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The Mental Health Movement, 1949–1979

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HISTORIANS OF THE FUTURE may mark the year 1978–1979 as the end of three decades of social experimentation that they may choose to call a reasonably peaceful revolution. A rich and prosperous country believed, or many of us did, that we could rehabilitate our enemies of World War II, placate our allies with money, and control the Soviets with threats and superiority of production. The health professionals and institutions, as is proper and inevitable, moved with the cultural tide.

For those of us in the mental health professions, they were heady times. Investigations by science writers, such as Al Deutsch (1939) and Mike Gorman (1948; 1956), focused public and political attention on the ubiquitous nature of mental disorder and of mental distress, and on the regrettable tendency to reject and neglect affected patients. Official recognition resulted in the formation of the National Institute of Mental Health (NIMH), reorganization of many state programs for detention, and treatment of the mentally ill. The National Governors Conference, as well as their component

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regions, focused attention on the mental health problems of their citizens.

As the programs broadened to include more types of patients, larger numbers of staff with additional kinds of training were required to care for them. Congress, state and local governments, and concerned citizens were surprised and anguished by this unexpected development and the costs and other problems that resulted. Neither manpower nor money was available to cope. Support of undergraduate and graduate teaching for mental health professionals (psychiatrists, clinical psychologists, social workers, and psychiatric nurses) offered substantial help, and averted disaster, but failed to grow rapidly enough to fully staff the service, teaching, and research needs of the concerned institutions.

The mid-fifties spawned additions to the concept of what was perceived as a mental health problem. Since training and recruiting enough professionals seemed impossible, programs were broadened to include paraprofessionals whose skills were to be focused on specific aspects of the treatment and rehabilitation of mentally ill persons. These groups began to reject the term "paraprofessionals" and now prefer to be called "new professionals," whether or not they possess the required educational equipment.

Development of the psychoactive drugs stimulated more attention to biological causes and pharmacological facets of treatment of mental disorders. The effectiveness of the medications in controlling behavior, hallucinations, and delusions made institutional care unnecessary for many patients. The increased focus on the somatic aspects of behavior proved a threat to well-meaning social scientists, some psychiatrists, and many of the new paraprofessionals. Forgetting (or being ignorant of) the teachings of Adolf Meyer that psyche and soma are mutually interdependent in explaining behavior, either adaptive or decompensating, they coined the term "medical model," of varying and always imprecise definition but invariably pejorative as used.

Leaders in health matters in the House of Representatives (especially John Fogarty), the Senate (especially Lister Hill), and in the National Governors Conference perceived the need for a study of requirements and a plan of action for the coming decade. Kenneth Appel of the American Psychiatric Association and various members of both sides (with strong support from Dan Blain, then medical director of the American Psychiatric Association, Charles

Schlaifer of the National Association of Mental Health, and Robert Felix, then director of the National Institute of Mental Health) formed the Joint Commission on Mental Illness and Health (1961), which published *Action for Mental Health.* Each of a group of important national bodies of broad interests (see list in *Action for Mental Health*) nominated a representative to serve on the policy-making body of the study ("The Commission") and to keep their respective memberships informed of plans, progress, and recommendations as they developed. This concept assured a broad, influential, and informed public who could influence the directions of the study, the evolving plans, and the implementation of the recommendations. For details of the origin of the Joint Commission, see Ewalt (1977).

There were a number of recommendations whose central theme was that the collective human minds of our people are the greatest national resource, and that we should nurture its development and treat and rehabilitate it when decompensated.

The portions that captured the interest of President Kennedy were those concerning the development of community mental health centers (CMHCs), so that persons could have the kind and amounts of treatment they needed near their homes. No longer would their symptoms or complaints need to fit specific requirements to qualify them for service in the health care facilities of their community. Rather, the community service would be adapted to the needs of the citizens. Related to this were recommendations about the future size and use of state hospitals, the broadening of the responsibilities of the nonphysician members of the mental health professions, and more emphasis on basic research and education. The most obvious result of these recommendations was the Community Mental Health Centers Act, sponsored and supported by President Kennedy and under the congressional leadership of Senator Hill and Congressman Fogarty. I believe that a major part of the credit for the adoption of this program must go to the commission members and the support they generated among the members of their large and influential organizations.

Congress quickly adopted the concept of community centers for mental health problems. Many hundred citizens from all walks of life participated in planning for services perceived as needed in their community. The members of Congress who wholeheartedly supported the concept, the planning, and the creation of CMHCs were reluctant to support operations. Traditionally, the provision of

One group is a modification of traditional psychiatric hospitals, including those operated by private or government agencies. Most of this group care for all forms of severely psychotic and behavior-decompensating persons both inpatient and ambulatory, including patients suffering alcohol and other substance abuses, psychogeriatric patients, and those developmentally slowed. Most of these services offer some family and school outreach program for relief of stress, plus education and facilitation of rehabilitation measures. Many such centers also offer substantial educational opportunities to students and recent graduates in the several mental health professional and paraprofessional groups. These centers often have medical leadership or substantial involvement of psychiatrists as well as other professionals in their planning and execution of programs for prevention, treatment, and rehabilitation. The quality of research varies from excellent to mediocre, even as the scale and subject of observations may vary from molecular finitude to larger units of families, hospital wards, or the international scene.

