provide for and look after him. Under such circumstances, a patient can live out his life in a large mental hospital without being stimulated toward rehabilitation.

Teaching the patient to share responsibility for his own management and finally to assume this responsibility totally is an important part of therapeutic management, be it in the clinic or in the hospital. But the patient should reside in the hospital full time only for

brief periods to tide him over some type of social or medical emergency.

The use of psychologists of intermediate training and of clergy with proper training in counseling and guidance forms an important supplement to better trained therapeutic personnel in aftercare programs. In some of the smaller communities where the day care center is part of a general hospital, family physicians may also help if they have the time. Psychologically oriented family physicians may support, advise, and guide the public health nurses, social workers, and clergy in managing these persons, especially in rural communities, but they usually are busy with general medical problems. A properly established outpatient service and a day hospital operating in collaboration with the local community hospital psychiatric unit would be great assets in managing the patients.

Alternate types of cases requiring support and treatment in the evening because of the lack of family ties may be cared for in a *halfway house* or, as some hospitals have developed it, by a *night hospital* which functions in essentially the same way. The principal difference is that the halfway house is usually not under the management of medical personnel but under someone with social service skills or perhaps merely a warm, motherly person. These units are used to give patients support and a sense of belonging to a group, and to provide them some moderate type of supervision when they are away from work. Such a system works well in treating character disorders, schizophrenics having trouble in rehabilitating themselves in the community, practically any type of person who has no family ties in the community, and many of the alcoholic patients who tend to relapse when away from work.

In summary, events of recent years have demonstrated unequivocally the value of positive efforts towards rehabilitating patients who have been mentally ill, or have had chronic neurological diseases. Examination of our methods in rehabilitation, however, would indicate that they are crude, imprecise, and not highly specific for persons with different kinds of mental and character disorders. Much research is needed in this area. Further inquiry is necessary into the kinds of persons who make the best rehabilitation workers and the

kinds of professional skills that should be incorporated into this new professional group. While there is a heady interest in rehabilitation and such services have widespread popular acceptance, sufficient support for research in this area is an urgent requirement.

PUBLIC INFORMATION ON MENTAL ILLNESS

The staff of the Joint Commission on Mental Illness and Health has reviewed the problem of communications in the field of mental health and mental illness in relation to the lag in the progress toward adequate care of the mentally ill. In its interpretation, the longstanding preference of voluntary agencies for the teaching of mental hygiene, or positive mental health, principles over insistence on humane and healing care for the mentally ill constitutes one of the dimensions in which the public rejects the mentally ill and their problems (see Chapter III). The fact that mental health education has gone on despite lack of good evidence that it does, in fact, prevent mental illness lends weight to our interpretation. It furnishes an alternative more pleasant than consideration of the plight of mental hospital patients.

The Joint Commission has attempted no study of mental health education per se. It has the full advantage, however, of the excellent report, *Mental Health Education: a Critique,* emanating from the National Assembly on Mental Health Education held at Cornell University in Ithaca in September 1958, a project of Pennsylvania Mental Health, Inc., co-sponsored by the American Psychiatric Association and the National Association for Mental Health. The conference was attended by 45 mental health leaders, including six members of the Joint Commission.

The National Assembly on Mental Health Education (1960, p. x) was successful in illuminating an essential conflict between the provision of better care for the mentally ill and the promotion of better mental health through public education:

> A great many people assume that education, both to prevent mental illness and to enhance mental health, is worthwhile. *On the other hand, no one is sure this is so;* and, faced with the unquestioned need to marshal our available

resources to increase and improve facilities for the treatment of the sick and the near-sick, the directors of the citizens' mental health movement have a responsibility to channel its efforts in the most effective pattern.

It seems certain, however, that no concentration on therapy alone is going to take place, not only because of the practical difficulties in reaching so sharp a focus and because of the lack of knowledge of mental therapy, but also because the American mind is deeply attached to the values of education.

Because of this, mental health associations are likely to continue their educational programs. But if they are going to distribute all sorts of literature aimed at all sorts of groups, to use the mass media to "promote" mental health among the general public, to train and supply speakers and discussion leaders, to show films and put on plays, to organize institutes, discussion groups, workshops, seminars and conferences, and to engage in "miscellaneous educational projects," these multifarious activities ought to be submitted to some assessment.

All social movements and educational programs need periodic stock-taking because, as they grow, they tend to substitute organizational values for their original goals. Movements tend to become their own excuse for flourishing, and sometimes they acquire some of the nonrational attributes of a cult.

Although it was the intention of the Assembly to focus on prevention of mental illness through education, its principal agreements, as reported in *Mental Health Education: a Critique,* related to mental illness:

The consensus that truly united the members was that efforts to ameliorate mental illness and to rehabilitate the mentally ill were valid, and that efforts to prevent mental illness . . . by education for better mental health were largely a matter of faith (p. 22).

Most members of the Cornell Assembly would like to see some kind of committee or commission *range through present bodies of knowledge and inform the entire field of what are now accepted principles upon which action and education may be built* (p. 46).

When we are critically short of trained professionals and of mental health principles, is it ethical for the mental health movement to tell millions of normal persons that they should understand a great deal more about psychology and psychiatry so as to use this new knowledge in their daily lives? (p. 47).

We must admit that we cannot now estimate the effectiveness of education for positive mental health, regardless of what techniques are used. We do have

an obligation to discover how this can be done. We must, therefore, lend ourselves to doing this job . . . within a framework of evaluation and research (p. 49).

We in the mental health professions talk a great deal about "mental hygiene principles." Seeking to summarize those basic to mental health education, the Assembly reached a "nuclear consensus" on the following (p. 29):

Human behavior is caused; it is not random, no matter how bizarre or deviant it may appear.

Most human actions are complicated and are a product of many causes. By no means are all known.

Human behavior is determined by emotional drives which sometimes compete with rational considerations; human behavior is influenced, in part, by unconscious motivation, which is relatively refractive to logic and "will power."

The need to be stimulated and protected is present in all human infants. Furthermore, a *need to be loved* and the *ability to love,* which begins in early infancy, leads to the *need to love* which seems a crucial aspect of human behavior.

As *Mental Health Education: a Critique* commented, the above rather general statement appeared to exhaust the areas of agreement: "Perhaps in this field we are not ready to formulate a set of more complete and specific working principles. This, in itself, is an important finding. . . ."

Such a finding suggests to the Joint Commission that, in making recommendations in the public relations area of a national mental health program—specifically, a program for improvement of care for the mentally ill—*we should avoid the risk of false promise in "education for better mental health" and focus on the more modest goal of disseminating such information about mental illness as the public needs and wants in order to recognize psychological forms of sickness and to arrive at an informed opinion in its responsibility toward the mentally ill.*

Indeed, this choice seemed implicitly endorsed by the report of the National Assembly when it stated (p. 4): "Most delegates agreed that the mental health association should continue to teach the 'facts of life' about mental illness. . . ."

We *believe* that sound public education in what is known of the psychology, bodily effects, intellectual processes, emotional reactions, and motivations of the human mind would lead to greater understanding of ourselves and others and therefore toward greater peace of mind or strength of mind. But we *know* that in any channel of communication—whether it is science, the press, the bar, the legislature, or executive management—all pertinent and relevant information is desirable in order to understand a situation and make a wise judgment on it. Whether the information makes the recipient feel better or worse is not in question; it is necessary that he have the needed information and, of course, that he comprehend it, if he is to have rational attitudes and take reasonable actions.

It is possible to make certain general recommendations about dissemination of information concerning mental illness aimed not only at a greater public understanding of the mentally ill and those who care for him, but at the avoiding of *mis*understanding in the relations of one professional group with another, as well as the relations of the mental health professions with the lay public.

In our devotion to seeking social justice for the mentally ill, we have overlooked the importance of making sure that others understand what we are driving at. A recent and profound observation, the product of cultural anthropology, is that human understanding is achieved not when John understands Bill according to John's way of looking at life but according to *Bill's* way. In short, the usual thing in listening to another person is to hear only ourselves.

