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LABOR MUST FACE UP TO THE CHALLENGE OF MENTAL ILLNESS

Speech at

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by

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In the course of the past two decades of evangelizing on the subject of mental illness, I have talked to many labor groups. In all but a few isolated instances, I had the very strong impression that I was not getting through to the audience. I might summarize the reaction of the typical worker to my presentation in this way:

"He is talking about something which doesn't affect us to any great degree. We are not crazy and even if we were, we wouldn't admit it."

A second reaction almost as typical can be summed up in the observation that when I talked about psychiatric treatment, I was referring exclusively to rich people who could afford to go for ten years to a Viennese-born analyst to find out why they were crazy enough to make all that money.

Tonight I want to explode a number of myths concerning the worker and mental illness, including many perpetuated by professional people who take great delight in delivering long and quite dreary papers on how the worker differs from all other segments of American society and why present modes of psychiatric treatment are supposedly unsuited to him.

The first and most nagging myth is that mental illness is somewhat of an exotic disease. Decent, "normal" Americans never encounter it and if they do, it is really a failure of will power. It can be easily overcome by telling oneself to snap out of it, taking a subscription to The Reader's Digest, or subscribing to a Dale Carnegie course. Furthermore, you never get mental illness, nor does your family -- it is always the guy down the street or around the corner. This amazingly prevalent attitude is borne out by statistics from insurance companies which send their subscribers questionnaires on whether they would like coverage of mental illness for a small additional payment each month. Invariably, 80 to 90% of the respondents reply in the negative -- they don't think it is going to happen to them, so they don't need the coverage.

The facts are all to the contrary. Every competent survey has turned up an incidence of mental illness far in excess of the most gloomy projections of the professional experts. For example, the magnificently-detailed Cornell Study of my home area of Yorkville on the upper East Side of New York City disclosed that four in every five persons surveyed had at one time or another in their lives suffered an emotional disturbance so upsetting that they thought of obtaining treatment, and one in five had either been hospitalized or treated for mental illness.

This "exotic" illness this year fills more than 50% of all this nation's hospital beds -- over one million Americans are confined in federal, state, private and general hospitals for severe mental illness. Last year, an estimated three million people received psychiatric care in hospitals, clinics or private offices; another two million people sought treatment, but were unable to obtain it, due to shortages of facilities and personnel and/or the economic barrier due to the high cost of private psychiatric care.

Although there has been a heartening drop in the number of patients in our state mental hospitals, the number of people being treated for mental illness is still escalating at an enormous rate. For example, last year state mental hospitals admitted 314,000 patients, as against only 178,000 a decade ago. 860,000 people were seen in mental health clinics in the same period -- a precipitous jump of 200,000 patients treated in clinics since 1963. In 1965, general hospitals handled and discharged more than 600,000 mental patients -- a 50% increase over the past decade.

If these statistics don't convince you that mental illness strikes practically every family in this nation at one time or another, let me give you some figures on emotionally disturbed children which I presented earlier this week to an audience in Battle Creek.

The best estimate we have today is that there are four million children who are so seriously disturbed that they need treatment. Very few are getting it. Some 15,000 children are hospitalized in state institutions -- where they really don't belong -- and another few thousand are hospitalized in private residential hospitals where the cost to the parent runs from \$900 to \$1,500 a month. Over and above this, approximately 300,000 children were seen in outpatient clinics last year. Most of these children received only token treatment, since a great number of these clinics have very little psychiatric time available.

I had occasion just recently to review a report on last summer's experience with Operation Head Start; I was shocked at that section of the report which indicated that 10% of the 600,000 children reached by Head Start were already so emotionally disturbed by the age of four that they could not be helped through the enrichment programs offered by the Head Start program.

A second annoyingly prevalent myth is that mental illness is really a fringe disturbance having only a small impact upon the strength and viability of our democracy. In other words, there are 40 or 60 or 80 more important things to do before we tackle what the American Medical Association has described as "America's most pressing and complex health problem." In this area, and in this area alone, I believe that American labor has a considerable way to go to catch up with this progressive statement by the American Medical Association.

