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WE HAVE COME A LONG WAY

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by

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I come to you here tonight with a genuine sense of optimism concerning present and future developments in the care of the mentally ill in this country.

In a relative sense, it has been only a short time since we began overturning the traditional concepts governing our care of the mentally ill. As a newspaper reporter in the late 1940's, I toured scores of state mental hospitals in which a low level of custodial care was the order of the day; hospital superintendents boasted to State Legislatures that they were spending only sixty or seventy cents a day for each mental patient confined in the massive institutions then in vogue. In point of fact, the sorry situation existing in the 1940's differed little from the practices which had prevailed since the establishment of the first state mental hospital in Virginia in 1773.

In the initial years of the present era of reform, it was almost impossible to get a Governor or a state legislator to visit these institutions. The seemingly inevitable response to such an invitation was that the mentally ill were hopeless

and incurable, and that state government was pursuing the wisest course in isolating them in institutions purposely removed from the stream of life.

The first significant breakthrough came in 1949 when the National Governors' Conference authorized a comprehensive study of existing conditions in our state mental hospitals. The findings of that study shocked the chief executives of our states, and from that time on they have provided significant leadership in proposing alternatives to the futile policy of constructing thousands upon thousands of additional hospital beds at a staggering cost to the taxpayer.

In 1955 the Congress, now keenly aware of the ferment at the state level, appropriated money for a sweeping investigation of the way in which the mentally ill were handled in this nation. The organization which conducted this inquiry was the Joint Commission on Mental Illness and Health, composed of representatives from 36 national professional and lay organizations.

The Joint Commission filed its report with the Congress in March 1961. In November of that same year, a special National Governors' Conference on Mental Health was held in Chicago for the purpose of discussing how the several states could carry out the major recommendations of this historic report.

Endorsing the recommendation of the Joint Commission on Mental Illness and Health that most psychiatric treatment in the future should take place in the heart of the community, the Governors cited example after example of new services designed to achieve this objective.

Governor Kerner told the conference that Illinois is currently constructing six 300-bed intensive treatment centers so located that the vast majority of its citizens will be but an hour's drive from a complete range of mental health services for both adults and children. Governor Vandiver, declaring that every general

hospital of 100 or more beds should have psychiatric services, described Georgia's bold experiment in hospitalizing more than one thousand patients in general hospitals in four major cities at a tremendous saving to the state due to the 28-day average length of stay. Governor Andersen of Minnesota depicted his state's chain of 17 community health centers supported by federal, state and local matching monies, giving a wide range of treatment, training, consultative and rehabilitation services which have resulted in a sharp drop in admissions to state hospitals. Governor Swainson of Michigan told of the enormous potentials involved in increased health insurance coverage of mental illness.

The final policy statement of the Conference, unanimously agreed to by the 19 Governors in attendance, was infinitely more forward-looking, hard-hitting and specific than the earlier declaration by the 1954 Governors' Conference on Mental Health.

The key recommendation calls for a fresh approach to mental illness based upon a wide range of treatment services in the community designed to keep as many persons as possible out of state mental hospitals.

"Indications are that 75 percent of the acutely mentally ill who receive intensive treatment in community facilities will not require costly institutionalization," the Governors declared. "Long-term, costly hospitalization of the mentally ill should be avoided, not only for the sake of economy, but also in the best interest of the patient. Whenever possible, the patient should be treated in the community through mental health clinics, emergency and short-term psychiatric services in general hospitals, day and night hospitals, halfway houses and other rehabilitation facilities."

Where hospitalization is necessary, the Governors recommend that treatment "be given in small hospitals providing both inpatient and outpatient care in the heart of the community. Programs, therefore, should follow the recommendation of the Joint

Commission that smaller hospitals should be constructed and that no beds be added where large facilities exist. Where they do exist, steps should be taken to de-centralized them internally into units of appropriate size to ensure the best patient care and maximum efficiency."

Are these revolutionary proposals too Utopian for achievement?

