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TEAR DOWN THE WALLS!

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by

MIKE GORMAN - Washington, D. C.
Executive Director, NATIONAL MENTAL HEALTH COMMITTEE

(Mr. Gorman is a former newspaperman and magazine writer who has specialized in the mental health field for the past eleven years. In 1948 he received the Lasker Award of the National Committee for Mental Hygiene. That same year his book, "OKLAHOMA ATTACKS ITS SNAKE PITS" was condensed as a book supplement in the READERS DIGEST. His new book, "EVERY OTHER BED", a study of the current status of psychiatric research, will be published in April. He has written numerous magazine articles on mental illness.)

Dr. Hoch, Dr. Hunt, members of New York State's Community Mental Health Boards, distinguished guests:

In 1945, which seems only a very short time ago, I embarked upon a tour of state mental hospitals in the South, Southwest and Midwest. My point of origin was Oklahoma where I was then a reporter on the largest newspaper in the State.

The largest mental hospital in Oklahoma was situated in the beautiful university town of Norman, only 20 miles from Oklahoma City. The hospital itself was less than a mile from the superbly appointed campus of the University of Oklahoma, yet for all practical purposes it could have been a thousand light years away. There was a guard at the gate of the State hospital and you had to wait until he cleared you with the

central office before you got behind the high walls surrounding the institution. There were no discernible contacts between the State University and its medical school and this large mental hospital.

It had all the rigidity of a medieval morality play - you went from the Heaven of a university campus to the Hell of a block of old dungeons holding thousands of sick, screaming patients.

Walls, walls, walls. They had a reality to me far beyond anything else I saw at that time. I had a fantasy of borrowing a bulldozer and running it from the university campus right smack through the walls of the State Institution. For the walls represented to me one thing - they were a physical symbol of the fears of the community outside. The people in the intellectual little university town of Norman somehow felt protected because a wall symbolized the end of one kind of life and the beginning of unmentionable misery and madness.

Was it like this in other states? I had heard much of the work of the Menningers and I journeyed to Topeka to try and get some answers. The Menninger Clinic itself was not too far removed from the community, although it would be an exaggeration to say that it was enthusiastically embraced by the rock-ribbed citizens of Topeka. However, the wall was around Topeka State Hospital, an unfashionable institution just a mile from the Menninger Clinic. Puzzled by what seemed a vicious distinction between a private clinic and a public mental hospital, I took my questions to Dr. Karl Menninger. Why, I asked him, was there this great wall between the two? He replied that he could not justify it, that it was much on his mind, and that somehow it must be torn down.

I wanted to find a public mental institution where the wall didn't exist - where the hospital was an integral part of the community. In the course of my researches I came across the following statement of what a mental hospital should be:

"We feel that the psychopathic hospital movement is the natural outcome of

many years of striving and earnest effort to place mental disorders on the same basis as physical disorders. We are approaching the time when general hospitals, with their splendid delivery rooms, solaria for tuberculosis, excellent orthopedic applicances and apparatus and modern facilities of all types, will also have provisions for the adequate care and treatment of mental patients."

Words of true wisdom. I looked at the date of the article - June, 1925! The author was Dr. Franklin Ebaugh, who in 1925 had journeyed from the staid comforts of Philadelphia to the wilds of Colorado to set up an intensive treatment hospital for which the good people of Colorado had voted a bond issue in 1924.

I lost no time in going to Colorado to visit the Colorado Psychopathic Hospital. I saw the hope of the future in the operation of this hospital. The psychiatric unit was an integral part of the university hospital and medical school. Internes and residents rotated through the psychiatric ward as well as through all of the wards in the hospital. I even saw lordly surgeons in broad daylight on the psychiatric ward. I looked everywhere for a wall, large or small, to protect the community from this radical experiment. I found none. At the conclusion of a week's visit, I complimented Dr. Ebaugh extravagantly on his accomplishments. He replied, a little sadly and quite firmly:

"The Colorado Psychopathic Hospital is a monument to failure - the failure of society to create the necessary conditions for the full healthy adjustment of individual minds."

He then described to me his plans for an Institute for Community Psychiatry on the university grounds. He described its purpose as that of a "class room in mental health for the entire state." Its major unit would be a mental health center whose main purpose would be the setting up of treatment demonstrations for every school and welfare agency in the state. At this institute, workers from well-baby clinics, visiting nurse associations, public schools, juvenile courts, Parent-Teacher Associations, religious and industrial groups would be taught, in

a basic mental hygiene curriculum, practical methods of handling all types of behavior problems. For his Institute staff, in addition to psychiatrists, psychologists and social workers, he planned to have an educator, a public health nurse, a personnel consultant from the industrial field, a vocational counselor, a public relations man and a minister. These staff people and others of like training would bring psychiatry out into the community and would bring the community to them.