I live in the so-called Capital of the Free World and, particularly during the past month, I have listened to an increasing crescendo of comments from Congressmen on both sides of the aisle to the effect that we can declare a moratorium on the health, education and welfare of our children because our military posture in these troublous times is the overriding issue. I worked for President Harry Truman during the period covered by the Korean War, and the cries were the same then as they are now and from the very same people -- those who have never voted for social legislation in peace time and now have the opportunity to wrap the American flag around their diligent efforts to repeal the 20th century.

Mental illness is a big and costly and crippling problem in our effort to build a strong America. Last year, Selective Service rejected more than one out of every three young men called up -- the so-called cream of our nation; more than half the rejections were based upon the emotional difficulties or mental defects of the potential draftees.

It has been reliably estimated that the national cost of mental illness exceeds \$4 billion a year. The states are spending \$1.2 billion a year just to house a half million patients. The Veterans Administration last year spent \$850 million in hospital and compensation costs for mental illness.

These and other documented costs are really just the top of the iceberg. Underneath there are the hidden costs of crime -- \$20 billion a year; juvenile delinquency, school dropouts due to emotional maladjustment, divorce, alcoholism, drug addiction, and so on.

You in labor should be particularly interested in the loss of human productivity due to the so-called three A's of industry -- absenteeism, alcoholism and accidents. The Industrial Division of the Menninger Foundation, on the basis of a survey of a number of industries in various parts of the country, estimated recently that each year absenteeism costs industry \$13 billion, alcoholism \$2 billion and accidents more than \$3 billion. In their detailed investigations of the scope of these problems and their lengthy interviews with workers, the Menninger Foundation investigators concluded that the greatest percentage of these losses is traceable to emotional disturbance.

These Menninger studies, and many other comparable surveys, have motivated only a handful of industries into doing anything in the way of providing psychiatric services for emotionally disturbed workers. In a few industries executives with raging ulcers, or drinking problems, or persistent high blood pressure, have been provided with analysts to help them find out why the executive dream is sometimes a nightmare of bitter tension and competition.

However, when it comes to the blue collar worker who has comparable tensions or drinking problems, or a messed-up family situation, there is little or no provision for his needs. I don't blame industry as much for this as I blame labor -- for years, like most of the American people, you have indulged in self-denial of the existence of mental illness. As a result, your leaders -- with a few commendable exceptions -- have not gone to the bargaining table and aggressively demanded psychiatric services as an absolute right for every worker disabled by emotional trouble.

I am aware of some pious declarations at the last two Constitutional Conventions of the AFL-CIO about mental illness being a naughty thing, but I do not have the feeling that your leadership has yet locked horns with this problem in the same way in which, for example, you have thrown your powerful weight behind decent medical care for the elderly of this nation. Furthermore, as I have said publicly a number of times in recent years, the legislative representatives of American labor in Washington have been amazingly insensitive to this gut problem of mental illness which cripples and maims the lives of hundreds of thousands of American workers each year.

I wonder how many of the 13½ million members of the AFL-CIO know that we are presently engaged in an enormous revolution in the care of the mentally ill in this country. For almost two centuries we dumped these people in massive human warehouses, out of sight and out of mind. As a number of studies have pointed out over the years, it was the working man who received the short end of the stick in this disgraceful abandonment of people whose only "crime" was that they had broken temporarily under the stresses of living. For the working man and his family, there was no opportunity for private psychiatric treatment, or even community psychiatric care, which might have prevented a more serious illness. The first stop, and frequently the last stop for the worker, was the state institution.

As just one illustration of the tragic price of this neglect, when mental illness reached diagnosed proportions among workers, 80% of its victims were already psychotic.