A second configuration is an independent facility, under a variety of sponsorships, developed and expanded from child guidance clinics (called by many names) or social service agencies (also called by many names). Some of these CMHCs started de novo but with bloodlines to one or both of the above program models. In these agencies, the emphasis is on the sociocultural factors, milieu manipulation, psychotherapy, and a variety of group therapies, including in some rare instances techniques that border on religious (cult?) exercises. Acute alcoholic, schizophrenic, manic-depressive and depressive, and organic patients when accepted are referred to their inpatient unit, if they have one, or to an adjacent one where arrangements have been made for severe crisis intervention. Such patients may or may not be accepted for follow-up care when they can be managed by the staff and facilities of that particular center. Centers of this configuration have decreasing input from psychiatry (often on a part-time or consultation basis) and the major therapeutic and educational efforts are by social workers, psychologists, and members of some of the "new" professional groups. The nature of the staff and the organization both directly and indirectly influence the emphasis and priorities of the program, so that more attention can be given to the troubled and inept and less to those with more disruptive forms of problems. Many more school problems, marital problems, and other problems of living will be

dealt with here, and fewer unkempt schizophrenics. Both types of centers are needed. For the future, we should urge greater broadening of the resources of both groups, irrespective of their current concept of priorities. Priorities make little sense when people are hurting.

A third configuration may be called an assembled or multisited center. In this pattern several agencies agree to collaboration, free referral of cases, interchange of staff, and other patterns for use of several existing community resources, to offer a complete spectrum of mental health services. Although complex to administrate and a bit cumbersome to operate, the system has the advantage of utilizing community resources, and avoids the risk of unnecessary duplication of scarce and expensive services. In some cases a cooperating agency may offer only one service (for example, a sheltered workshop, or a special program for education of the developmentally disadvantaged), while in others it may offer several of the necessary programs for a comprehensive mental health center.

Other workers in the field may think of different or additional ways a comprehensive program can be developed. The emphasis should be on quality and a comprehensive program for the patients in a particular community, and not on some professional turf, or on a particular narrow theory of the origins of the variety of human problems that need attention.

An important feature of planning, operating, and supporting a CMHC is provision for change. Society (especially in the United States) continually broadens the concept of what constitutes a mental health problem. Over the past hundred years, the sufferers from major psychoses and severe neurotic impairments have been linked as "mental health problems" with violators of law, the poor and discontented, victims of inadequate education or unemployment, and even with those of habits once considered "sins"—alcohol or drug abuse, and gambling. In my presidential address to the APA in 1964, I spoke of this trend and warned of our lack of sufficient knowledge of how to cope with many of the old as well as the new "mental health problems." I could with equal accuracy repeat that statement today, some fifteen years later. At the time we published *Action for Mental Health,* we stated that we did not know how to prevent aging, schizophrenia, manic-depression, or depression illness. We do not know today. We also said that early detection and treatment (secondary prevention) was often effective, and was one of the

reasons for opting for CMHCs. I see no reason based on substantial new knowledge to change that picture in 1979. It may be that support of the quality of life of our citizens may reduce the population of troubled, deprived, and dependent persons. At least we hope so. I do not believe that we need justify proper living, educational, and working conditions on the basis of preventing anything. It is enough to reduce by a fraction of one percent the occurrence of major health disasters or of human unhappiness.

And now a few words on that aging straw man, the "medical model." Its origins in social theory are unknown to me, but the originator was certainly ignorant of the practice of medicine, and perhaps of the multifocal basis of social theory. As used today, it seems to be a pejorative term to aid in criticizing some aspect of the health care system that a particular author finds objectionable. Some authors who use the term seem to equate it with the primitive concept of the bacterial cause (or specific cause) of disease. Used in this way it yields no information on how a bug and a person interact to determine whether exposure will result in improved resistance to the bug, in illness, or in no discernible change in the person (presumably the bug and his colleagues investing that person die). They display ignorance not only about infectious diseases, but also of the fact that a minority of serious illness is of microbiological origin (at least by current knowledge). And I believe the "purest" social theorist would agree that human behavior, individually and collectively, has causes, complex though they be. Which reminds us of the teachings of Southard, Meyer, Cobb, and later leaders in psychiatry.

Other authors equate the medical model with a pyramidal structure of authority in health care agencies. This concept historically has more validity, but no relevance in current health care delivery. Multiprofessional, nonprofessional, consumer, and legislative bodies all play their role. In fact, part of the inflation in health care costs is due to the multidimensional and multilevel programs for determining policy in the health care systems, and the costs engendered by record keeping, data gathering, and inspections.

Proposition 13 in California (and imitations in other states) promises to balance the budget by cutting services, rather than by controlling inflation and increasing production. These 1978 trends herald the end of our era of expansion in health and social programs. Whether the people will accept this, or whether the revolution of the

next decades will be less peaceful and produce fundamental changes in our system of government, is uncertain at this time (or at least not clear to me). The fact that our people are coming to a realization that "life, liberty, and the pursuit of happiness" applies to us all and not just to business, professional, criminal, and government workers suggests that the changes of the last thirty years are but the prelude. I hope I am around to see at least part of the show.

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