

MENTAL HEALTH IN THE UNITED STATES: AN APPRAISAL OF ADVANCES AND PROBLEMS

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BACKGROUND TO THE PRESENT SITUATION

As with all movements, the present situation with regard to the improved condition in the delivery of mental health services to the United States did not come about overnight. Without taking too much time to go too far back into historical antecedents, it should be mentioned that a Task Force was created by the United States Congress in 1955, and this Task Force on Mental Health and Mental Illness worked for five years, produced some ten reports, and climaxed its work by the publication of a book entitled *Action Against Mental Illness*. This book is now a valuable historical document. It was written by Jack Ewalt, M.D., and was circulated widely in the United States. It recommended many improvements in the care and treatment of the mentally ill in America. It pointed out carefully that barely 20% of the available knowledge of how to improve the treatment of the mentally ill was being utilized in the United States. It called for a broadening of the base of "psychotherapy," essentially suggesting that other disciplines, working under supervision, could carry out effective therapy with the emotionally disturbed. It recommended abolition of the large state mental hospital and suggested that future hospitals should not be built with more than 500 beds. It also carried out numerous suggestions for the training of manpower and for the recognition that mental illness was the number one health problem in the United States but received comparatively little state and federal government support in its prevention and treatment. It dwelt at length on the stigma of mental illness and called for a changed attitude on the part of the American public with regard to the mentally ill.

It is interesting after ten or so years to read the Joint Commission Report again. Students in my Seminar in Community Mental Health find the report exceedingly conservative and lacking in imagination. It is a fitting tribute to the advances that have taken place in the last ten years. *Action Against Mental Illness*, when it was published in 1960, was basically a radical document. In 1963, the late President Kennedy made history by bringing to the attention of the United States Congress the need for a federally supported program to deal with the many problems of mental illness. This was

followed by the Mental Health Facilities Act of 1963, and later on by a number of other pieces of legislation designed to bring about innovations in the care, treatment and prevention of mental illness. Perhaps the most prominent feature of President Kennedy's program was the transfer of the main emphasis on the treatment of the mentally ill from the state hospital situation to the community health approach. The reasons for de-emphasizing institutional care are and were many. First of all, it was recognized that there was a limit to the number of people who could be put into institutions, and that alternatives had to be found to institutional care. The effectiveness of various forms of drugs made it possible for psychotic individuals as well as those less disturbed to improve somewhat and certainly made their management easier within institutional settings. Virtually thousands of patients who had once been listed as "uncooperative" and severely disturbed were now more able to face reality and ready to return to communities if there were any facilities for them in the communities. Added to this factor was the increasing recognition that the emotionally disturbed person should be treated as close to home as possible and that the community in which he lived played an important part both in the cause of the illness and in its treatment. Studies by anthropologists and sociologists as well as psychologists have suggested, for example, that communities differ tremendously in how they go about helping the emotionally disturbed and how they deliver services to persons who need them.

In essence then the advent of the community mental health facilities movement meant the assuming of responsibility by the federal government in conjunction with the states. Although federal funds were not directly put into state mental hospitals and in some ways earmarked for community mental health centers, these funds nevertheless helped state hospitals in reducing patient populations. Also at the same time there was an outpouring of much money to be used in hospital improvement grants. These grants given to state hospitals allowed them to experiment with new ways of treating severely disturbed populations.

Originally federal money was given to states and communities based on a formula which, for example, would allow 90% of the money to come from federal sources and only 10% from state and local sources. This formula, however, had within it a decreasing ratio of state support so that after roughly five years almost the full share was to be borne by the community. It should be pointed out that a term entitled "catchment areas" was coined, and that roughly a catchment area was to serve a population of no more than one hundred to one hundred and fifty thousand population. A community mental health center within a catchment area was and is responsible