In the late 1940's, when I toured most of the state mental hospitals in this country, the average daily operating cost for each patient was about a dollar for all food, clothing, medical and spiritual care. The ward attendants, who were the closest to the patient, were paid from \$60 to \$100 a month -- good union wages. For that munificent salary, the hospital frequently purchased sadists, drifters, alcoholics, drug addicts and other highly skilled professionals to handle people sick in mind. Patients were rarely visited by either relatives or friends, and hospitalized workers were not visited by their

fellow union members. At the risk of being considered somewhat subversive, may I point out that in Russia things are quite different -- it is standard practice for the patient to be visited by a group of his fellow workers who bring him vodka, gifts and the reassurance that they are waiting for him to return to the job.

We cleaned up the snakepits to some degree in the decade following 1945, but the real revolution began with the Congressionally-appointed Joint Commission on Mental Illness and Health in 1955. Its six-year study led to President Kennedy's historic message of February, 1963 in which he called for the eventual abandonment of massive, isolated mental institutions and the creation of 2,000 community mental health centers within geographic and economic reach of all of our citizens.

I want to emphasize quite clearly that those of us who had a hand in drafting the Kennedy legislation were adamant on one point -- we would accept no application from a community for matching federal money which did not include provision for those people who could not afford even a limited amount of money for treatment. As I told the American Psychiatric Association at its 1964 annual meeting:

"Those of us who participated in the drafting of the Kennedy mental health legislation were careful to place the greatest emphasis upon limited federal support in the initial staffing of these centers. We envisioned these centers as primarily serving the low and middle income groups not now receiving adequate psychiatric care. We knew that patient fees could not support these centers, and we knew quite well that many of these people did not have health insurance."

The community mental health center concept is a clear and democratic one. Its essential elements include inpatient care, outpatient clinic care, day and night hospitalization, and a walk-in clinic where anyone in trouble may step through the doors and receive immediate aid. There is no means test, there is no legal voodoo -- there isn't even a fat sheriff with handcuffs dragging the patient to a hospital. The services

don't have to be in one building. A number of community agencies, such as general hospitals and clinics, can band together to provide these services as long as one thing is very clear -- there must be continuity of service based upon the needs of the patient rather than the administrative convenience of the center.

The preventive goal to which these centers address themselves was summed up most concisely by Congressman Billie Farnum of Wayne County at the recent National Governors' Conference on Mental Health in Chicago:

"A great number of patients in our state mental institutions come from the lower end of the socio-economic scale. This, I think, is not altogether coincidental. How many such persons would now be productive members of our society if they had been accorded adequate treatment for their problems before their illness reached almost insurmountable proportions?"

Time does not permit more than a passing mention of other developments which, in combination, are breaking down the economic barriers to psychiatric care and making it increasingly available to those of us who work for a living.

As you probably know the landmark Medicare legislation of 1965, whose passage was largely due to the leadership of two great Presidents of this country and to the untiring efforts of American labor, for the first time removes practically all restrictions against the coverage of mental illness for Social Security and Old Age Assistance recipients. It is estimated that during the first year of its operation, the Medicare program will cover approximately \$200 million in inpatient and outpatient psychiatric benefits for our senior citizens.

For those under 65 years of age, the picture is not as rosy. We have had a long and arduous fifteen-year struggle with Blue Cross, Blue Shield and the commercial insurance companies trying to persuade them to cover mental illness on a scale commensurate with their coverage of physical illness. A recent Blue Cross study pointed up the long road we still have to travel when it reported that "restrictions on benefits for mental

illness are common, and among those covered for mental illness, the proportion with full coverage (the same benefits as any other illness) was somewhat less than one-third of those covered."

There are also some forty million Americans without any health insurance coverage whatsoever, and we must somehow give them benefits commensurate with those who have reached their 65th year.

I am having a very tough time convincing Blue Cross and the commercial companies to cover partial hospitalization -- for example, day hospital coverage. This is better for the patient, it keeps him close to the family and it is much cheaper for the insurance company than 24-hour coverage. However, insurance actuaries get very nervous when you talk about anything less than 24-hour coverage -- it spoils their bookkeeping and their graphs. However, a few companies are beginning to cover day hospital treatment, and they are finding it much more economical and much more satisfactory to all concerned.