On the contrary, A quick look at present developments across the country shows that many of these recommendations are already being carried out in varying degrees.

The breaking up of the big hospital into smaller self-contained units -- almost separate hospitals in themselves -- is going on at a rapid pace. Kansas pioneered in developing such discrete hospital units for the complete treatment of the patient, from his admission to his discharge. Iowa has recently experimented along similar lines and several hospitals in New York State are now engaged in imaginative experimentation designed to reduce massive state institutions to workable, therapeutic size.

The small, intensive treatment hospital in the heart of the community is more than just a blueprint.

In addition to the major reform along these lines in Illinois, which has 50,000 mental patients presently located in large and generally out-moded institutions, several other states are moving in the direction of concentrating future psychiatric resources in the community.

At the recent National Governors' Conference on Mental Health Dr. Wilfred Bloomberg, Connecticut's Commissioner of Mental Health, told the delegates:

"We will not add additional patients to any of our existing state hospitals in Connecticut. Our three major hospitals have each a resident patient load of about 2,700, which we think is at least five times too big. We propose to build community-based, small branch hospitals of 75 to 100 beds in the urban communities from which most of our patients come, and plan to take care of the mentally ill where they live and where their families and clergymen and their family doctors are."

Along the same line, Governor Volpe of Massachusetts described a plan drawn up in his state for the construction of six to eight 40-bed mental health centers in the large cities for early diagnosis, treatment and intensive aftercare for both adults and children.

The rapid growth of psychiatric units in general hospitals is probably the most exciting break with the past. A little more than a decade ago, most general hospitals resisted the creation of psychiatric units. Today, more mental patients are admitted to general hospitals each year than to state institutions.

The Georgia experience dramatically exemplifies the total commitment of a state to this idea. In less than two years of operation, 1,800 patients from 151 counties in Georgia have been treated in general hospitals. Although the daily cost to the state has been high -- \$30-35 -- the approximate cost per patient has only been about \$1,000, considerably less than the cost of long-term treatment at the antiquated state hospital in Milledgeville.

Even more important than the economic savings have been the savings in human resources. After they were treated in the general hospitals, only 7% of the patients were sent on to Milledgeville. Furthermore, approximately one-fourth of the patients treated who were not employed before hospitalization were able to obtain jobs.

On the basis of the Georgia experience and additional experiences in several other states, the 1961 National Governors' Conference on Mental Health strongly recommended that "states allocate specific appropriations for the support of psychiatric beds in general hospitals."

An astounding variety of community psychiatric facilities is developing at a rapid rate. Day and night hospitals, where the old 24-hour institutionalization has gone by the boards, are less of a rarity each year. According to a recent survey by the American Psychiatric Association, 76 general hospitals have day programs and 53 general hospitals have night programs. In an exciting extension of this flexibility of treatment, Nebraska is now experimenting with a week-end hospital where patients can come in for a complete psychiatric work-up and treatment.

The aftercare clinic movement has come of age. We now have five-year studies in a number of states and in New York City indicating that patients treated in these clinics have a readmission rate to state hospitals of around 10%, as against the 35-40% readmission rate before the advent of these clinics.

Over the past few years, we have witnessed the burgeoning of emergency psychiatric services where an emotionally troubled person can receive immediate treatment without any legal formality. So-called trouble-shooting clinics have been set up in New York, Boston and several other cities.

As a consequence of these moves emphasizing greater patient freedom, our rigid commitment laws are being challenged on many fronts. An increasing number of patients are admitted to institutions by voluntary certification; in Connecticut, 75% of all admissions are now voluntary.

The training of general practitioners in psychiatric skills moves forward at a remarkable rate. A recent issue of the "Journal of the American Medical Association" noted that psychiatry is now the most popular area of postgraduate

education for physicians, with more than 100 separate courses being given in various parts of the country. These efforts are not restricted to doctors in our large cities -- we have had recent reports of remarkable general practitioner training programs in Northern Vermont, Western Nebraska and in the rural counties of Maryland.