In order to influence people, one must *convince* them, appealing to their feelings as well as their reason. Social scientists have shown us that we have missed an important point in our overinsistence that the public recognize that mentally ill persons are sick, and should be treated no differently from other sick persons. People appear willing enough to give this position lip service, but a majority apparently don't really believe it, and thus are not moved. The expert sees differences in behavior of the mentally ill and mentally healthy largely as a matter of degree, and recognizes that anyone may at some time reach his breaking point, but he taxes credulity by stating that "one in one" is or will be mentally ill. In contrast, the typical layman re-

serves his understanding of mental illness for those who engage in extreme forms of "acting crazy." He sees the mentally ill person as quite different from the physically ill and, in this instance, seems somewhat wiser than the expert. *Major mental illness* is *different from physical illness in one important aspect—it tends to disturb and repel others rather than evoke their sympathy and desire to help.* At the same time, the layman may not realize that mental illness inescapably involves us in each other's behavior and therefore needs to be recognized for what it is, so that it may be intelligently resolved. He also may fail to see that the strength of the professional mental health worker—what differentiates him from the uninformed layman—is that he *does not* reject the mentally ill person but tries to understand him and find a means of helping him.

A sharper focus in a national program against mental illness might be achieved if the information publicly disseminated capitalized on the aspect in which mental differs *from physical illness. Such information should have at least four general objectives:*

1. To overcome the general difficulty in thinking about recognizing mental illness as such—that is, a disorder with psychological as well as physiological, emotional as well as organic, social as well as individual causes and effects.

2. To overcome society's many-sided pattern of rejecting the mentally ill, by making it clear that the major mentally ill are singularly lacking in appeal, why this is so, and the need consciously to solve the rejection problem.

3. To make clear what mental illness is like as it occurs in its various forms and is seen in daily life and what the average person's reactions to it are like, as well as to elucidate means of coping with it in casual or in close contact. As an example, the popular stereotype of the "raving maniac" or "berserk madman" as the only kind of person who goes to mental hospitals needs to be dispelled. We have not made it clear to date that such persons (who are wild and out of control) exist, but in a somewhat similar proportion as airplanes that crash in relation to airplanes that land safely.

4. To overcome the pervasive defeatism that stands in the way of effective treatment. While no attempt should be made to gloss over

gaps in knowledge of diagnosis and treatment, the fallacies of "total insanity," "hopelessness," and "incurability" should be attacked, and the prospects of recovery or improvement through modern concepts of treatment and rehabilitation should be emphasized. One aspect of the problem is that hospitalization taking the form of ostracism, incarceration, or punishment increases rather than decreases disability.

Attention also is needed as to the manner in which professional persons and groups approach the public, since winning friends and support for care of the mentally ill depends first and foremost on not giving cause for offense (and therefore rejection). Since World War II psychiatry has enjoyed a considerable popularity among an upper middle-class minority and the reading public is wont to turn to it for opinions, but close observation suggests that it may lose influence almost as rapidly as it gains it. *We recommend that the American Psychiatric Association make special efforts to explore, understand, and transmit to its members an accurate perception of the public's image of the psychiatrist.* This is a problem in manpower recruitment as well as public information. Such efforts could pay a great dividend in "education of the public" if the profession were to be cautioned, perhaps as a part of its formal training, against overvaluing, overreaching, and overselling itself and, in general, against assuming attitudes of omniscience or superiority that are neither becoming nor soundly based. To be sure, these characteristics are not peculiar to psychiatry; to some extent, they apply to condescension of members of any profession toward laymen, but they are especially injurious to progress in the mental health movement. Intelligent, educated laymen in close contact with psychiatrists and, to some extent, with psychologists and social workers, commonly state *ad nauseam* that "the less they have to do with these infuriating people the better."

For example, members of the mental health professions commonly assume positions of authority on matters within their field on which they have no knowledge as well as matters clearly outside of their special competence in which certain "laymen" are highly competent.

When the public approaches the psychiatrist for an "expert opinion" on world morality, totalitarian ideology, or leisure time activities, he sometimes is loath to point out that he is not an expert in *these* fields. Some psychiatrists, such as Dr. Daniel Blain, have repeatedly emphasized the need for restricting the range of psychiatric activities to more acceptable dimensions. In sum, psychiatrists too commonly act as if the public were "on trial" for its educational and psychological backwardness, whereas many public opinion makers tend to regard psychiatry as "on trial," both in relation to its new, incredible, and unproved theories and to its unfulfilled promise of help to the mentally ill.

We can derive a specific recommendation out of what the layman probably resents most of all—the physician's presumption of authority in the layman's own special field of expertness. *The primary responsibility for preparation of mental health information for dissemination to laymen should rest with "laymen" who are experts in education and mass communications and who will work in consultation with mental health experts.* But the mental health expert and the educator or mass communications expert have the primary problem of fully communicating with one another before communicating with the public. Otherwise, they invite misunderstandings and conflicts. Too often the basis for discussions among mental health professionals and laymen is the easy assumption on both sides that the other fellow doesn't know what he is talking about. The expert looks down on the layman as "ignorant" and the layman feels that the expert is "arrogant."

As a matter of policy, *the mental health professions can now assume that the public knows the magnitude if not the nature of the mental illness problem and psychiatry's primary responsibility for care of mental patients. Henceforth the psychiatrist and his teammates should seek ways of sharing this responsibility with others and correcting deficiencies and inadequacies without feeling the need to be overbearing, defensive, seclusive, or evasive. A first principle of honest public relations bears repeating: To win public confidence, first confide in the public.*

THE COST

Dr. Rashi Fein, in the Joint Commission monograph, *Economics of Mental Illness* (1958, p. 137), addressed himself to the question, "What *can* society afford to spend on mental illness?" and found that, as an economist, he could not answer it. Said Fein:

> An economy can afford to spend whatever it desires to spend. All that is necessary in order to spend more on one thing is that we spend less on something else. We would have to give up something (*in the short run*) if expenditures on mental illness were increased (. . . the long-run situation might be far different).
>
> What society can spend (and ultimately what society should spend) depends on the value system that society holds to. It is obvious that society *can* spend much more on mental illness (or on anything) than it presently is doing. Whether or not it chooses to do so is another question.

This is the question to which the Joint Commission must finally address itself: What should society choose to do about mental illness? The decision is not ours, but the responsibility of making a recommendation is.

Democratic society never seems quite to have settled what should be done with "crazy people," to borrow its own term. In principle, we (the well people, so-called) would like to have the mentally ill treated humanely and, if possible, in a manner that will enable them to recover. In practice, however, we still tend to subscribe to the "once insane, always insane" principle in our public actions toward the mentally ill.

The prevailing system, with few exceptions, has been to remove the acutely ill of mind far from the everyday scene—to put them away in human dump heaps. How mental patients are treated typically depends on what socioeconomic class they spring from and on which heap they land.

From the viewpoint of biology, economics, or politics—from the standpoint of the greatest good for the greatest number—there is nothing intrinsically unhealthy, antisocial, or extravagant in such a disposal system. Every biological organism or social system produces

waste in the pursuit of its purposes and disposes of it or perishes. Nature herself is merciless in destroying the malformed or misfit. Some totalitarian governments have adopted this policy of sacrificing members who do not serve their ends.

In our free society such an approach perhaps makes sense, in systems not involving human life. It is characteristic of the human mind as it has evolved through democratic processes, however, that it attaches the highest value to individual human life—an even higher value, it would seem, than that placed on the future of the total group. In the survival of the human race, it may not be of critical importance whether 50 per cent or 96 per cent of children survive the first ten years of life or whether total life expectancy averages 40 years or 70 years. Both extremes have been true, respectively, of child death rates and life span in the United States within the last 100 years.

Yet it is individually and socially important to us that as many persons as possible survive in good health as long as possible and that, if they fall sick, we make every effort to restore their health. In the confidence that this is so, the healthy find a sense of security and peace of mind. We are speaking, in short, of faith in our fellow men. In conserving useful life, civilized man achieves his most glorious moments. It is our creed that life is sacred, that bodies should be healed when sick, and that law violators should have the opportunity to reform. Every living man has a right to be treated as a human being.

Yet we know that this philosophy of humanitarianism does not achieve full expression in the prevailing system of caring for the mentally ill. As if to mock the human mind, we do a reasonably good job of keeping these persons *physically* alive but, to a great extent, ignore their *mental* life, which is the only part that is uniquely human. People appear of uneasy conscience about this maltreatment each time our archaic asylums undergo public investigation and exposure. The moral indignation temporarily engendered would indicate that we regard it as unthinkable that human beings should be so treated. The facts so arouse a sense of guilt that, even within the mental health professions, we would rather not dwell on them.