for five basic mental health services, namely, outpatient services, inpatient services, day hospital, emergency care, and education and consultation. As one would predict in these matters, communities all over the United States eagerly reached for the federal money while not quite prepared for the decreasing federal support formula. The result was that as the five years began to expire many if not most community mental health centers in the United States could not raise sufficient local funds to continue the programs that were previously supported by federal funds. Rather than face a massive closing down of facilities, the federal support was extended to eight years, that is to say, a longer term of life was given to the community mental health centers, and all over the United States there is presently the question of whether the federal support will be extended again as time runs out and whether communities will be able to raise enough of their "local share." This problem became especially severe in mental health centers set up to serve the poor. As is well known, there is virtually very little taxable property or income in these areas. Despite all of the financial problems it should be pointed out that hundreds of communities in the United States are now accustomed to having at least some money raised for mental health purposes. For example, in my own city of Austin five years ago no money was appropriated by the City Council for mental health activities; presently some \$65,000 is appropriated annually. It goes without saying that the community mental health approach as expressed in the community health centers has become an integral part of many communities, and it is doubtful whether the citizens served by these communities will allow local funds to decrease, or for that matter, on a national level, will allow federal funds to be withdrawn.

What have been some of the results of the community mental health approach? It is of course too early to tell, but there are some figures that reveal a nation-wide trend of reduced first admissions to state hospitals, shorter stays in state hospitals, and an increasing usage by citizens. Previous to the advent of the community mental health center very little attention was paid to the mental health of the poor. In fact, it is in this area that the community mental health centers in the United States still are in need of much improvement. It has become increasingly obvious that traditional psychotherapeutic approaches are not well suited to persons of lower income or who are socially disadvantaged. They have neither the time nor the inclination, nor for that matter the sophistication, to go back early in their lives and find the cause of their problems. In fact, there are emerging on many fronts new psychotherapeutic approaches to the poor. For example, the lower one goes in the socio-economic scale, the more difficult it becomes to distinguish psychopathology from the

effects of social pathology. In support of this observation, the very poor frequently come to mental health centers not to have their psychological functioning improved as much as seeking assistance with problems of living such as a job, housing, welfare assistance, hospitalization, and the like.

It is easy to see, therefore, that mental health in the United States is increasingly being interwoven with the material status of the persons it deals with. The mental health of the poor is receiving increasing attention. As it receives attention we begin to question many of the assumptions gained working with middle class persons. One of the greater challenges to mental health in the United States will be finding ways to deliver effective mental health services to the poor.

THE NEW CONSUMERISM

There are indications of increasing sophistication on the part of consumers of mental health services. While this is for the most part still mainly concentrated in the middle classes, it does have some rather important implications. For example, in one instance in the United States a mental health program in an economically depressed area was taken over by the residents of the community. They protested the services that were given them. That terrorized the mental health professionals such as psychiatrists and psychologists and social workers. One can easily predict that unless community mental health centers become more cognizant and more tuned into the needs of the poor such demonstrations will increase. There have been attempts to ask the poor what types of services they would prefer. These services differ markedly from the conceptions of the psychiatrists and psychologists. For example, since the poor are usually working during the day, they would like services at night and weekends. This runs contrary to the fine American middle class value system which suggests that no one has any problems after five o'clock Friday, nor should he ask for any help until nine o'clock on Monday morning. Living in a state of crisis as do the poor, it is understandable that they want services as soon as possible, and that they do not have the time to take off from work during regular clinic hours in many cases. It is interesting to note that those clinics which have attuned themselves to the life styles of their clients are those that receive the most public support.

NEW TYPES OF MANPOWER

Perhaps the clearest thing that has emerged in the last ten years in the United States has been the recognition (sometimes grudging) that traditional mental health manpower, ie., psychiatrists, psychologists, social workers, psychiatric nurses, could not fill the need for services, and that indeed there was some question as to whether per-

sons differently trained could be even more effective. What has emerged is a variety of new types of manpower sometimes called indigenous nonprofessionals, non-traditionally trained personnel, para-professionals, neighborhood aides, etc. All of these people have received some degree of training, mostly on-the-job training. Despite some protests from us well-situated professionals, there is little doubt that the non-traditionally trained personnel do very good work and will continue to do so. This of course poses a threat to professional mental health personnel. This threat is being met in various ways, and the issue is far from resolved. One thing is certain, however; the public need not wait until the mental health professionals have decided what to do. Faced with a need for mental health services, they will find some ways of getting them. This is especially so in dealing with the less severe emotional disturbances. Some very interesting findings have emerged. For example, it has been shown that college students can be effective companions to hospitalized psychotics to the extent that the psychotics improve tremendously and maintain this improvement for long periods of time. It has been shown that nurses, acting as mental health technicians, can do very effective psychotherapy with disturbed persons. Teachers can be especially trained to work with emotionally disturbed children within classroom settings. These are just a few examples of the changes in mental health manpower that have come about.