Health insurance coverage of mental illness, a sporadic thing only a decade ago, is becoming increasingly common. There is little doubt that, within the next few years, all health insurance plans will have to cover mental illness for at least 30 hospital days a year.

But it may well be asked at this point: Can a nation make so dramatic a break with tradition in a relatively short period of time? In other words, can it provide a comprehensive battery of community mental health services designed to eventually replace the present chain of state institutions?

There are many current examples of just such nationwide services. For purposes of comparison, however, the most complete data we have come from England. There is a mistaken impression that the English mental hospitals were always in the vanguard in the application of new approaches to mental illness. To correct such an erroneous notion, here is a quote from a report of a Royal Commission which thus describes English mental hospitals before 1945:

"With a few exceptions, treatment was purely custodial. It consisted of segregating the patients into huge, prison-like asylums, mostly situated well away from large centers of population. Here, there was little danger of their interfering with the normal business of society, and land was cheaper. Admission, needless to say, was often long-term or lifelong. These hospitals stand today -- like obsolete battle ships stranded on some remote sandbank -- a formidable problem bequeathed by our Victorian predecessors."

Today the situation in England is dramatically different. As Dr. Maxwell Jones has noted: "It would seem that the idea of a mental hospital as such is becoming out of date. In Britain, the new Mental Health Bill does away with the designated hospital and any hospital may now have psychiatric beds where patients may come and go without any formality whatsoever."

The British Ministry of Health recently announced, in spelling out a ten-year plan, that no more large mental hospitals would be built and that all new hospitals -- with the general hospital as the mainstay -- will be built inside city limits, with sites chosen with an eye to the convenience of patients and the availability of staff.

In England, flexibility of psychiatric treatment is the order of the day. The initial attempt is to keep the patient in the home; in 1958 more than 22,000 home visits were made by psychiatrists, many in the company of the patient's family doctor.

The tie between the regional mental hospital and the general hospital has become a very real one. For example, the psychiatric outpatient departments of general hospitals are staffed by psychiatrists from the public mental hospitals.

The report of the Joint Commission on Mental Illness and Health offers us an enormous opportunity to reform the care of our mentally ill in this country.

While there has been considerable concentration on the financial recommendations of the Joint Commission report, there has not been enough attention paid to the fact that the report represents a massively documented repudiation of the custodial state mental institution as it has existed since 1773.

In its insistence upon intensive care for all who are mentally ill, the Joint Commission rightly argues that a much higher level of financial support is needed to provide a whole new constellation of psychiatric services in the community. It therefore proposes a tripling of national expenditures for mental health services by 1970, with the federal, state and local governments sharing in these expenditures.

Most heartening to all of us who have served on the Joint Commission for the past six years was the whole-hearted acceptance of the report's findings by the Governors of the several states. They bear the major burden for the care of the mentally ill at the present time; they are most deeply aware of the difficulties in raising additional revenues, but they faced the problem forthrightly and honestly at the Chicago Conference when they unanimously declared:

"We heartily commend the Joint Commission for an excellent study; we accept the findings that much remains to be done; and we endorse the concept that federal, state and local government, as well as private and voluntary efforts, must be combined to achieve the goals we seek . . . It is obvious that substantially greater sums must be appropriated by all levels of government to accomplish the objectives stated in this policy declaration."

All across this land, influential voices have joined in a collective demand for a new day for the mentally ill.

In an address a few months ago while still President of the American Psychiatric Association Dr. Walter Barton, a conservative superintendent of a large mental hospital, made the following bold prediction, one that would have been greeted with cries of disbelief a decade ago:

"Statisticians think that within ten years the mental hospital population will decline by half despite an increase in the general population and a larger number of hospital admissions. Obviously, the length of

hospitalization will decrease. Today about 25% of our patients leave the hospital within ten days and 60% leave within thirty days. By 1970, it is reasonable to expect 60% will be able to leave within fifteen days."

