

THE COMMUNITY - THE NEW MENTAL HEALTH FRONTIER

SPEECH AT

THE BULLETIN CIVIC SERVICE COMMITTEE WORKSHOP ON MENTAL HEALTH

10:00 A.M., Monday, October 15, 1956

Hotel Drake, Philadelphia

by

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Governor Leader, Secretary Shapiro, Workshop delegates:

The fact that we are assembled here this morning to talk about community action in the field of mental health is dramatic evidence of the tremendous progress we have made over the past decade.

[In 1945, when I started touring the state mental hospitals of this country as a newspaper reporter, the major job was bringing an awareness of the deplorable conditions in these hospitals to the attention of the average citizen. There was a tremendous wall between the state mental hospital system and the citizens in the community, and our early efforts were dedicated to removing this wall and convincing the people that these hospitalized patients were deserving of their deep and abiding consideration.]

As you well know here in Pennsylvania, mental patients in state hospitals are no longer considered beyond the pale of the concern of the citizens of this democracy. Major credit for this great awakening must go to the press and to the Governors of the 48 States. You in Pennsylvania have reason to be

very proud of your Governor, your Secretary of Welfare, your legislature and your newspapers for the job they have done over the past few years in bringing home to the public the need for a dynamic program to convert these mental hospitals from tenements of despair to modern therapeutic facilities.

[From the time of the establishment of the first state mental hospital in Williamsburg, Virginia in 1773 up until very recently, we were still living in what I have often referred to as "The Age of Banishment". This age is coming rapidly to a close and I think it is fair to state that we are on the threshold of a great new era - the treatment of mental illness in the heart of the community. As we have over the past several decades built a magnificent hospital and medical care system for the treatment of physical ills within the confines of our community, so shall we in the next several decades do the same for mental illness.]

It is right and fitting that the community become the focal point for modern psychiatric treatment. Dr. Franklin Ebaugh, who in 1925 journeyed from the hub of the universe - Philadelphia, of course - to the wilds of Colorado to set up an intensive psychiatric hospital unit in the heart of the city of Denver, has been pointing out for thirty years that our state mental hospitals are monuments to the failure of our communities "to create the necessary conditions for the full, healthy adjustment of individual minds".

In "The Community Stake in the Mental Health Program", a brilliant address before the 1955 convention of the American Psychiatric Association, Dr. Jack Ewalt, who trained under Ebaugh, argued that the citizens of a community are directly responsible for the success or failure of any program designed to "develop a population with character strong enough and resilient enough to adjust to the demands of their particular environment".

"Behavior is a person's solution to the problem of living at that moment in the community," Dr. Ewalt told his colleagues. "Adaptation will be more constructive and will improve as the individuals within the community become more mature, and more understanding of human needs...Thus, persons living in a healthy community will tend to work out their problems in a healthy way."

Since this is a forum dedicated to the promotion of community action in mental health, I want to talk to you this morning about some specific community resources which must be tapped in establishing a sound foundation for the community treatment of mental disorders:

1. THE GENERAL PRACTITIONER

The general practitioner is the first line of defense in the community against the initial onset of mental illness. However, up until very recently he has isolated himself from psychiatry, and psychiatry has isolated itself from him. Most of the family physicians practicing today have had little or no training in psychiatry, since medical schools ignored the naughty subject in their curricula. Because the mental hospital system was out in the woods and isolated from the main stream of American medicine, the family physician felt no responsibility for the care of mental patients. As a matter of fact, he frequently refused to visit a distant mental hospital to treat patients.

With the advent of the new tranquilizing drugs, the situation has changed dramatically. The family physician today is probably prescribing more medication for disturbed individuals than is the psychiatrist.

This is a natural development. Dr. Francis Braceland, President of the American Psychiatric Association, pointed out recently that "the key

preventive agent in the entire mental effort may well be the physician in community practice, for the physician in general practice sees every segment of the population, every age group, and persons at all economic and social levels... In his care of expectant mothers, in his obstetric work, in his care of babies and children, he may accomplish preventive psychiatry of heroic proportions".

Echoing the Braceland theme, Drs. Fred W. Langner and Robert L. Garrard of North Carolina gave it added emphasis in a paper delivered earlier this year before the Tri-State Medical Society.

