Creation of the National Institute of Mental Health

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"We are in the midst of a revolution in the status of psychiatry," Karl A. Menninger wrote in 1945. His words were to prove prophetic. Within less than a decade, the mental health scene would be reshaped by a generation determined to create a new psychodynamic psychiatry and to shift the care and treatment of the mentally ill from the asylum to the community.

More than any other event, World War II was the catalyst for this change. During that conflict, military psychiatrists found that neuropsychiatric disorders were more pervasive and serious than previously recognized, that environmental stress associated with combat contributed to mental maladjustment, and that early treatment in noninstitutional settings produced favorable outcomes. These beliefs, brought to civilian life by a group of psychiatrists who had served in the military, became the basis for claims that early identification of symptoms and treatment in community settings could prevent the onset of more serious mental disorders and thus reduce the need for prolonged institutionalization.

Out of the crucible of war emerged a model that emphasized the superiority of community-based over mental hospital systems. During the global conflict, substantial numbers of young physicians were recruited into psychiatry and trained in psychodynamic concepts; they subsequently transformed their specialty. A series of exposés of conditions in mental hospitals reinforced the belief that new approaches were both necessary and inevitable. An overwhelming military victory also set the stage for postwar euphoria. Just as science and technology had contributed to military victory, so could they be applied to social and medical problems. Within this context the National Mental Health Act played a crucial role in reshaping the mental health scene.

To alter mental health policy required that the public and its elected representatives be sensitized to the need for change. A decade and a half of depression, war, and neglect had led to a massive deterioration in the public mental hospital system of most states. State officials, moreover, were not in a position to generate pressure for national change; the existence of 48 separate state systems made it difficult to create a coalition that could transform the mental health system. A more plausible alternative was to expand the role of the Federal government.

Dr. Robert Felix, first Director of the National Institute of Mental Health. (Courtesy of James Pittman.)

Traditionally, mental health had been a state responsibility and the Federal government had remained relatively uninvolved in this area. The Public Health Service (PHS) Division of Mental Hygiene, created in 1930, dealt largely with narcotics addiction. And an effort in the late 1930s by Lawrence Kolb, the Division's head, to establish a National Neuropsychiatric Institute modeled in part after the National Cancer Institute (established by law in 1937) failed when war-related concerns overwhelmed domestic issues.

At the end of the war, conditions appeared propitious for dramatic changes in the nation's health care system. By then, the PHS under Surgeon General Thomas Parran had laid the foundations for a major extramural research program in the National Institute of Health. The passage of the Hill-Burton Act in 1946, which provided generous subsidies for hospital construction, was another symbol of an expanded Federal role. Moreover, the emergence of a health lobby promoting massive federal support for biomedical research ensured that the agenda for health policy changes would increasingly be centered in Washington. The overwhelming faith in medical science was reflected in

President Harry S. Truman's Scientific Research Board, which not only reaffirmed its faith in medical progress but insisted on the necessity for a "national policy."

None of these initiatives, however, included mental health despite the fact that there were hundreds of thousands of chronically ill patients in state hospitals. The task of making mental health policy an integral part of Federal biomedical policy was undertaken by Robert H. Felix, who had succeeded Kolb as head of the Division of Mental Hygiene. Felix's training under Franklin G. Ebaugh at the University of Colorado and early experiences at a problem-plagued mental hospital had led him to take a public health approach to mental disorders. In late 1944 he set to work to create a new Federal bureaucratic structure that would alter the entrenched tradition of state responsibility and employ the prestige and resources of the national government to redirect policy. He began by drafting legislation that provided for the creation of a National Neuropsychiatric Institute whose functions included, but were not limited to, the support of research. A master of bureaucratic and organizational politics with a gregarious, humorous, and charismatic personality, Felix was able to cultivate close relationships with key Congressional figures.