Testifying earlier this year before a Senate Appropriations Committee Dr. Robert Felix, Director of the National Institute of Mental Health, noted that there were 108,000 less patients in state mental hospitals in 1961 than had been predicted by the Institute on the basis of trends between 1945 and 1955. Dr. Felix told the committee:

"I am willing now and for the first time will publicly say, and with all due consideration of what I am saying, that if these recommendations can be followed with what we know today, if the communities will enter into cooperation with the Federal Government and the private foundations and agencies with right good will, public mental hospitals as we know them today can disappear in 25 years."

On December 1, 1961, President Kennedy appointed a Task Force of Cabinet officials to study the Joint Commission report with the objective of recommending legislation to carry out the federal share of the major recommendations. While their report has not been officially released, its conclusions can be summarized in a general way since they have been agreed upon for some time.

The heart of the new approach consists of federal and state matching support for the construction of community mental health centers. These centers, combining residential beds, children's services, an outpatient clinic and a host of precare and aftercare services, will follow the pattern established in Illinois, Connecticut and Massachusetts of being located close to existing medical resources. In essence, they represent the most revolutionary break with the past tradition of isolating the mental patient.

The second major emphasis of the Presidential Task Force is upon the development of comprehensive state plans for the training of scarce medical and auxillary personnel. Under this recommendation, the federal government would provide matching grants to all states submitting comprehensive training programs. Since it is obvious that the potential supply of psychiatrists is severely limited, the new program will concentrate upon the training of general practitioners so that they can handle most early manifestations of mental illness. In addition, training programs would be inaugurated for many new types of sub-professional personnel needed in the staffing of these community mental health centers.

A third major recommendation calls for federal matching grants for the construction of psychiatric units in general hospitals. Because of the central location of most general hospitals, their wealth of medical resources and their acceptance by the family, this recommendation is of key importance in bringing the mental patient back into the mainstream of the community.

In financing these services, the role of voluntary health insurance must be strengthened. While a significant number of health insurance plans now cover mental illness for short periods in a general hospital, practically all non-hospital services are excluded. This is a grave deficiency since much of the planned treatment of the future will take place in mental health centers, rehabilitation facilities and in the private offices of practising physicians. For these reasons, it is suggested that the federal government reinsure the risks of those insurance companies willing to experiment with extended coverage of mental illness.

This long-range thinking at the federal level is being paralleled by the emergence of a significant number of long-term plans at the state level.

In January of this year, Governor Rockefeller announced a master plan for New York State, whose 86,000 patients comprise the largest public mental hospital system in the country. New York currently spends approximately \$34 million in matching state and local funds for community mental health services, and the master plan would accelerate this trend.

Your neighboring state of California is presently involved in the most exciting and comprehensive planning I have seen anywhere in the country. At the request of the 1961 state legislature, 150 Californians served on eleven task force committees in the preparation of a comprehensive plan which was completed in March of this year.

The core of the California plan is contained in this statement from the report to the Legislature: "Adequate treatment should be available as early as possible; as continuously as possible; with as little dislocation as possible, and with as much social restoration as possible."

The California plan holds firmly to the present policy of refusing to build any large new hospitals or adding beds to existing hospitals. In concentrating upon state support of community mental health services it envisions a time, probably after 1975, when most of the state's mentally ill will be treated either by private physicians or in state-assisted mental health services.

Space does not permit detailed mention of additional state planning efforts. These endeavors received the strongest possible kind of endorsement in the following resolution unanimously passed by the National Governors' Conference at its 54th annual meeting in Pennsylvania in July of this year:

"Now therefore, be it resolved by the Governors' Conference that each state develop a comprehensive master plan for coping with mental disability and promoting mental health that will mobilize state and local, private and voluntary resources, and stimulate greater community initiative and provide a long-term basis for meeting this great human responsibility."

I am delighted to learn that Oregon is moving in the direction of achieving many of the aforementioned national and state objectives. The creation of a new Mental Health Authority and the passage of legislation providing community mental health services are tremendously significant developments.