There are other important breakthroughs -- somewhat spotty, but highly significant.

The Federal Employees Health Benefits Program, enacted by the Congress in 1959, covers more than two million federal employees and their four million family members for both basic psychiatric hospitalization and, under an optional major medical plan, for out-patient care including a limited number of visits to a private psychiatrist. A survey on the first three years experience with the plan reports one annual admission for psychiatric illness for every 500 members, and an average hospital stay of only 11 days per admission. This is much less than the admission rate for most other illnesses -- for example, there are ten times as many admissions under the federal plan for respiratory diseases. We live in constant hope that this and similar data will convince the non-profit and commercial companies that mental illness is a highly insurable and definable risk -- that workers do not run into the streets trying to catch schizophrenia so that they can bilk insurance companies.

As a result of a two and a half year trial period of coverage of a sample of its subscribers, Group Health Insurance of New York City now offers broad psychiatric benefits to all of its close to one million members.

There are a few large companies which now provide a decent level of psychiatric coverage. One of the oldest is the General Electric insurance plan, which reaches more than a half million of its employees in various parts of the country. An evaluation of the plan several years ago pointed up the fact that coverage of mental illness accounted for only 2½% of the total number of cases handled under the plan.

Over the past two decades, American labor has moved with supreme caution into this very vital area of providing psychiatric services for its union members.

In 1945, the St. Louis Labor Health Institute developed a pioneer outpatient program providing psychiatric treatment to its members. In 1948, as a result of some very tough collective bargaining, the United Mine Workers included 90 days of psychiatric hospital care per year in its contracts with the coal operators. However, the plan evolved into what amounted to a closed hospital system with major emphasis upon 24-hour hospitalization.

More recently, the Chicago ILGWU Health Center has jointed with the medical units of three other unions in launching that city's first mental health clinic for blue collar workers. The clinic is called the Eleanor Roosevelt Union Health Guidance Center; the project was initiated by the Labor Education Division of Roosevelt University. Some 50,000 union men and women -- as well as members of their families -- are eligible to participate in this plan.

In 1964, the New York Joint Board of the Amalgamated Clothing Workers of America, through its Sidney Hillman Health Center, embarked on a pioneer effort in the mental health rehabilitation of a large union population. According to its Medical Director, Dr. Morris

Brand, the heart of the program is an attempt to break down worker resistance to psychiatric treatment by establishing the labor union as a legitimate resource to which to turn for help with emotional problems; by developing new techniques for case-finding in order to discover stressful situations before they incapacitate the worker or a member of his family and, finally, to use all the resources of the union to maintain the emotionally ill worker on the job through appropriate supportive services.

However, as most of you in this audience know, the biggest breakthrough in coverage of psychiatric illness for workers was the landmark UAW contract of 1964. Even more important than the fact that it covers 2½ million workers and their dependents in 77 major American cities, is its provision of a wide variety of services for mental illness not covered under most standard insurance plans. Its emphasis upon outpatient treatment either in the doctor's office or in day hospitals, community mental health centers and clinics, its use of group psychotherapy and its coverage of services provided by all members of the psychiatric team embody the most enlightened principles of progressive psychiatric coverage. Furthermore, and this may be its most important contribution, it encourages the worker to seek treatment by providing the first five visits for therapy at no cost, and then slowly increasing the co-insurance contribution over the duration of the period of treatment. This is the obverse of most present plans, which insist upon a high deductible and heavy early co-insurance to deter utilization.

Dr. Daniel Blain, President of the American Psychiatric Association when the UAW contract was negotiated and now an active participant in its implementation, recently hailed the UAW plan as establishing "a prototype which, if emulated in future collective bargaining contracts throughout American industry, will for the first time in history make adequate psychiatric care available to scores of millions of Americans who have been deprived of it."

All of the aforementioned developments are exceedingly heartening, but I must say to you in all candor that they are tentative, exploratory steps. As one who has worked with the UAW in its negotiations and who has talked to union leaders and medical directors of union plans in many parts of the country during the past decade, I must confess that we in the mental health field have the feeling that we have not yet involved American labor to a significant degree in our efforts to persuade you to give a high priority to psychiatric coverage of your membership.