I dwell upon these experiences because I want to convey to you how very recent is the effort to bring psychiatry back where it belongs - into the community and into the main stream of medicine. The intensive treatment community mental hospital is really a product of the 20th Century, as is the movement to establish psychiatric wards in our general hospitals. In fact, the first psychiatric unit in a general hospital was established in Albany in 1902 in connection with the medical school and hospital there. The first intensive treatment hospital associated with a state mental hospital system - Boston Psychopathic - was not opened until 1912. The New York State Psychiatric Institute did not open its doors until 1929 and it was followed in 1930 by the Psychopathic Hospital here in this city.

I think it is fair to state that the development of public intensive treatment hospitals has been mystifyingly slow and disappointing. In a speech, "The Psychopathic Hospital in the Total Spectrum of Mental Hospitalization" delivered in November, 1955, Dr. Daniel Blain, medical director of the American Psychiatric Association, expressed deep disappointment over the spotty development of this tremendous resource. Citing the six receiving hospitals of Ohio, he expressed puzzlement that no other states have followed this fruitful trail.

However, since the end of World War II we have taken the first steps in the long campaign to create a nationwide chain of community psychiatric resources.

As you know, the first big step was the passage of the National Mental Health Act of 1946 which established the National Institute of Mental Health. Its impor-

tance lies in the fact that the Congress created it for three major purposes - research, training and community services.

In many respects, the community services program of the National Institute of Mental Health has been its most successful operation over the past decade. It has made possible the establishment of more than 200 new clinics and provision for additional services by another 200 clinics. It has been a tremendous catalyst in attracting large state and local funds for clinics and other community mental health functions. In 1948 state and local community services appropriations totaled only about \$2,500,000; in 1954 these contributions had soared to more than \$12,000,000, far outdistancing the small federal appropriation of \$2,325,000.

However, many of us feel and have so testified before Congressional committees, that the federal program has fallen far short of its initial goals. In 1954 Dr. Leo Bartemeier, chairman of the Council on Mental Health of the American Medical Association, testified before a Congressional committee on these community services programs. He cited the following major deficiencies in our community mental health resources:

1. There is a documented need for at least 840 full time mental health clinics. "I dare say there is hardly a clinic in any part of this country which does not have a long waiting list," Dr. Bartemeier told the Congress.

2. According to a study published by the Child Welfare League of America, 80 percent of American communities fail to provide adequate facilities for emotionally disturbed children. According to the report, 25 states have no child guidance centers and there are only 30 residential treatment centers in the country which are altogether capable of treating 1,500 children per year. These centers have ten times as many applicants as they are able to handle.

3. According to a three year survey conducted under the auspices of the Columbia University Department of Psychiatry, a minimum of 10 percent of public

school children in the U.S. are emotionally disturbed and need mental guidance. But the majority of the schools lack the trained personnel or facilities to aid these disturbed children. In 80 percent of the schools surveyed, mental hygiene problems were not even discussed in the classroom. Dr. Bartemeier referred to psychiatric personnel shortages in the schools as "appalling" - one psychiatrist for every 50,000 children, one psychologist for every 10,000 children and one psychiatric social worker for every 38,000 children.

Protesting the cuts in federal support for these services, Dr. Bartemeier spelled out their vital importance in these eloquent words:

"When we use the term 'community services', I sometimes think we fail to convey the specific help given at the state and local level under the umbrella of these programs. For example, grants-in-aid under this program support many activities directed toward the psychiatric education of school teachers, ministers, public-health personnel, vocational rehabilitation specialists, etc. This is an exceedingly important enterprise. These are the professions which contact large segments of the population in the course of their regular duties. They are in a strategic position to engage in mental health education.

"Moneys under this program also support community education activities - varied efforts to alert communities to the problem of mental illness and ways of handling it. Many parents are reached through prenatal and well-baby clinics. Printed material and visual aids go to countless civic organizations. Yet only nine states have trained educational personnel on their mental health staffs.