The future of the United States, as we conceive it, lies in its con-

tinuance as a free society, where the individual rather than the State is supreme and life is inviolable. This is the nature of our strength. Therefore, the answer to our question, "What should society choose to do?" is simply to say that the choice already has been made. We must do what is necessary. It is necessary to treat mental patients as human beings—a moral task—it is further necessary to bring them the benefits of knowledge insofar as we have advanced it to date—an administrative task—and, we must seek greater knowledge—a scientific and educational task.

Having decided that we cannot turn our backs on the mentally ill without turning our backs on our ideals, what then? What must legislators, with the general support of the mental health professions and the more enlightened segments of the public, do?

The mentally ill cannot, for the most part, pay for their own care. Persons of middle incomes or less cannot afford the cost of prolonged treatment. In the first place, the legislator must recognize the need in this instance of rising above political and partisan motives, just as the psychiatrist must rise above his pre-eminently professional obligations and loyalties in the hope of achieving a greater good than his profession as a whole yet has found practicable. It is in the nature of their illness that mental patients are among the most self-centered and unfriendly people in the world; to help them, we shall have to emerge as the most unselfish and friendly people in the world.

Our final recommendation in this report concerns money for care of the mentally ill. The proposal is therefore simple to state: *Expenditures for public mental patient services should be doubled in the next five years—and tripled in the next ten.* Only by this magnitude of expenditure can typical State hospitals be made in fact what they are now in name only—hospitals for mental patients. Only by this magnitude of expenditure can outpatient and ex-patient programs be sufficiently extended outside of the mental hospital, into the community.

If such an objective is to be pursued, it is obvious that Federal aid will be needed, in large sums. It is self-evident that the States for the most part have defaulted on adequate care for the mentally ill, and have consistently done so for a century. It is likewise evident that the States cannot afford the kind of money needed to catch up with

modern standards of care without revolutionary changes in their tax structure.

Recently, there has been much hope and some study centered on the possibilities of voluntary health insurance, or prepayment, as a means of financing hospitalization and/or psychiatric treatment of the mentally ill. When the observer notes statistics indicating that over 70 per cent of the American people are covered by some form of health and hospital insurance and that such prepayment plans presently pay 57 per cent of private expenditures for hospital services, the success of the voluntary approach in the general health area encourages him to ask why the voluntary prepayment principle should not be extended to care of the mentally ill. The answer is, in part, that some progress has been made, for example, in Blue Cross Plans. In 1955, only 39 Blue Cross Hospital Service Plans provided at least 21 days of care for mentally ill persons; in 1960, the total was 62 of a total of 85 Blue Cross Plans with such coverage (Joint Information Service, 1960b). However, only seven of the Plans offer their subscribers mental illness coverage equal to that for the physical illnesses covered. Many of the Plans bristle with limitations and restrictions in coverage for those who become mentally ill.

It would appear that voluntary insurance is valuable and merits further expansion, as it applies to the short-term care of mental patients in general hospitals, where, as we saw in Chapter IV, the average stay per mental patient is four weeks. It is extremely doubtful, however, and in our opinion not feasible, that the principle of low-cost voluntary insurance can be applied with the effectiveness needed in the care of many patients with a major mental illness. Such patients often require prolonged or repeated periods of hospitalization and treatment usually totaling several months and sometimes one, two, or more years of intensive or continued care of the highest quality.

All this does not gainsay the desirability of pilot studies to test out various voluntary methods of prepaid care for mental illness. What has been commonly overlooked in discussions of mental health insurance, however, is the fact that extensive coverage under Blue Cross (for example) would inevitably increase premium costs at a time

that Blue Cross officials are burdened with increased payments due to continually increasing hospital costs plus increased hospital use in the fields of general medicine and surgery. In addition, the 85 Blue Cross Plans continue to be handicapped by their inability to provide an integrated system offering uniform coverage on a nationwide basis. There is every reason to believe that the vast majority of mentally ill Americans will require in the future, as they have in the past, care at public expense.

It is a matter of precedent that in matters involving the common good and affecting the welfare and safety of the Nation, the United States Government can assume responsibility for constructive action if it chooses. It has done so in modern times, in the fields of health, education, and public welfare.

It is a matter of history that Dorothea Dix, as the last public act of her career, proposed Federal aid to the insane in the form of vast land grants and made a stubborn, uphill, six-year fight for it, and that both houses of Congress in 1854 passed the "12,225,000-acre bill" in response to her heroic stand against denunciations of her as an "impractical idealist" (Deutsch, 1949, p. 178). It is also a matter of history that President Franklin Pierce vetoed the bill. He held that Congress did not have this power to usurp States' rights—even in defense of human rights.

The health, education, and welfare legislation of the last quarter century has effectively repudiated the Pierce philosophy. Had he sustained the measure we can well imagine that such books as *The Shame of the States* and *A Mind that Found Itself* would not have been written, and this final report of the Joint Commission on Mental Illness and Health would not have been needed. For, as we have seen, it was a historic mistake to make the State alone virtually responsible for public care of its mentally ill residents, relieving the local communities of all further concern and, until recent times, sparing the Federal government anything but peripheral involvement in the problem. Their single source of financial support guaranteed the isolation of State hospitals and the dumping-ground effect that we have stressed.

Therefore, *we recommend that the States and the Federal govern-*

ment work toward a time when a share of the cost of State and local mental patient services will be borne by the Federal government, over and above the present and future program of Federal grants-in-aid for research and training. The simple and sufficient reason for this recommendation is that under present tax structure only the Federal government has the financial resources needed to overcome the lag and to achieve a minimum standard of adequacy. The Federal government should be prepared to assume a major part of the responsibility for the mentally ill insofar as the States are agreeable to surrendering it.

For convenience, the Veterans Administration mental hospitals can be taken as *financial* models of what can be done in the operation of public mental hospitals (see the section, *New Perspectives on Mental Patient Care,* in Chapter IV). Thanks to Federal appropriations, the VA mental hospitals have been able to spend an average of $12 a day per patient, compared to an average of about $4 a day per patient in State hospitals. With this amount of money, as we have seen, the VA mental hospitals have been able to employ twice as many persons per patient, have been able to introduce innovations more frequently in the therapeutic environment, and have been able to undertake more training and research programs. Their more fortunate financial position has enabled them to explore and develop types of treatment and hospital ward management not so freighted with custodial restrictions or so dependent on the scarce psychiatrist as are the traditional patterns of State hospital staffing.

Congress and the National Institute of Mental Health, with the assistance of the intervening administrative branches of government, should develop a Federal subsidy program that will encourage State and local governments to emulate the example set by VA mental hospitals. We do not here intend to idealize these hospitals beyond reason—they themselves are unevenly developed, suffer from some deficiencies, and many are overly large—but they nonetheless serve as a minimum standard of what is presently obtainable in public mental hospital care.

In a period of inflation and of continued increases in appropriations designed simply to hold our ground or perhaps gain a little, it

is foolish to make recommendations in dollar amounts beyond the next fiscal year, and we shall refrain from doing so here. It is possible, however, to state certain principles which should be followed in a Federal program of matching grants to States for the care of the mentally ill. It is also possible to illustrate what the application of these principles would mean in various dollar amounts, merely for the purpose of easier visualization.

Let us say that Congress wishes to adopt the policy of Federal aid to the State and local governments for the care of the mentally ill, and plans to double and eventually triple the total expenditure for this purpose, as we recommend.

The *first principle* is that the Federal government on the one side and State and local governments on the other should *share in the costs* of services to the mentally ill.

The *second principle* is that the total Federal share should be arrived at in a *series of graduated steps* over a period of years, the share being determined each year on the basis of State funds spent in a previous year.

The *third principle* is that the grants should be awarded according to *criteria of merit and incentive* to be formulated by an expert advisory committee appointed by the National Institute of Mental Health.

In arriving at a formula, such an expert committee would establish conditions affecting various portions of the available grant. We can think of the following conditions, and they are sufficient for the purpose of this recommendation, although it might prove desirable for the expert advisers to modify one or another and perhaps add others:

1. *Bring about any necessary changes in the laws of the State to make professionally acceptable treatment as well as custody a requirement in mental hospitalization, to differentiate between need of treatment and need of institutionalization, and to provide treatment without hospitalization.*

2. *Bring about any necessary changes in laws of the State to make voluntary admission the preferred method and court commitment the exceptional method of placing patients in a mental hospital or*

other treatment facilities, and to emphasize ease of patient movement into and out of such facilities.