I have a file about two feet wide filled with resounding statements from labor leaders coming out for motherhood and free beer and against mental illness, but lofty declarations are no substitute for hard, collective bargaining to achieve specific benefits.

Let me illustrate this point. In November, 1963 the 5th Constitutional Convention of the AFL-CIO adopted a ringing policy statement on mental health which included the observation that "the incidence of mental illness among low income groups is the highest in the nation. Existing methods of reaching low income workers with appropriate mental health services have been shown to be inadequate."

As a follow up to this declaration, the Department of Community Services of the AFL-CIO convened a conference in 1964 which brought some of us in the mental health field together with what the conference brochure described as "the labor leadership". As far as I could ascertain, the labor leadership was concentrated in the presence of just one union president, David Sullivan of the Building Employees Union. The majority of papers at the conference were presented by professional members of the Social Security Department of the AFL-CIO and several very bright psychologists from the National Institute of Labor Education, whose work is supported largely by the National Institute of Mental Health -- not by labor.

Much of the discussion revolved around the insistence of these psychologists and their colleagues that current psychiatric therapy was upper and middle class oriented and not suited to workers. Since I believe that this point, while valid ten or fifteen years ago, has little relevance to many of today's eclectic psychiatrists who use drugs and short, directive therapy, by the end of the third day I was in a fair state of impatience with the theological writhings of the technicians.

I find little fault with the document which came out of the conference. In describing the kind of psychiatric services labor wants for its membership, it declared:

"Essential services should be immediately available. There should be no time or money barrier. There should be special attention to those who cannot afford to pay, with no means test in whatever disguise... Special efforts should be made to secure early utilization of services by those population groups who have in the past not sought services until mental illness was far advanced and possibly more difficult to treat."

I agree with these sentiments, although I must say that President Kennedy said it much more eloquently in his 1963 message, and those of us who drafted the community mental health center legislation were much more specific in spelling out the goals of community mental health centers particularly designed to cover low and middle income workers without any geographic or economic limitations whatsoever.

During that 1964 conference, I felt that we never came to grips with the really tough educational task of how to break down the worker's resistance to psychiatric treatment and how to get him deeply involved in pushing for better psychiatric benefits for himself and his family.

By way of contrast, the State of Washington held a conference just a year ago which brought mental health leaders and labor leaders together in a hard-hitting discussion of just how this worker involvement could be achieved. For example, at that conference there was an exciting description of how Retail Clerks' Local 770 in Los Angeles had, through a dynamic program of worker education, changed the whole attitude of its membership toward psychiatric treatment.

Dr. Philip S. Wagner, Director of Psychiatric Services for the Retail Clerks, was frank to admit that when the clerks went out on strike in 1959 for 28 days in order to achieve psychiatric benefits in their contract, the membership at large really did not know what the essential goals of the program were. As he put it:

"In a sampling of membership attitudes, we found that 90% of the workers thought that psychiatry was only for crazy people."

However, the workers won the strike and the plan started. During the first year of the program, only one per cent of the membership sought and received psychiatric services; by the end of the third year, three per cent received psychiatric services, and the percentage has gone up rapidly since then. This increase in utilization has been based, not upon negative statements about the unsuitability of present psychiatric techniques for blue collar workers, but upon the positive premise that psychiatry and its allied specialties have a great deal to offer to the worker and his family who are undergoing emotional difficulties.

The employers contribute two cents an hour in fringe benefits for the psychiatric program. This generates about \$600,000 a year, and provides psychiatric hospitalization and unlimited outpatient care. Any clerk or his dependent can, in the course of a year, come in for any kind of program: a long, chronic problem, an education program, a problem concerning the speech difficulty of a child, parent-child guidance, diagnostic evaluation, marital and pre-marital counselling -- in other words, the whole spectrum of psychiatric services as we know them today.