"There are other activities too numerous to mention here. These moneys support technical consultative services to local school districts, health agencies, juvenile courts, and welfare agencies. Public health personnel are in the forefront in helping to organize local mental health programs. They have also been most active in the rehabilitation of the mentally ill, participating in workshops, institutes, and case conferences with rehabilitation specialists. They

have also been engaged in a number of outstanding special projects - extension of nursing services to families of the mentally ill; projects to train lay leaders in community mental health workers, and many, many more."

Last year the National Mental Health Committee conducted a major campaign to increase federal support for community mental health services. We managed to get the appropriation lifted from \$2,325,000 to \$3,000,000. This is still far from adequate and we will testify more aggressively next month for a federal appropriation of at least \$6,000,000 for these activities..

The most dramatic development in recent years in the entire field of preventive mental health services has come through successive actions by the National Governors' Conference on Mental Health in 1954 and subsequent actions by regional conferences in every part of the country. There is a magnificent stirring going on at the state level and the walls are tumbling down all over this great land.

Summarizing these developments, Sidney Spector, director of the Interstate Clearing House on Mental Health set up by the National Governors' Conference, had this to say in November, 1955:

"Considerable progress was made this year in stressing mental health clinics and services. I was tremendously impressed with the clear, well-presented program of the Florida Association for Mental Health - and even more impressed with the results. The legislature this year more than doubled the appropriation for mental health clinics for this present biennium as compared with the one ending last June. In Arizona, the legislature appropriated \$12,512 this year, compared with nothing at all the previous year; in Connecticut, funds for operating state clinics and for grants to community clinics and general hospitals with psychiatric services were increased by a fourth. For the first time in the history of Idaho, funds were made available for preventive mental health - \$41,310. In Illinois, \$696,000 was allocated by the legislature for mental health services -

a 286.7 percent increase over the previous biennium. In Indiana, there will be available \$290,000 for community clinics this biennium, compared with only \$70,000 previously. Similarly, in North Carolina, the budget for mental health services was more than tripled; Tennessee approximately doubled its sum; and the State of Washington increased its appropriation 138 percent. But the giant stride in this area of mental health is the tremendous step taken in New York in getting under way with its impressive Community Mental Health Services Act. The State of New York alone will be spending for this purpose, in 1955-56, as much or more than all other states combined."

In the brief time at my disposal I can only indicate the enormous variety and experimentation characteristics of many of these state mental health services:

Connecticut has an excellent grant-in-aid program for psychiatric clinics for children.

Illinois has made extensive grants for rehabilitation services for conditionally discharged patients and for day nurseries for emotionally disturbed children.

Massachusetts has an excellent on-going program in which the state provides key professional personnel and professional direction for community clinics while local communities provide quarters, equipment, supplies and additional personnel. Joint state and local financing now exists in two-thirds of the 16 active community clinics. Most important, a training program was started in July, 1955 in conjunction with the Harvard School of Public Health for the position of mental health center director. Furthermore, a two year seminar program has been established under the Division of Mental Hygiene for the training of mental health consultants.

Missouri has appropriated \$480,000 for the operation of six traveling clinics.

North Carolina has appropriated significant sums for the establishment of mental health centers which go far beyond the narrow concept of a mental hygiene clinic.

Pennsylvania is concentrating its efforts in state grants to general hospitals for the establishment of intensive treatment units, child guidance clinics and

mental health centers. It has drawn up a program calling for the expenditure of \$6,000,000 for these purposes.

I am most impressed with the Ohio program. The 1955 Ohio legislature appropriated approximately \$2,800,000 for state support of mental health services - an increase of 45 percent over the previous biennium. These services include clinics, educational and other services, family care and community classes for the mentally retarded. Ohio now spends \$450,000 in state grants for community classes for the mentally retarded, a most significant development.

Furthermore, in Ohio they put the horse before the cart. They know that you have to train an enormous amount of additional psychiatric personnel if you are to expand your community mental health resources. So the 1955 Ohio legislature appropriated \$10,000,000 to be used during the coming biennium for the training of psychiatric personnel. Three new institutes for training and research have been created in Cleveland, Cincinnati and Columbus. I don't like to indulge in invidious comparisons, but it is my understanding that New York State spent \$35,000 last year in its psychiatric training programs. I cannot over-estimate the importance of a long-range training program to produce the people to staff your community facilities. I think we have much to learn from industry, which plans its expansions in close relation to its recruitment and training programs.

All of us in the mental health field were tremendously stirred when the New York State legislature adopted the Community Mental Health Services Act in 1954. Your program has been in existence a little more than a year and it would not be fair to subject it to sharp analysis at this point. As Dr. Hunt pointed out in a stimulating speech to the Northeastern State Governments Conference on Mental Health in April of last year, your first year has really been one of getting off the ground, of setting up your community mental health boards and of taking inventory of existing community psychiatric resources.