3. *Accept any and all persons requiring treatment and/or hospitalization on the same basis as persons holding legal residence within the State.*

4. *Revise laws of the State governing medical responsibility for the patient to distinguish between administrative responsibility for his welfare and safekeeping and responsibility for his professional care.*

5. *Institute suitable differentiation between administrative structure and professional personnel requirements for (1) State mental institutions intended primarily as intensive treatment centers (i.e., true hospitals) and (2) facilities for humane and progressive care of various classes of the chronically ill or disabled, among them the aged.*

6. *Establish State mental health agencies with well-defined powers and sufficient authority to assume overall responsibility for the State's services to the mentally ill, and to coordinate State and local community health services.*

7. *Make reasonable efforts to operate open mental hospitals as mental health centers, i.e., as part of an integrated community service with emphasis on outpatient and aftercare facilities as well as inpatient services.*

8. *Establish in selected State mental hospitals and community mental health programs training for mental health workers, ranging in scope, as appropriate, from professional training in psychiatry through all professional and subprofessional levels, including on-the-job training of attendants and volunteers. Since each mental health center cannot undertake all forms of teaching activity, consideration here must be given to a variety of programs and total effort. States should be required ultimately to spend 2½ per cent of State mental patient service funds for training.*

9. *Establish in selected State mental hospitals and community mental health programs scientific research programs appropriate to the facility, the opportunities for well-designed research, and the research talent and experience of staff members. States should be re-*

quired ultimately to spend 2½ per cent of State mental patient service funds for research.

10. *Encourage county, town, and municipal tax participation in the public mental health services of the State as a means of obtaining Federal funds matched against local mental health appropriations.*

11. *Agree that no money will be spent to build mental hospitals of more than 1000 beds, or to add a single patient to mental hospitals presently having 1000 or more patients.*

We regard the above principles and conditions as the essentials, in broad outline, of a soundly financed national (Federal, State, and local) mental health program. One of its most important features, we feel, is that the program would not only relieve the States of the sole responsibility for public care of the mentally ill but would also meet the great objection to Federal aid to the States, which is that it usurps or weakens local responsibility. *Our proposal would encourage local responsibility of a degree that has not existed since the State hospital system was founded;* at the same time it would recognize that the combined State-local responsibility cannot be fulfilled by the means at hand without elevating the State, county, town, and municipal tax structure beyond what is presently feasible.

Let us now resort to certain hypothetical examples of how a Federal-State-local matching program incorporating the suggested merit and incentive features might work if, in such a combined program, we should seek to double expenditures for public mental patient care in five years and triple it in ten years through a graded matching plan.

In Table 7, we have assumed that the States will soon reach an expenditure of $1 billion a year for mental patient care, and will continue at least at that level (in 1959 the figure was $854 million). We also have assumed that such a program can induce local tax participation to the extent of $60 million after a five-year period and $250 million after a ten-year period.

Our proposal is in *two parts.* The *first part* is to grant Federal funds in the ratio of 1 to 10 of State funds in the first year of operation and raise this ratio in annual steps until it reaches 1 to 2 after five years and 1 to 1 after ten. Operating from the hypothetical base

Table 7—Hypothetical Costs to Federal, State, and Local Governments of Doubling Expenditures for Public Mental Patient Care in Five Years and Tripling Costs in Ten Years Under Proposed Matching Plan (in Billions of Dollars)

Year	State Expenditure	Federal Grants without Local Participation	Total	Local Participation to Extent of:	Federal Grants for Local Participation	Grand Total
1	1.0	0.1	1.1	——	——	1.1
2	1.0	0.2	1.2	.03	.17	1.4
3	1.0	0.3	1.3	.04	.26	1.6
4	1.0	0.4	1.4	.05	.35	1.8
5	1.0	0.5	1.5	.06	.44	2.0
6	1.0	0.6	1.6	.08	.52	2.2
7	1.0	0.7	1.7	.10	.60	2.4
8	1.0	0.8	1.8	.15	.65	2.6
9	1.0	0.9	1.9	.20	.70	2.8
10	1.0	1.0	2.0	.25	.75	3.0

of $1 billion of State expenditures, such a program would cost the Federal government $100 million in the first year, $500 million in the fifth year, and $1 billion in the tenth year, at which point we contemplate the Federal proportion would reach its peak, the actual total Federal-State-local appropriations moving up or down with the purchasing power of the dollar and increasing as necessary to keep pace with the population growth.

The *second part* of the proposal is to match Federal against local (county, town, or municipal) expenditures for mental patient services on a 5⅔ for 1 basis beginning in the second year of the program and continuing until a ratio of 7⅓ to 1 is reached in the fifth year. Thereafter the ratio diminishes as funds increase until stabilized at a 3 to 1 in the tenth year. At this time, this portion of the program would account for one-third of total expenditures for mental patient services, the Federal government providing $1.75 billion, the States $1 billion, and the local governments, $250 million. No local matching grants are anticipated in the first year, inasmuch as it would appear likely that some time would be required to establish the present extent of local participation and thereafter initiate a program. As an incentive for local action, a premium value has been placed on this part of the program in the matching ratios provided. Federal-local matching grants would be expended in the community that has financed mental health services.

Our hypothetical table naturally creates some artificial situations which may never actually exist. For example, there is no reason to believe that State expenditures will remain fixed on a $1 billion plateau. Indeed, since the Federal grant is in direct proportion to what the State spends, we might suppose that some States will be moved to spend more in order to obtain more Federal aid. It would seem doubtful that they would be moved to spend less.

It is also apparent in our illustration that we have drawn a total picture related to the present average expenditure of about $4 per mental patient per day. This $4 actually represents a range of from $2 to $6 depending on the State. As indicated, we do not propose that the matching formula be geared to expenditures for hospitalized patients but for mental patient services of any kind. Therefore, except perhaps as a rhetorical convenience, it would be improper to think in terms of increasing the $4 to $8 and so on to $12, although this might be a partial effect of the total program. On the other hand, there are better and more economical ways of caring for some mental patients than putting them in the stereotyped State hospital which is the source of this daily cost figure. In addition, intensive treatment centers can be expected to have higher costs than those devoted to the care of chronic cases alone.

We can predict a variety of objections to our proposal for a Federal-State-local matching program, despite the fact that it represents (Dorothea Dix not excepted) *the first proposal in American history that attempts to encompass the total problem of public support of mental health services and to make minimum standards of adequate care financially possible.*

One objection might be that our principles for Federal-State-local matching grants do not, as in the case of some grant-in-aid programs, attempt to compensate for the varying needs and resources of the States as measured by such criteria as population, patient load, low level of expenditures, and per capita income. We agree that such factors deserve general consideration in the making of the proposed grants, particularly in relation to population shifts requiring rapid expansion of facilities, but we would disagree that the magnitude of the grants should be in inverse proportion to a low level of expendi-

tures. The factors of mental hospital utilization in relation to population and per capita income vary from State to State and are not thoroughly understood. For example, New York State ranks second in the average number of daily resident patients in public mental hospitals, but nineteenth in the average daily maintenance expenditure per patient (Joint Information Service, 1960a), whereas Kansas ranks second in expenditures but only forty-first in patients per population. New Mexico ranks seventh in per patient expenditures but last in patient load. Mississippi ranks thirty-sixth, above Kansas, in patients per population, but last in patient expenditures. There being no basis for believing that the true incidence of major mental illness varies widely from one State to the next, it would appear that other factors in addition to population and per capita income affect State hospital utilization and appropriations for mental health services.

In any event, our proposal is primarily intended to provide State and local incentive to raise standards of care, and therefore is geared to recognize and reward demonstrations of greater State-local financial effort and higher standards of care. To double or triple expenditures in a State spending only $2 a day per patient will take as much skillful doing to produce the desired results as to do so in a State spending $6 a day. Furthermore, all experience indicates that one effect of expanded services is increased utilization. Expansion should be carried out gradually; disproportionately large grants in the absence of commensurate facilities and manpower would serve only to overtax and disrupt services of value in bringing about improvement or recovery of patients.

Another objection is that money alone will not produce the well-trained psychiatrists, psychologists, social workers, nurses, and other personnel who are needed to bring patient care up to a decent level. We agree; higher motivation, better recruitment, and vastly strengthened educational facilities are also required. On the other hand, we will never attract vastly greater numbers of such persons into mental health careers and never be able to strengthen recruitment and professional educational facilities unless we have the money to do so.