Since the first clinic was opened in 1959, a second clinic has been set up directed toward the family problems of the worker. It is located in a rapidly growing community of small homes with an average family of four or five members. Rather than waiting passively for the worker to seek treatment, the clinic is rooted in his neighborhood and attempts to seek him out before emotional problems become frozen into a chronic illness. Two years ago, a third clinic was opened -- this one for workers' children with educational and/or emotional problems.

As a result of renewed negotiations in 1964 which provided an additional half cent an hour per employee, the Retail Clerks have opened a Youth Opportunity Center in a depressed area of Los Angeles where Negroes and Mexican-Americans predominate. Knowing that adolescents won't seek out "head shrinkers", the Center is developing a total social program to involve these youths and then to move in on their emotional problems.

Dr. Wagner admitted that in the beginning of the total psychiatric program there was a good deal of resistance, apathy and even hostility, but he observed on the basis of six years of constant education of the workers that "we found these prejudices are not too difficult to set aside -- there is even a kind of pride among the Retail Clerks that they have their own program and their own psychiatrists."

He pointed out that he knew of not one case of a worker losing his job -- or being discriminated against -- because of an employer's knowledge that he was receiving psychiatric treatment. Furthermore, he noted an increasing use of clinic services by employers who used them as an aid in resolving some on-the-job disputes between the supervisor and the worker.

Dr. Wagner takes a dim view of those who continually emphasize that the worker is different from any other segment of American society and cannot be successfully reached by modern psychiatric methods. I quote him:

"Is the working man a different kind of person from the average psychiatric patient? Should he be treated differently? Somewhat, yes. He is not oriented to just talking for an hour and having somebody silently listening. He wants participation and he wants active interest -- not pity or sympathy. He needs to feel an awareness that the therapist has some skill, and can get to the kind of thing that bothers him. Does he need some special language? He can't be talked to as a middle-class intellectual might be talked to by some psychoanalyst in Beverly Hills. But you can reach him. He is a feeling person. In my view he is a better patient than the middle-class intellectual, because the working man is sincere, is frank, and he knows something is wrong. He brings his kids in, they all yell at one another and cry at each other, and some helpful things happen."

Another point made at the Washington conference is directly relevant to you in labor and to us in the mental health field as we draw together in pursuit of our common objectives.

According to Marjorie Miller, Director of Research and Retirements, American Federation of State, County and Municipal Employees, in 1960 there was a total of 236,000 full-time unionized employees working in state and federal institutions for the mentally ill and the mentally retarded. This is 12% of the entire membership of the AFSCME. In 1960, there were 174 local unions in 313 hospitals, and I am sure the figure is appreciably higher today.

This great revolution in the development of community mental health services across the length and breadth of this land will require a whole new labor force. It is a people-to-people program which automation can never replace, and you in labor can play a significant role in recruiting and supplying the people we need. As Dr. William Conte, the Commissioner of Mental Health in the State of Washington, put it recently:

"If I understand correctly, organized labor is interested in finding jobs for people. Mental health services and labor are the natural bedfellows of the future."

We want people who care about people -- thousands and thousands of them. Most people in need of psychiatric care are individuals who have not had any really warm, close interpersonal relationships.

We have only begun the new day in mental health and organized labor through its manpower, through its need to locate jobs, through its desire for job security and through its national, state and local organizations providing both a lobbying force and a mechanism for operation, has a singularly important contribution to make and to enjoy in the mental health services of the future.

How do you get the deep worker involvement so soundly achieved in the Retail Clerks Local 770 plan? Again I turn to an observation, based upon long experience on the firing line, from Dr. Wagner:

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"My good friend and teacher in this field, Mr. Joseph DeSilva, of the Retail Clerks union in Southern California, says that whenever I talk to an audience I should tell them that the only way for unions to get a plan like the one I have described is by negotiating for it over the bargaining table. Don't ask other people to do it for you. You can't wait for the federal government. You can't wait for private funds to do it. You are close to the people, you know what their needs are: fight for them and negotiate for psychiatric services."