I am somewhat impressed with your total budget for these services, which ran

in excess of \$10,000,000 for the past year. However, I have become a little wary of big appropriations. Knowing the acute shortages of psychiatric personnel in your state, I cannot but believe that a major part of this money is going into support of existing activities. I do not say that this is improper, nor that it is not dictated by present circumstances. However, the intent of the act was an overall expansion of community resources and not a mere transfer of fiscal responsibilities.

I am tremendously heartened by some of the things you are attempting to do. For example, on December 15, 1955 Dr. Paul V. Lemkau, the very capable director of the New York City Community Mental Health Board, announced that a portion of community services funds in that city would go toward the support of psychiatric beds in several voluntary general hospitals. The New York Times quoted Dr. Lemkau as follows on the goal of this program:

"Every general medical hospital should have a psychiatric outpatient department and all large ones should have in-patient units."

A most commendable goal and one that ties in very beautifully with the dynamic new program now under way in the state under Dr. Paul Hoch, the State Mental Health Commissioner. Dr. Hoch is concentrating on new intensive treatment units in a number of key state hospitals and he is also expanding several of the after-care clinics in the metropolitan area into residential treatment centers.

The combination of Doctors Hoch and Lemkau augurs well for the future of psychiatric services in the community. I fervently hope that they will receive the full cooperation of the medical profession in their endeavors. As a native of New York City, I have always been sorely tried by the wall which exists there between public psychiatric institutions and the private practice of psychiatry. There are approximately 1,000 psychiatrists practicing in the New York City area, but I think this would be startling news to the 50,000 sick patients in the state institutions in and surrounding the metropolitan area. I respectfully urge many

of the distinguished private psychiatrists now practicing along Park and Fifth Avenues to take an exploratory walk into other areas of the great city. There is much to be done and great personal satisfaction to be gained from it.

By the same token, the generality of medical practitioners must be brought increasingly into mental health work in both state institutions and in the community. With the present critical shortage of psychiatrists, our state institutions and our communities must call upon the services of the general practitioner of medicine and of the specialists in the field of organic medicine.

I commend to every doctor in the State of New York a remarkable speech by Dr. Elmer Hess, the President of the American Medical Association, at the 1955 convention of that organization. Calling mental illness the nation's number one medical problem, Dr. Hess proposed a five-point program for increased participation by all physicians in the care of the mentally ill. Because of its importance I list these recommendations 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.

Reversing the coin, the state and the local communities must plan actively to employ these doctors. I know that Dr. Hoch has a plan of this nature and I am sure that Dr. Lemkau is fully aware of the need to utilize the medical resources of the metropolitan area. In testimony before the New York State Joint Legislative Committee on Problems of the Aging just a few weeks ago I summarized the problem as follows:

"New York is blessed above all other states in psychiatric resources. It has ten medical schools - one-eighth of the national total. It has the largest concentration of psychiatrists in the world. It has a number of famous psychiatric research centers. It has all all of these and yet it also has a high wall between the state mental hospital system and private psychiatry. Break down this wall and New York State will move psychiatrically into the 20th Century."

All of us are enormously interested in what you will do in expanding psychiatric services in the schools of this state. I don't think there is a greater challenge facing you than this. There will be obstacles, but you must surmount them. In the speech referred to above, Dr. Hunt mentioned a ruling by the New York State Comptroller that school funds outside of New York City cannot be used for matching purposes in programs such as you contemplate. I would not be paralyzed by such an unimaginative ruling. Comptrollers are both amenable and fallible, as are Governors and State Legislators. I see no reason why strong efforts should not be made to use these school funds for matching.

In New York City, where this matching is possible, we intently await a comprehensive plan for psychiatric services in the city schools. As an alumnus of the New York City public school system, I realize the difficulties in setting up such a program. However, there is no excuse for the mediocre psychiatric services now available in the New York City schools. I know there are egos involved, there are conflicting jurisdictions involved - there are even "empires" involved. But there are also thousands upon thousands of terribly sick children involved and I think

this is much more important than a wounded Emperor or two.

Finally where do we go from here? What are the big challenges in the field of community mental health services?

I think the biggest challenge is attitude. We are freighted down with an excess baggage of out-moded concepts concerning the time and place for psychiatric treatment. The walls are still with us, maybe not as visible as before, but still there.