The *three principal features* of our proposed financial break-

through on the mental health front are calculated to prevent any sudden flood of money from overwhelming or cheapening the existing short-staffed services.

One feature is that the plan does not propose to reach its goal in one mighty crash but would proceed step by step and blow by blow, over a period of years, with increases in expenditures graded accordingly. The total Federal grant program proposed for the first year is $100 million, a sum that could readily be absorbed in salary raises calculated to hold professional personnel now being lost when they complete their training, or in attracting private practitioners who have indicated a preference for hospital or clinic psychiatry but cannot presently afford it. This effect would produce a big dividend in service to patients, and make it feasible to undertake a variety of training programs for nonmedical career and volunteer personnel that are presently out of the question.

The *second feature* is that States are required to qualify for participation and therefore the proposal acts as a tremendous stimulus for improvement of their mental health services. If they cannot qualify, there is no cost to the Federal government.

The *third feature* is that the proposal spreads financial responsibility for mental health over all taxing agencies; by sharing the responsibility with local government, it should have some firsthand effects on negative public attitudes toward the mentally ill. It is, in effect, an instrument of public education as well as of service to the mentally ill and a stimulus to recruitment, training, and research.

Another objection might be that such a program would foster socialized medicine. Indeed, it would. The fact is that we have had State medicine in the public care of the mentally ill since the middle of the nineteenth century and, except for its poor quality, there has been little or no objection to it. Since mental patients, their families, and the various forms of voluntary health insurance can pay only a portion—usually small—of the total costs of treatment, we have no choice but to turn to the public treasury—no choice unless we choose the do-nothing course we have tended to pursue in the past.

This leaves only the objection that our proposal would cost a lot of money. It certainly would. In time, it would add hundreds of millions

of dollars to the Federal budget. While others may disagree, we submit that such an expenditure is not only worthwhile but also long overdue. As Dr. Fein has pointed out, we can spend the money to fight mental illness if we want to, though we may have to spend less on something else. We believe that, in the long run, the American people will feel well repaid.

The outstanding characteristics of mental illness as a public health problem are its staggering size, the present limitations in our methods of treatment, and its peculiar nature, which differentiates its victims from those with other diseases or disabilities. It would follow that *any national program against mental illness adopted by Congress and the States must be scaled to the size of the problem, imaginative in the course it pursues, and energetic in overcoming both psychological and economic resistances to progress in this direction.* We have sought to acquit our assignment in full recognition of these facts and judgments.

We believe that the time is at hand and their courage is such that modern legislators may make history by adopting a new policy of action for mental health.

NOTE ON IMPLEMENTATION

Readers of this report, even though they agree with its theme, spirit, and objectives, and even though they recognize that the financial breakthrough it recommends is commensurate with the size of the problem, may wonder how and where to begin. (We hope, of course, that all persons and organizations who sincerely wish to improve the health of the mentally ill would begin by openly embracing this report and vocally supporting it in its broad outlines, if not in all its detail.)

For example, one governmental adviser said to us that he would find it difficult, if he were a legislator, to know just what to propose if he took it upon himself to write legislation to meet the recommendations contained in the report: "The problems touched upon and the reforms needed are so diverse, so far-reaching, and so interconnected with general social and political issues that it would indeed

be a difficult job to solve some of these problems through legislative efforts. The suggestion is therefore made that perhaps some further consideration be given to the kind of legislation needed; to the priorities of public action in this area; to the criteria that must be observed in producing manpower, teaching facilities, research facilities, and treatment facilities; and perhaps a timetable related to the priorities and criteria just mentioned."

If, in the face of the difficulties propounded, what the governmental adviser wishes is to reduce the mental health problem to a more manageable size through a variety of easily legislated piecemeal and stop-gap measures, then perhaps he has not responded to the challenge that we have projected. The United States Constitution and its Amendments, and the State Constitutions and their Amendments, plus the great body of Federal and State statutes, the laws by which we live, were not achieved without difficulty and, in some historic instances, were fashioned from blood, sweat, and tears spread over the span of many years. On the other hand, if the gentleman simply wished to point out that what we have recommended would take "a powerful lot of doing," then we are in complete accord.

Perhaps it would be well at this point to restate that the function of the Joint Commission, as conceived by its own charter and directed by the Mental Health Study Act of 1955, has been that of a study group. Its mission is essentially complete with the transmission of this report. Political or legislative action is not our function or forte. We are neither lobbyists nor lawmakers. We have made a study and from it drawn recommendations for a national mental health program.

It is easy, however, to visualize the next two steps, and even a third. The first is the formation of public opinion for or against the program we propose. The second is the formation of legislative opinion pro or con. The third, and *one which we urge the Congress to take immediately, is the formation of a Committee of Consultants who would concern themselves with standards and requirements for implementation of our program and with the kinds of enabling legislation that will be needed.* Eventually, we can see that a comparable

expert committee, forming an effective channel of communication between the legislature and the mental health professions, will be needed in every State.

In the matter of establishing priorities as they relate to the broad areas of patient care, recruitment, professional education, and research in mental health, we would sound a note of caution. In the final analysis, our judgment warns us against imposition of a system of priorities. The reason is that we actually have no choice, as humanitarians as well as educators and scientists, but to move as rapidly as possible on all fronts at once.

Solution to the mental health problem can and already does pursue two courses, as we have indicated. One course is to intensify the search for new knowledge in the hope of mastering the terrain of unknowns to be traversed, and of finding bypasses or more direct routes resulting in preventive measures or treatment methods that are faster-working and better adapted to mass application. Another course is to make better use of the knowledge and experience in the treatment of mental illness that we already have amassed, the knowledge on which the broader concepts of treatment in this report are based.

The question is not which course to pursue more intensively. Professional services, education, and research move together in medicine insofar as they center on or relate to patients. Indeed, it is impossible to separate the patients who must be cared for from the persons who must be trained to care for them, and it is impossible to separate either patients or professional personnel from the search for new knowledge of vital concern to both.

Indeed, we can see only one matter that takes priority over all others in the program we propose and that is to obtain vastly increased sums of money for its support. Without adequate financial resources, we cannot take care of patients, we cannot educate professional personnel for public service, and we cannot pursue the basic knowledge needed for the prevention and cure of mental illness.

We began this report with a demonstration of the lag in adequate efforts and support in behalf of the mentally ill of America. The

amount of effort and support required is staggering because we have quantified them in proportion to the distance we must go to catch up. It remains to be determined whether the nation does, in fact, wish to make the effort and expenditure to catch up. This is the challenge of *Action for Mental Health.*

Appendixes

Appendix I

Public Law 182—84th Congress
Chapter 417—1st Session
H. J. Res. 256

JOINT RESOLUTION

Providing for an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness, and for other purposes.

Mental Health Study Act of 1955.

Whereas some seven hundred and fifty thousand mentally ill and retarded patients are now being hospitalized on any given day, and

Whereas 47 per centum of the hospital beds in the Nation are occupied by mental patients; and

Whereas the direct economic cost of mental illness to the taxpayers of the Nation, including pensions to veterans with psychiatric disabilities, is over $1,000,000,000 a year and has been increasing at a rate of $100,000,000 a year; and

Whereas the emotional impact and distress suffered by millions of our people anxiously and justifiably concerned about the welfare, treatment, and prospects of mentally afflicted relatives is incalculable and is one of the most urgent concerns of our people; and

Whereas the Governors of the several States, through national and regional Governors Conferences and through the publications of the Council of State Governments, have shown great initiative in their cooperative attempts to develop better methods of meeting the challenge of mental illness in their States; and

Whereas there is strong justification for believing that this constantly growing burden may well be due primarily to an outmoded reliance on simple custodial care in mental hospitals as the chief method of dealing with mental illness; and

Whereas there is strong reason to believe that lack of early intensive treatment facilities has created such a backlog of mentally deteriorated patients that it has become virtually impossible for the States to meet the need for mental hospital facilities; and

Whereas there is strong reason to believe that one of the greatest impediments to more rapid progress in the field of mental health is a definite shortage of professional personnel in all categories; and

Whereas there seems to be a discouraging lag between the discovery of new knowledge and skills in treating mental illness and their widespread application, as is evidenced by the fact that whereas only about one-third of newly admitted mental patients are discharged from State hospitals in the course of a year, in a few outstanding institutions the recovery rate is 75 per centum or more; and

Whereas experience with certain community out-patient clinics and rehabilitation centers would seem to indicate that many mental patients could be better treated on an out-patient basis at much lower cost than by a hospital; and

Whereas there is strong reason to believe that a substantial proportion of public mental hospital facilities are being utilized for the care of elderly persons who could be better cared for and receive better treatment in modified facilities at lower cost; and

Whereas there is reason to believe that many emotionally disturbed children are being placed in mental hospitals, which have no proper facilities to administer to their needs; and

69 Stat. 381.

Whereas mental illness is frequently a component of such nationwide problems as alcoholism, drug addiction, juvenile delinquency, broken homes, school failures, absenteeism, and job maladjustment in industry, suicide, and similar problems; and

69 Stat. 382.

Whereas there seems to be no overall integrated body of knowledge concerning all aspects of the present status of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, although only through the development of such a body of knowledge can the people of the United States ascertain the true nature of this staggering problem and develop more effective plans to meet it: Therefore be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That this joint resolution may be cited as the "Mental Health Study Act of 1955." Short title.