Your new Dammasch Hospital near Wilsonville follows the current trend toward relatively small hospitals with good outpatient services. The Department of Psychiatry at the University of Oregon Medical School, under the excellent leadership of Dr. George Saslow, plays a vital role in the training of young psychiatrists and an even more important role in providing psychiatric leadership to the state.

Oregon actively participates in the many psychiatric activities of the Western Interstate Commission on Higher Education. It is my conviction that WICHE has the outstanding program in the country in the psychiatric education of general practitioners; it has shown enormous imagination in developing circuit-riding teams which have gone to some of the most isolated spots in the Northwestern and Mountain states to bring psychiatric information to interested family physicians. Its comprehensive program for the professional up-grading of the skills of state hospital personnel in all thirteen states within its jurisdiction has received national commendation. Finally, it has broken important ground in the recruitment area by providing summer clerkships for college students with a potential interest in working in the field of mental health.

What can you do in the years ahead to improve the mental health situation in Oregon?

I think you would be willing to admit that the greatest weakness of your mental health program is the inadequate number of community mental health facilities. According to the most recent figures released by the American Psychiatric Association, you are 35th in the nation in per capita expenditures for community mental health services. The legislation passed in 1961 gives you a tremendous opportunity to combine state and local tax support not only for clinics but for desperately needed psychiatric services in the schools, the courts, and in social agencies of all kinds.

There is an equal need for progressive treatment facilities for children. If you do not provide these now, you will continue to reap a tragic harvest in terms of subsequent treatment and hospitalization of these individuals as their malfunctioning continues. It is therefore most essential that you establish a children's unit at Dammasch Hospital, and that you plan for additional residential treatment units for disturbed children in other parts of the state.

There is also a fine opportunity for the linking together of your state hospital resources and your community mental health resources. An illustration is the project currently under way at Oregon State Hospital under the direction of Dr. Maxwell Jones. Dr. Jones plans the creation of a 300-bed regional unit, separated from the rest of the hospital and serving two counties adjacent to the hospital. By developing a continuity of care based upon breaking down the walls between the hospital and the community, he will eventually use a day hospital, a

night hospital, a halfway house and an ex-patient's club to smooth the transition to the hospital and from the hospital. By focusing on two counties, he will be able to concentrate on developing working relations with the general practitioners, the social agencies, the courts, the schools and the churches within each county.

In any discussion of mental health services for an entire state, we come up against the problem of the state's financial capacity to support them.

The aforementioned American Psychiatric Association survey listed Oregon as 19th among the states in per capita personal income, but only 29th among the states in percentage of general state expenditures devoted to mental health. Here in Oregon you spend only 2% of your state budget on mental health, as against the national average of about 3%.

A more fundamental question involves the ability of state government generally to handle additional expenditures in the health and welfare fields. We hear much talk these days of state taxes already having reached a confiscatory level.

What are the facts? It is true that state taxes have gone up an average of a billion dollars a year since 1948. However, personal income has risen almost as rapidly. For example, a study by the Council of State Governments noted that state taxes were 3.1% of personal income in 1948 and 3.5% of personal income in 1958. As the Council study notes:

"In summary, it appears that a constant dollar measure of several types indicates that relative to our individual incomes we are not devoting much more to state revenues than we did ten years ago."

Furthermore, as many prominent economists have noted, a rapidly expanding population and increasing automation have made it absolutely necessary that we

create millions of new jobs in the so-called service professions. Mental health services, which fundamentally depend upon the training of new personnel, offer an ideal area for job expansion.

In terms of our gross national productivity, we can well afford these additional expenditures. What we cannot afford is higher unemployment, juvenile delinquency, inadequately financed schools, and inferior mental health services.

When all the myths are eliminated, the choice is a rather simple one. If we have the will and the determination, the financial means are present to support our goals. If we argue that we cannot afford these services, then we must be prepared to pay a much higher price in terms of the inferior productivity and functioning of thousands upon thousands of our fellow citizens.

You face such a decision in the coming years here in Oregon, and I am confident that you will make the right one.