"Psychiatry offers many useful tools with which to ameliorate this situation, but it lacks the manpower to implement them adequately," they contended. "... The general practitioner enjoys several strategic opportunities not shared by the psychiatrist. First, because of his closeness and position of confidence with the families in his community, he is accepted as liaison officer between medicine and the community... Second, in the treatment of emotional disorders he maintains a position of advantage over the psychiatrist in two significant areas: he is more intimately acquainted with the patient's total environment and he sees the patient earlier in the development of the illness. The general practitioner has another great advantage in working with emotional illness in that he is more apt to talk the language of the patient and relatives. He usually knows the entire family and is able to ease anxiety and tension in other members who are threatened."

The North Carolina doctors concluded with a plea for increased use of this great medical reservoir:

"... Psychiatry is moving out of the mental hospitals and into the community, and the general practitioner will practice more and more psychiatry. The most powerful and frequently used drug in general practice is the doctor himself. None of the miracle drugs can hope to prove more powerful than the inter-personal relationship between the doctor and the patient. This still remains the greatest single tool of psychiatry and one which is available to every physician. The wise family doctor knew this to be true before the word psychiatry was devised."

This raises several serious problems. First of all, the general practitioner must receive some post-graduate training in the handling of emotional illnesses. He must know much more about the diagnosis of the various mental illnesses, and he must learn the difficult art of proper referral to a psychiatrist.

The professional organizations in this country have been slow to appreciate the gravity of this situation. Although the American Medical Association established a Council on Mental Health four years ago, it has done little or nothing about this problem. And this despite the fact that it has been offered a superb blueprint for a national campaign to educate the general practitioner in the specialty of psychiatry.

This imaginative blueprint calls upon the American Medical Association to draw up a platform of activity to bring every state and local medical society into the fight against mental illness. Activities would include the following:

1. A proclamation from the President of the American Medical Association calling upon all affiliated state and local medical societies to tackle the mental illness problem.

2. State-wide meetings between state medical societies and state mental health authorities to:

- a. Establish mutual interest and contact between these two hitherto separated branches of medicine.
- b. To discuss the role of the general physician in using all means at his disposal to keep the patient out of the state mental hospital.
- c. To keep the family physician completely informed on the progress of any of his patients admitted to state mental hospitals or other state facilities.
- d. To work out standard procedures for the follow-up of discharged mental patients, particularly those on maintenance dosages of the tranquilizing drugs.

3. A call to every state and local medical society to arrange mental illness seminars, and to bring outstanding psychiatrists to talk to the general physicians on the newer treatments now in use.

4. A call to all state and local medical societies to emphasize mental illness at their annual meetings and Postgraduate Institutes.

5. The use of educational films, closed circuit television, exhibits and special publications to bring the busy physician the latest developments in psychiatric treatment.

While this blueprint for action has been gathering dust in the catacombs of the American Medical Association, the American Psychiatric Association and the American Academy of General Practice, the latter representing more than 20,000 family physicians, both acted at their 1956 conventions to set up committees to work together on this problem. Many of us in the field are hoping

that the American Academy of General Practice, a dynamic professional organization dedicated to expanded professional training for the family physician, will move into the current vacuum and get things rolling.

On a number of occasions I have urged the American Medical Association to heed the wise words of Dr. Elmer Hess of Erie, who in 1955 told his fellow members of the American Medical Association that their number one medical problem from now on in was, and would be, mental illness. Dr. Hess proposed a 5-point program for increased participation by all physicians in the care of the mentally ill, which, because of its importance, I list here:

1. Physicians should take an increasingly active part in the development of more psychiatric units in general hospitals.

2. Physicians should give one day a week to work in state or County hospitals near their home.

3. Young physicians should be retained on a part time basis as attending staff physicians in mental hospitals.

4. Residency training programs for non-psychiatric residents should be developed in state mental hospitals. This will recruit the other medical disciplines into mental hospital work. St. Elizabeths in Washington, and a number of mental hospitals in Illinois and Massachusetts, have already developed programs of this nature.

5. State and county medical societies should establish psychiatric consultation services for their general physician members. These services would be provided by the psychiatrists who are members of the societies. This type of consultative service would be particularly valuable in the administration of the new drugs on an out-patient basis.

The education of the general practitioner in the handling of mental illness is also a responsibility of the Commonwealth of Pennsylvania. It is in the long-run interest of Pennsylvania to educate its family physicians so that they may prevent the hospitalization of thousands of patients. Since the shortage of psychiatrists and allied personnel will be with us for at least another twenty years, it is absolutely vital that the other segments of the medical profession be educated in handling mental illness. I think the Commissioner of Mental Health of Pennsylvania has a definite responsibility to plan a series of institutes for the training of the family physician in the handling of psychiatric problems.