STATEMENT OF PURPOSES AND POLICY

SEC. 2. (a) It is the sense of the Congress that there exists a critical need for such an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness and of the resources, methods, and practices currently utilized in diagnosing, treating, caring for, and rehabilitating the mentally ill, both within and outside of institutions, as may lead to the development of comprehensive and realistic recommendations for such better utilization of those resources or such improvements on and new developments in methods of diagnosis, treatment, care, and rehabilitation as give promise of resulting in a marked reduction in the incidence or duration of mental illness, and, in consequence, a lessening of the appalling emotional and financial drain on the families of those afflicted or on the economic resources of the States and of the Nation.

(b) It is declared to be the policy of the Congress to promote mental health and to help solve the complex and the interrelated problems posed by mental illness by encouraging the undertaking of nongovernmental, multidisciplinary research into and reevaluation of all aspects of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, including research aimed at the prevention of mental illness. It is the purpose of this joint resolution to implement that policy.

SPECIAL PROJECT GRANTS FOR COMPREHENSIVE MENTAL HEALTH STUDY

SEC. 3 Part A of title III of the Public Health Service Act is amended by adding after section 303 the following new section: 60 Stat. 423. 42 USC 242a.

"GRANTS FOR SPECIAL PROJECTS IN MENTAL HEALTH

"SEC. 304. (a) (1) The Surgeon General is authorized, upon the recommendation of the National Advisory Mental Health Council, to make grants for the carrying out of a program of research into and study of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, such programs to be on a scale commensurate with the problem.

"(2) Such grants may be made to one or more organizations, but only on condition that the organization will undertake and conduct, or if more than one organization is to receive such grants, only on condition that such organizations have agreed among themselves to undertake and conduct, a coordinated program of research into and study of all aspects of the resources, methods, and practices referred to in paragraph (1). 69 Stat. 382.

"(3) As used in paragraph (2), the term 'organization' means a nongovernmental agency, organization, or commission, composed of representatives of leading national medical and other professional associations, organizations, or agencies active in the field of mental health. 69 Stat. 383.

"(b) For such purpose there is hereby authorized to be appropriated for the fiscal year ending June 30, 1956, the sum of $250,000 to be used for a grant or grants to help initiate the research and study provided for in this section; and the sum of $500,000 for each of the two succeeding fiscal years for the making of such grants as may be needed to carry the research and study to completion. The terms of any such grant shall provide that the research and study shall be completed not later than three years from the date it is inaugurated; that the grantee shall file annual reports with the Congress, the Surgeon General, and the Governors of the several States, among others that Appropriations.

the grantee may select; and that the final report shall be similarly filed.

"(c) Nothing in this section will in any way affect the availability of amounts otherwise appropriated for work in the field of mental health; nor be construed to interfere with or diminish the more limited and specific programs of research and study being carried on through or under the auspices of the National Institute of Mental Health.

"(d) Any grantee agency, organization, or commission is authorized to accept additional financial support from private or other public sources to assist in carrying on the project authorized by this section."

Approved July 28, 1955.

Appendix II

Joint Commission on Mental Illness and Health

PARTICIPATING AGENCIES

American Academy of Neurology
American Academy of Pediatrics
American Association for the Advancement of Science
American Association on Mental Deficiency
American Association of Psychiatric Clinics for Children
American College of Chest Physicians
American Hospital Association
American Legion
American Medical Association
American Nurses Association and The National League for Nursing (Coordinating Council of)
American Occupational Therapy Association
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Current Concepts of Positive Mental Health

This study grew out of discussion at the meetings of the Advisory Committee on Mental Health in Education, and did not have an advisory committee of its own. However, the following panel of consultants was selected to review, discuss and criticize working papers prepared by Dr. Marie Jahoda with the assistance of her immediate colleagues (she was then at New York University):

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Epidemiology and Etiology of Mental Illness

This study did not have an advisory committee as such, but benefited by a working relationship with various individual consultants and the submission of working papers representing a number of viewpoints on the etiology of mental illness. The viewpoints and their exponents follow:

Religion: The Rev. George C. Anderson, S.T.B., Director, Academy of Religion and Mental Health, New York, N.Y.

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Appendix III

Sources of Financial Support

Grants from National Institute of Mental Health:	
Mental Health Study Act of 1955	$1,250,000.00
Special Project	60,600.00
Supplementary Grant	100,000.00
Total	$1,410,600.00
Other Grants:	
American Association on Mental Deficiency	$ 100.00
American Association of Psychiatric Clinics for Children	200.00
American Legion	10,000.00
American Medical Association	1,000.00
American Occupational Therapy Association	100.00
American Orthopsychiatric Association, Inc.	100.00
American Psychiatric Association	500.00
American Psychoanalytic Association	500.00
Association for Physical and Mental Rehabilitation	150.00
Carter Products Company	5,000.00
Catholic Hospital Association	500.00
Field Foundation	3,477.21
Henry Hornblower Fund	100.00
National Association for Mental Health	5,000.00
National Committee Against Mental Illness	5,000.00
National League for Nursing	200.00
National Rehabilitation Association	500.00
Rockefeller Brothers Fund	60,000.00
Benjamin Rosenthal Foundation	20,000.00
Smith, Kline and French Foundation	25,000.00
Total	$ 137,427.21
Grand Total	$1,548,027.21

Appendix IV

Joint Commission Monograph Series

1. *Current Concepts of Positive Mental Health*
   Marie Jahoda, Ph.D., Basic Books, 1958. $2.75.
2. *Economics of Mental Illness*
   Rashi Fein, Ph.D., Basic Books, 1958. $3.00.
3. *Mental Health Manpower Trends*
   George W. Albee, Ph.D., Basic Books, 1959. $6.75.
4. *Americans View Their Mental Health. A Nationwide Interview Survey*
   Gerald Gurin, Ph.D., Joseph Veroff, Ph.D., and Sheila Feld, Ph.D., Survey Research Center, University of Michigan, Basic Books, 1960. $7.50.
5. *Community Resources in Mental Health*
   Reginald Robinson, Ph.D., David F. DeMarche, Ph.D., and Mildred K. Wagle, M.S.S.A., Basic Books, 1960. $8.50.
6. *Epidemiology and Mental Illness*
   Richard J. Plunkett, M.D., and John E. Gordon, M.D., Basic Books, 1960. $2.75.
7. *The Role of Schools in Mental Health*
   Wesley Allinsmith, Ph.D., and George W. Goethals, Ed.D. (in preparation).
8. *The Churches and Mental Health*
   Richard V. McCann, Ph.D. (in preparation).
9. *New Perspectives on Mental Patient Care*
   Morris S. Schwartz, Ph.D., Charlotte Green Schwartz, M.A., Mark G. Field, Ph.D., Elliot G. Mishler, Ph.D., Simon S. Olshansky, M.A., Jesse R. Pitts, Ph.D., Rhona Rapoport, Ph.D., and Warren T. Vaughan, Jr., M.D., (in preparation).
10. *Research Resources in Mental Health*
    William F. Soskin, Ph.D., (in preparation).