EMPHASIS ON MENTAL HEALTH RATHER THAN MENTAL ILLNESS

The increase in knowledge about mental illness has followed the inevitable pattern that is linked with knowledge, namely it is circulated. It can be said that mental health in the United States has moved away from traditional approaches and has become more secular and more the province of disciplines that were previously not involved in mental health. Traditional psychiatry and traditional clinical psychology are under attack. They have simply failed to meet the mental health needs of the populace. This accounts, for example, for the fantastic increase in such areas as community psychiatry, social psychiatry, and community psychology. It is well said in the United States that the traditionally-oriented psychiatrist or clinical psychologist, unless he works in the private sector, has very little to contribute to the mental health movement. In contrast, faced with an alarming increase in what Szasz would call "problems of living," it has been necessary to produce new approaches to certain problems. For example, the alarming increase of drug usage in the United States has resulted in all sorts of different types of treatment mostly carried out by indigenous nonprofessionals, ex-addicts, and a variety of persons especially trained for the problems. There has been an increase in "do it yourself" approaches. Alcoholics Anonymous is

perhaps the best example. Despite all the sophisticated approaches to the treatment of alcohol abuse in the United States, it still remains the Number One drug problem, and Alcoholics Anonymous probably carries on the greatest percentage of treatments of alcoholics. There is no evidence that Alcoholics Anonymous does less effective a job than traditional psychiatric and psychological treatment.

There was a time not long ago when the incidence of mental illness was judged simply by the number of first admissions to mental hospitals and the total number of patients resident in mental hospitals. A significant factor in the mental health of the United States today is that there is less emphasis on mental illness and more emphasis on improving the overall functioning of human beings. This is especially so amongst the young who, to the great consternation of their elders, seem to reject the materialistic values of the American culture and talk in such terms as honesty, self-fulfillment, and sexual freedom. Although sexual morality and sexual problems persist for older Americans, they do not seem to be that much of a problem for the younger generation. They wonder "what all the fuss is about." Whether this is a good or a bad trend is beside the question. The trend is there and strongly there. In response to the positive mental health approach, there are beginning in the United States some approaches to primary prevention and intervention. For example crisis-oriented clinics are set up to deal with persons on a no-waiting basis. The object is to get to the problem as soon as possible and get the person functioning more effectively. The emphasis is on effective coping rather than on adjustment. Allied with this approach have been a number of developments in the area of group therapy such as Marathons, Encounter Groups, Micro Laboratories, and of course T-Groups. For the most part these developments are geared to persons who are basically mentally healthy and wish to broaden the base of their experience. Perhaps the latest trend is an increased emphasis on working with children and the recognition that children have parents, and that family therapy may be the treatment of choice for disturbed children.

One could go on and relate various other developments in the United States. In some ways the developments described have been extremely encouraging, and all in all one must be encouraged by the progress to date. However, it is characteristic that once some progress is made more progress is expected. There still exist enormous problems in planning for the effective delivery of mental health services and in the financing of these services through local, state and federal sources. It is to be hoped that the federal government will continue its support of mental health facilities. It is further to be hoped that communities will recognize the value of having men-

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ally health citizens and raise the funds to promote and maintain this mental health. The broadened definition of mental health will certainly mean that new patterns of fund raising and new patterns of delivery of services will emerge. One can predict with confidence that ten years from now, hopefully at an Interamerican Congress, we can look back and see how far we have come. It would be of great interest to compare the approaches taken by our neighbors in the Americas to their problems of mental illness and to trade information with regard to innovations, recognizing that we all face many similar problems in our concern for the psychological health of all our citizens.