These Institutes should be planned in consultation with state and local medical, psychiatric and general practice societies, and should preferably be held at the local mental hospital or medical school. The New York and Illinois departments of mental health have embarked on programs along these lines, and it is my understanding that a few additional states have recently joined the band-wagon.

2. THE PSYCHIATRIC UNIT IN THE GENERAL HOSPITAL

Although mental patients occupy more than half of all hospital beds in this country, general hospitals accommodate less than one percent of the mentally ill. Is it not a shocking thing that 950 large general hospitals in this country do not have a single psychiatric bed? We know this is a hold-over from the Age of Banishment, but the time has come to place psychiatric illness alongside other comparable illnesses in the medical programs of our general hospitals.

The benefits of this type of program are many. Most important, it tears the stigma away from mental illness. When there is routine voluntary admission to a hospital for this illness, then much of the old legal voodoo goes by the wayside. Furthermore, the family of the patient is close to him and the patient doesn't feel as though he had been banished into the woods for some evil thing he has done.

Of almost equal importance is the effect such psychiatric units have upon the medical profession. For decades and decades, interns, residents and consulting physicians never saw a mental patient. Whenever psychiatric units have been introduced into general hospitals, there has been an increased awareness on the part of the general medical staff of the importance of emotional factors in all types of illness.

As the psychiatric unit in the general hospital becomes more common, it is increasingly being covered by health insurance. Remarkable progress has been made during the past five years in health insurance coverage in acute mental illness, and efforts must continue to reduce the enormous economic burden of such an illness.

3. COMMUNITY TREATMENT FACILITIES FOR CHILDREN

A number of recent surveys have highlighted our failure to treat emotionally disturbed children in the early stages of mental illness. There are only 30 residential treatment centers in the country which are altogether capable of handling about 2,000 children a year. These centers have ten times as many applicants as they are able to handle; a recent study by the Child Welfare League of America put the number of emotionally disturbed children in this country at about 500,000 children.

Over the past several years, a few states and cities have completed surveys on emotionally disturbed children. The conclusions of these surveys are remarkably similar. They all conclude that the greatest difficulty is locating these sick children. They are buffeted about from jail to court to training school to mental hospital.

Our school systems do a very poor job with these disturbed children. According to a 3-year survey conducted under the auspices of the Columbia University Department of Psychiatry, a minimum of ten percent of public school children are emotionally disturbed and need psychiatric help. But the majority of school systems lack the trained personnel or facilities to aid these children. For example, the Columbia survey pointed out that in our nation's schools there is one psychiatrist for every 50,000 children.

Here is a great challenge for all of you in the community. I commend particularly to the parents of the community two great challenges which can keep you busy for the next decade - the establishment of community residential treatment centers for children and the creation of well staffed psychiatric services in the schools.

4. MORE FLEXIBLE FACILITIES FOR PSYCHIATRIC TREATMENT

As I told the Community Mental Health Boards of New York State earlier this year, we are freighted down with an excess baggage of outmoded concepts concerning the time and place for psychiatric treatment. In America, we have been uneasy about mental illness and we have been criticized by many leaders of world psychiatry for excessive emphasis upon restraint, locked doors and long-time confinement.

Europe has much to teach us in the relaxed handling of mental patients. All of you know of Gheel, Belgium where mental patients have been handled in the homes of the community for many centuries. In recent years, England has shown the way in tearing down the barriers which separate the mental hospital from the community.

Our northern neighbor, Canada, has pioneered in the development of day and night hospitals which keep the patient in close contact with the family and with the community. In the day hospital the patient receives active treatment during the day, but returns to the strength and warmth of his family and his community each night. Thus there is no breaking of the ties between the patient and the outside world. We have only begun using the day hospital in this country recently. Boston Psychopathic Hospital has had one for several years and there are two now getting under way in the New York State mental hospital system.

The night hospital is an even more important therapeutic development. In this facility, the patient goes to work during the day and returns to the hospital at night for necessary treatment. I saw one in operation recently in Montreal, and I cannot convey to you how much this facility meant to the patients being treated there. They had avoided the stigma of legal commitment and they were continuing their important daily activities while receiving the basic treatment they needed. We have only a couple of these night hospitals in this country and they do not begin to approximate the Canadian hospitals.

Finally, the Mental Health Center concept has been gaining increasing acceptance everywhere but in the United States.