Appendix V

Footnotes

Footnote 4–1: Dr. Tiedeman favors a "nutrition-like" theory of mental health which he says is rudimentary but evolving. He comments:

Throughout his life man engages in a process of "becoming." In "becoming," man searches for a station in life that gives meaning to his being. Guidance psychology aims squarely at facilitating this "becoming" of each person. The postures and attitudes a youth adopts toward assimilation, self, and occupation (in the most general sense) control his potential resolution of problems in "becoming" to a marked degree. Schools and colleges employ counselors to help each person achieve resolutions in his quest for meaning in being that are productively oriented. Persons with productive character orientations generally act confidently and accept the consequences of their action without unduly blaming self or others. Persons of productive character orientation also have deeply elaborated self-systems which offer strength for sustaining ego in times of stress.

The primary medium of guidance psychology for facilitating this formation of identity is short-term ego-counseling. This counseling is frequently organized in relation to important points of decision in "becoming," viz: (1) upon entry into high school; (2) upon transition from school to college or work; (3) upon choice of major in college; and (4) upon transition from college to work or graduate school. Enlightened graduate schools, governments, and industries are gradually realizing that "becoming" is a continual process and are providing professional counseling for their students or employees. It is now recognized that a school counselor at any rate cannot serve his charges adequately if they outnumber him by more than about 250. This ratio probably cannot be exceeded in college without sacrifice in the service. In fact the college years are so much an exercise in "becoming" that the ratio of 250 students to one counselor may well be too high. The useful ratio in industry and government will depend upon how many "problems" an employer will let his employee have. Actually the stew of "becoming" intensifies during one's twenties and thirties as well as near retirement. Society would gain if employers provided enough adequate counseling assistance for people of these kinds. Such services are an im-

portant adjunct to the career building and educational endeavors that are so heavily supported in American industry. They are also vitally needed in conjunction with publicly supported programs of education for adults.

The responsibilities of guidance psychology in identity development do not stop with counseling, of course. Hope, openness, and reciprocation of wish for identification are vital ingredients of the process. Guidance psychologists attempt to develop such resources by consulting with administrators and teachers in schools upon such matters and by acting responsibly as citizens in support and development of an open society. The guidance psychologist also attempts to inform all of opportunity, to clarify requirements, and to facilitate entry and progress upon a course.

Finally, "becoming" evolves in relation with the social, personal, human, and cosmic spheres of man's awareness. All that man learns either potentially determines or enables his identity. Hence guidance psychology is intimately entwined with education, the *liberating* of man to be. The counselor nudges here and there, slows down there and here. He must be entwined with ideas of man's existence and with the means man employs to validate his existence. The guidance psychologist aims to *generate* mental health, not merely to *cure* mental illness. Hence he strives mightily to insure that "self" does not get lost in school; he concerns himself with the methods of teachers; and he reviews curriculum to insure that detail is offered in technically sound ways but that knowledge is offered as "history" while application is offered as adventure in exploring the only dimly known circumstances of now. In short the guidance psychologist seeks to intensify the experience of *living* by focusing the attention of each young person upon the self.

We have already noted the clarifications which are needed if the teacher is to participate in secondary prevention in mental health without detriment to his instructional role. Further we have said that wisely used guidance psychologists are needed to perfect such clarifications. Unfortunately the role of the teacher in primary prevention in mental health is similarly clouded. The wise tutor of yore was undoubtedly the counsel inducting his charge into life. Quantity, technology, partitioning, and ensuing role conflicts fairly successfully rob the school, particularly the school beyond elementary grades, of direct attention upon the most precious element of each of us, our selves. Guidance psychology continuously readdresses the public mind to its responsibilities in this respect. This element quickly fades in the modern school without the guidance counselor. *We hold that this is America's first line of defense against mental illness.* The strong ego, the elaborated self, the accepted self, the responsible self, the confident self is the prime buttress of mental health in times of stress. Every school and college system needs professionals trained to provide such guidance services.

These professionals must define their functions in relation to those of the teacher so that teaching does not suffer from lack of clarity in this aspect of the program of education either. Intelligent, competent, skilled people are needed, and in much larger number, too.

Footnote 4–2: Miss Mary Switzer, Director, Office of Vocational Rehabilitation, United States Department of Health, Education, and Welfare, comments:

One cannot overlook the impact of our research projects in psychiatric rehabilitation, the increased opportunities for short-term in-service training for counselors working with the mentally ill, and the long-term counselor training programs at the graduate level which has greatly eased the recruitment of qualified personnel. All of this resulted from the 1954 Amendments of the Vocational Rehabilitation Act.

The problems mentioned were inevitable in the early years of the program. One of the greatest problems has been that of integrating the services of the vocational counselor with the traditional hospital team. One might say that in the beginning, through a lack of understanding of professional roles, each was suspicious of the other and channels of communication were poor or nonexistent. Recognizing this the Office of Vocational Rehabilitation in 1955 initiated a series of regional workshops which brought together vocational rehabilitation, hospital, and mental health personnel at the State level and provided an opportunity for frank discussion of problems and professional roles. As a result we find that in most hospitals a mutual respect has been developed and the fact is that we now find the hospitals asking for this service.

Many of the research projects in this field which are supported in part by this Office have been conceived at these workshops. The projects have undoubtedly had an upgrading effect on hospital treatment programs as well as increasing spectacularly the numbers of those rehabilitated. To name a few, in Oregon a project in which four State agencies participated, the Oregon State Hospital, the Oregon State Board of Health, the Oregon Public Welfare Commission, and Division of Vocational Rehabilitation, resulted in better treatment and rehabilitation planning both within and outside the hospital. The changes made in hospital management for the project proved so desirable that they are now an integral part of the hospital program. At the Vermont State Hospital the staff for the project was absorbed by the hospital when the project ended. In Arkansas and West Virginia the State vocational rehabilitation agencies operate vocational rehabilitation facilities on the hospital grounds, thus providing a variety of services hitherto unavailable.

Footnote 6–1: The Presidential Prizes program might operate approximately as follows:

1. All colleges, governmental agencies, and industries engaged in research and scientific education early in the year would be asked to submit scientist nominees to the governing board. Only scientific contributions made before the age of forty would be recognized.

2. An awards committee of senior scientists would screen the nominations according to established requirements. The governing board would publish a list of accepted candidates.

3. The committee men would then vote for those deemed most meritorious. The board would publicize the five scientists receiving the highest numbers of votes in the given category, but withhold the tally.

4. In the fall, the names of the top five candidates together with a factual report of each one's contribution and personal sketch would be made available to junior high schools desiring to participate. Science teachers would be asked to discuss the candidates' contributions and careers in a series of class periods, conduct a student straw vote, themselves vote, and forward the tally for all candidates to the governing board.

5. The board would tabulate the student and teacher votes, review the awards committee vote, and itself vote for the young scientist of the year. The result, together with the information on contributions and career, would then be publicized.

6. The board then would canvass the five leading candidates and, on the basis of their information and its own judgment, determine the teacher most deserving of recognition for inspiration of the scientist in his choice of career. The outstanding science teacher would then be announced.

7. As already indicated, the event would culminate with the President honoring the winners in a year-end ceremony reported to the nation through the press, radio, and television.

Such a program would be *an experiment in improving human values.* The proposal provides for participation at every level of interest—the educator, the scientist, the science teacher, the science student, the financial sponsor, the President, the general public, and its media of communications. It should bring the humane sciences and science education a larger share of public attention and favor.

The more general object is to create active public interest and a sense of participation in the affairs of science and education as they relate to mental health. One would hope that the awakened interest might lead school boards and State departments of education to improve their science teaching programs. At least, the event could be an implement in that direction.

The President's Prizes program probably could be conducted for $500,000

a year or less, the exact budget depending on the size of the prizes and how much aid might be obtained from sponsoring institutions and cooperating agencies.

Footnote 6–2: The following is a summary of the Bane Report recommendations on medical education:

SUPPORT OF STUDENTS:

1. Aggressive action should be initiated by foundations, individuals, industry, and voluntary agencies to obtain additional private support of medical students, including both low-cost loans and scholarships for persons who otherwise would be unable to finance a medical education.

2. States not already having such programs should make educational loans and grants or scholarships to selected medical students, in such amount and according to such criteria as each State may provide.

3. The Federal government should establish educational grants-in-aid for medical students on the basis of merit and need, similar in value and proportionate in number to grants now made to graduate students in other fields of specialization. These educational grants should be available to students so that they could attend a medical school any place in the United States.