The biggest need is a fresh look. Over the past several years, I have been deeply impressed with the pleas of Dr. Kenneth Appel for such a new look. His pleas have culminated in the establishment of a Joint Commission on Mental Illness and Health which, during the next three years, will take a more or less anthropological look at current practices in handling mental illness. As President of this new Commission, Dr. Appel described its exciting challenge in these words:

"The solutions devised by the Commission are not to be limited to professional practices, customs and traditions. The discovery or development of new approaches are looked for. A new look at the whole problem of mental illness is to be undertaken. New perspectives are to be sought. New departures, it is hoped, will be developed and examined. Perhaps radical reconstructions of the present system will be recommended."

There is a desperate need for imaginative experimentation in the whole field of mental health services. America, a nation which has pioneered in industrial innovations, is positively stuffy when it comes to social innovations. This was forcefully brought home at the 1955 convention of the American Psychiatric Association when two doctors from England expressed deep concern over the manner in which this country hangs on to the protective walls separating the community from the mental patient.

Dr. Maxwell Jones, a pioneer in the development of the democratic therapeutic community, had some sharp and amusing things to say about the American psychiatrist who wears a white coat and holds forth in lordly fashion in a room whose walls are plastered with "hideous diplomas which supposedly attest to his superiority over

the patient." Dr. Jones, as most of you know, works in a business suit and sits among his patients.

At that convention, we saw a magnificent film on the work of Dr. T. P. Rees of Croydon, England. In Croydon, where Dr. Rees' public mental hospital is situated, it is hard to distinguish where the community leaves off and the hospital begins. Practically all of the doctors in Croydon - psychiatric and otherwise - are on the staff of the hospital and patients move from office treatment to recreation center to in-patient hospitalization without bumping into any walls.

If time permitted, I would have liked to discuss in detail many of the innovations which are bringing psychiatry back into the community. I can merely list some of them and urge you to look into them very carefully:

1. The Day Hospital - It has been quite successful in England and Canada but has had only token acceptance here. The patient receives active treatment at the hospital during the day, but returns to the strength and warmth of his family or the community each night. Thus there is no breaking of the ties between the patient and the outside world. It is particularly useful for the aged because it relieves the family of the burden of care during the day. It has enormous possibilities and yet the few trials with it in this country have been conceived on a most limited basis.

2. The Night Hospital- I think this is an even more important therapeutic development than the day hospital. In this facility, the patient goes out to work during the day and returns to the hospital at night for necessary treatment. This is tremendously important during the period when a mental patient is returning to a job after a long absence. He may do well during the working hours of the day but with the night comes the anxiety. He therefore needs the strengthening support of an institution for a short period of time. We have only a couple of these night hospitals in this country and they do not begin to approximate the Canadian night hospitals.

3. The Half-Way House - This is a temporary residence for patients who have

left the hospital but need a period of adjustment and support before returning to the community. Dr. Blain has reported on the successful use of the half-way house in Australia. In this country, we really have nothing comparable. The fact that several of our state mental hospitals claim they operate half-way houses - which are in reality buildings on the grounds used for patients ready for discharge - is eloquent evidence of our stuffiness and our fear of the new.

4. The Residential Sheltered Workshop for psychiatric patients - In this country we are doing a fine job in creating such facilities for the physically handicapped, but practically nothing for those handicapped by emotional disabilities. Dr. Blain reports that he has not found a facility of this kind anywhere in the country.

5. The Mental Health Center - This has been described superbly in the Louisiana state survey conducted by the American Psychiatric Association in 1954. Its central unit would be a residential diagnostic and screening center. It would also include various referral and educational services such as those described by Dr. Franklin Ebaugh in his plan for an Institute for Community Psychiatry.

Summarizing these innovations, Dr. Blain had this to say:

"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."

I could go on listing the manifold challenges which you face. In the field of community mental health services, the world is really your oyster. You will succeed when the flame burns, and you will fail when the imagination is cold.

Set your goals high. When you run up against technical, jurisdictional and other obstacles, take a deep breath and think of the sick people you are dedicated to help, jurisdictions or no, Comptrollers' rulings or no. If the obstacles multiply, take an even deeper breath and think of the magnificent opportunity you have to change the face of modern society, to bring compassion and help where there is weakness and misery.

I truly envy you in your appointed task. God speed you in your superb work. Keep searching and questing for the better way. Take this thought with you:

"Woe to him who has found the wild bird and needs no searching more:

"Find never the wild bird."