These Centers have been remarkably successful in Canada where they are called Well-Being Clinics. Experience gained in development of community health programs in Canada revealed a desire on the part of many of the public for an opportunity to obtain a routine check-up for their mental health similar to the opportunity provided in the field of public health for physical check-ups. All those registered for Well-Being clinics receive a periodic mental health check-up. A rating scale covering the more important areas of personal and social adjustment is used. If the person presenting himself for a check-up is found to have serious emotional problems, he is referred to a psychiatric resource for further aid and treatment.

This mental health center development has enormous possibilities. There is only one functioning in this country today. It was started a year ago in Lafayette, Louisiana on a pattern laid down by the American Psychiatric Association.

5. REHABILITATION

As your own Dr. Kenneth Appel has pointed out time and time again, the community is doing an exceedingly poor job with the discharged mental patient. Although the state mental hospitals discharge approximately 250,000 patients each year, only a small fraction of these are rehabilitated and returned to productive employment. The U.S. Office of Vocational Rehabilitation recently released figures through June 30, 1956 indicating that only about 3,000 of the approximately 66,000 persons rehabilitated during the previous year were mentally handicapped.

The average mental patient discharged from a state hospital returns to a community which is almost totally indifferent to his needs. We have a

few token efforts like Fountain House in New York City but, for the most part, we have failed to provide the community facilities needed to bolster these discharged patients. Other countries have developed Half-Way Houses and Residential Sheltered Workshops for these patients, but in America we have not even begun the construction of major facilities of this type. No wonder we have such a high rate of relapse and return to mental hospitals; considering the total indifference of the community, it is really surprising that the relapse and return rate isn't much higher.

All of the resources cited above must be strengthened if we are to return psychiatry to the community. In a recent speech Dr. Daniel Blain, Medical Director of the American Psychiatric Association, stressed the importance of these resources in the following words which I commend to all of you:

"Most of these efforts are in the direction of reaching toward the onset of the illness, to get nearer home, to utilize the resources of the community, to stimulate social forces, the motivating elements, and apply them to the use of the healing process. We would hope that residential units would be less and less necessary. That earlier community effort would care for more and more and actively prevent hospitalization. That days spent in hospitals would be reduced. We can do this now for all categories except the aged. Even with the aged we can delay and defer the time for entering an institution, just as we have so successfully deferred, but never prevented, death. The hospital must and is already receding as the only locus of psychiatric treatment. It is gradually merging with other forces actively at work in dealing with disease.

"The hospital, however, cannot relinquish its paramount position until community clinics, mental health centers, home care and follow-up, screening and referral centers, more private practitioners, families and schools, social conditions and all the other assets of a community are developed."

It is gratifying to note that the states are on the march in the provision of tremendously expanded community mental health services. In a survey completed in November, 1955, the Council of State Governments reported that many states had doubled, and in some cases tripled, their appropriations for community mental health services. As all of you probably know, New York has led the way with a new community mental health services program which is currently budgeted at approximately \$13,000,000. Under the New York program, the state offers matching monies to local communities which agree to expand their psychiatric services in schools, the courts, general hospitals, etc. Ohio, Illinois, Indiana, North Carolina, and Washington are among the states which have inaugurated greatly expanded community mental health services.

I am pleased to note that you are on the move here in Pennsylvania, too. You have unified your mental hospital system and you are now ready to move on a state-wide scale. The action of the Pennsylvania legislature in appropriating more than one million dollars for psychiatric clinics for children and more than \$4,000,000 in state aid for clinics and treatment centers in general hospitals promises much for the support of community mental health services in Pennsylvania.

You have a great deal to be proud of here in Philadelphia. Your Department of Public Health has a Division of Mental Health headed by a full-time psychiatrist. As far as I have been able to ascertain, Dr. Maurice Linden,

the superb psychiatrist who heads the Division of Mental Health here, has the only job of its kind in any major American city. In his job function is wrapped up much of the future of American psychiatry, for his unique and basic task is the creation of community mental health services at the local level. During the next decade, I am sure that many large cities will emulate Philadelphia in creating a division for the support of psychiatric services in the local community.

There is one final thought I would like to leave with you. Many of these community mental health services look very good in the blueprint stage but they become effective only when you, the citizens, participate in them and give them your full support. No community psychiatric unit, whether it be in a general hospital or in a school, can be really effective unless it is constantly challenged by an enlightened citizenry. In the final analysis, you will decide the services you want for yourselves and your children, and you are in no position to criticize the professional groups for not providing these services. This forum here this morning is eloquent affirmation of your deep interest in a better day for the mentally ill, and it augurs well for the future of community mental health services in both Philadelphia and the rest of Pennsylvania.