4. The Office of Education in administering its program of student loans under the National Defense Education Act should give special consideration to the needs of institutions having medical schools, in order that medical students may receive loans in proportion to their urgent needs for assistance. Medical schools should make special efforts to participate in this program (pp. 58–59).

THE MEDICAL SCHOOL:

1. Public agencies as well as private individuals and organizations interested in increasing the nation's supply of physicians should see that such increases are made in a manner which protects the quality of medical education.

2. New medical schools should be established only with the type of faculty, facilities (including the teaching hospitals), financing, and university affiliation that will allow them to carry out a satisfactory educational program for a well-qualified student body.

3. Schools providing education in the basic medical sciences should meet the same educational standards as 4-year medical schools, and give special attention to problems of coordinating the program for the first two years with subsequent clinical training opportunities.

4. Greater attention must be given to the problems of existing schools whose educational plants or programs are now inadequately financed.

5. Schools should consider the effect of unreasonably restrictive admission policies on the quality of their students and the need for a student body with diversified interests and background (pp. 60–61).

FINANCING MEDICAL EDUCATION:

1. *Basic operating expenses.* There should be more generous public and private support for the basic operations of medical schools. This support must come from many sources, including State and local appropriations, endowments, gifts and grants, universities, and reimbursement for patient care.

2. *Research.* Research grants to medical schools should cover full indirect costs, so that medical schools are properly reimbursed for the contribution of medical education to medical research. The Consultants strongly concur with the Secretary's Consultants on Medical Research and Education (the Bayne-Jones group) in endorsing the need for institutional grants.

3. *Construction.* The Federal government over a period of the next 10 years should appropriate funds on a matching basis to meet construction needs for medical education, which include: expanding and improving existing schools, construction of new schools of basic medical sciences, construction of new 4-year medical schools, and construction of the necessary teaching hospitals.

Programs for the construction of teaching, research, and clinical facilities should operate within a common administrative framework in order to ensure proper balance in the planning and construction of facilities, uniformity of administrative methodology and practice, and program coordination (pp. 63–64).

PLANNING:

1. Existing medical schools should make every effort to increase enrollment, consistent with the maintenance of good educational programs.

2. States that are now without a planning group on higher education should develop such a group, with planning for medical education as a function, or with separate subgroups for medical education. The planning group should include representation from existing public and private schools. It should explore the expansion of existing schools, the possible establishment of 2-year as well as of 4-year schools, and the development of agreements for placement of the third- and fourth-year students from 2-year programs.

3. In carrying out the planning function, States should be encouraged to develop interstate cooperation. For the smaller States, with limited clinical facilities and small tax bases, there are substantial advantages in developing regional rather than State medical schools.

4. When Federal funds become available to aid medical education, a National Committee should be established to advise the Surgeon General on the administration of such funds. The work of the group should be closely coordinated with that of the National Advisory Council on Health Research Facilities and the Federal Hospital Council which are concerned with administering Federal grants for research facilities and hospital construction (pp. 64–65).

RELATED HEALTH PROFESSIONS:

1. The Surgeon General should establish a consultant group or groups to study the educational needs in the health professions related to medicine.

2. National, State and local professional and civic organizations should develop and conduct active programs for recruitment of qualified candidates for medicine and for all other careers in health services (p. 66).

Footnote 6–3: The Joint Commission, in its planning stages, made a list of study projects that could be fruitfully undertaken by the Mental Health Study as a part of its research design. Within the time and money at its disposal, more urgent or feasible projects were selected. Some, equally urgent, were not attempted. Among them:

Role of the family in mental health.
Mental health problems of aging.
Care of mentally ill children.
Mental health in industry.
Relation of military service to mental health.
Mental health and leisure-time activities.
Juvenile delinquency.
Alcoholism.
Crime.

Also on our list was a study of the law and mental health, a project undertaken by the American Bar Association but not available at this writing.

A study of the mentally retarded was undertaken by the National Association for Retarded Children and resulted in a volume titled *Mental Subnormality: Biological, Psychological, and Cultural Factors* (Richard L. Masland, Seymour B. Sarason, and Thomas Gladwin, Basic Books, 1958).

We contemplated a study of the effects of mass media on mental health but did not attempt it. The Institute of Communications Research, University of Illinois, has completed *The Development and Change of Popular Conceptions of Mental Health Phenomena* (Nunnally and Osgood, 1960), the first definitive study to be published in this field.

We likewise entertained the possibility of an exhaustive study of voluntary mental health organizations. The present final report provides a brief interpretive review of the mental health movement, and further information is supplied by *Mental Health Education: a Critique* (1960), the report of the National Assembly on Mental Health Education.

Appendix VI

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Appendix VII

Dissents

Francis J. Braceland, M.D.:

It is a wonderful, broad, warm, human document. It accomplishes what we were commissioned to do. Several of the points that troubled me have now been corrected.

The only thing that still concerns me a bit is our advice to the government on the tax structure. While I realize that every citizen has the right to make his opinions known, I really do not know enough to advise the government how to tax people or how to withhold taxes from others. As I read this carefully, however, I see that it simply represents an effort to get more bright kids through college; kids who are poor and who otherwise could not get through college. In other words, it advises the government that our first interest is in people and that people are our greatest resource. . . .

Had I been writing the report, I do not think I would have been quite as positive about some things. One gets the feeling in spots of a slight air of belligerence, but I know it was not intended. Besides, I guess my efforts would be designated as pusillanimous, and I guess one is as bad as the other.

Miss Loula Dunn:

Essentially I am in full agreement with [the report], except for one recommendation. On page 268 of the report, it is recommended that all existing State hospitals of more than 1000 beds be converted into centers for the long-term and combined care of chronic diseases, including mental health. I cannot agree with this recommendation since I believe that all of the reasons which contraindicate the care of patients in large mental hospitals apply equally to the care of patients with other chronic diseases.

Authorities in planning for the chronically ill have long pointed out that the institution which cares for the long-term chronically ill patient not only must provide essential medical care and related services but also must be

a home for such patients, often for the remainder of their lives. I cannot conceive of an institution with more than 1000 beds—sometimes many more than that—developing a home-like atmosphere. A second problem arising from the use of present state institutions of that size is that many of them are located at a considerable distance from urban areas which may be considered medical centers. Hence the source of medical personnel, including the many part-time specialists and consultants who may be needed for the care of such patients, is not readily available. Furthermore, the families of the patients in these institutions are handicapped by this distance in seeing them with frequency.

The Commission on Chronic Illness, which studied this entire problem very carefully during a seven-year period, has pointed out that nothing is to be gained by perpetuating the concept of the independent chronic disease hospital. If the Joint Commission's recommendation, therefore, is based on this approach, I would call your attention to the statement of the Commission on Chronic Illness that the independent chronic disease hospital will best serve itself and its patients by associating itself physically and administratively with the general hospital to the extent that it becomes a part of the general hospital (*Care of the Long-Term Patient, Chronic Illness in the United States,* Volume II, 1956).

I recognize that this recommendation is proposed as a solution to the problem of the tremendous state mental institutions which have developed. It would also be a solution to the need for beds for other types of long-term chronically ill patients. In my opinion, however, it is not a good solution.

Harvey J. Tompkins, M.D.:

I would like to be listed as approving the report with the following reservations . . .

(1) While it is agreed that the required total approach to meeting the needs of the mentally ill necessitates massive support, particularly monetary, the report, in my opinion, does not carry sufficient encouragement leading to a greater degree of nongovernmental community responsibility.

(2) I continue to believe any recommendations in regard to tax structure are not appropriate in this report; this would appear to be in the area of competence of others who are in a better position to equate specific requirements with overall demands on the country's economy and manpower resources.

(3) That the comments regarding psychiatric hospitals be considered as ultimate objectives with recognition of the need for a transitional phase including the opportunities for further investigative work on the particular aspects of the recommended changes.

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The Joint Commission on Mental Illness and Health is a multi-disciplinary organization representing thirty-six national agencies concerned with mental health and welfare. *Action for Mental Health,* the final report of the Commission following its five-year study of the mental health of the nation, is being presented—under the terms of its charter—to the United States Congress, the Surgeon General, and the governors of the fifty states.

THREE AUTHORITATIVE COMMENTS

"The recommendations (in *Action for Mental Health*) point up the realism of the whole report, in which spades are called spades, and there is no hedging on any significant issues, no matter how they cut across or run counter to entrenched attitudes and vested interests."

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