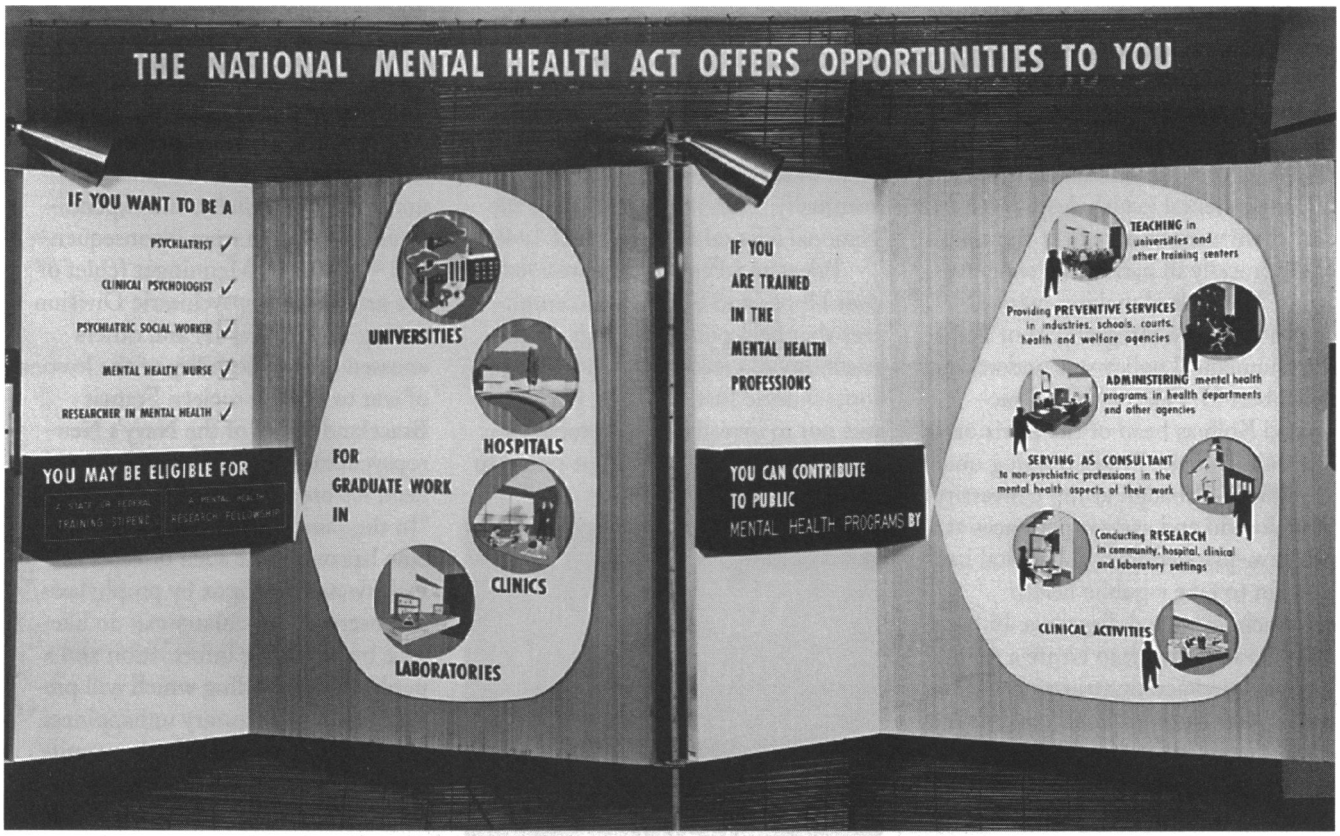
Felix first drew to his side Mary E. Switzer, an official who had played a key role in Federal rehabilitation policies, and Mary Lasker, a layperson with considerable resources who had just launched a career that would make her, along with Florence Mahoney, a major figure in the emerging biomedical lobby. Both Switzer and Lasker provided indispensable assistance in moving his agenda along. He also enlisted the aid of J. Percy Priest, an obscure Tennessee Congressman interested in mental illnesses, and subsequently received additional assistance from Senator Claude Pepper of Florida, a leading New Deal Democrat. Although denying that he was lobbying (and perhaps violating the provisions of the Hatch Act), Felix began to orchestrate a movement that would eventually result in the passage of the National Mental Health Act of 1946.

Priest and Pepper each presided over House and Senate Subcommittees that held public hearings on the feasibility of creating a National Neuropsychiatric Institute. The purpose was not to investigate the problems posed by mental illnesses but rather to mobilize support for the then radical concept that the Federal government could be a significant participant in mental health policy. A number of prominent figures appeared before each Subcommittee. Major General Louis B. Hershey described high rates of rejections for military service because of neuropsychiatric problems. Surgeon General Parran emphasized that "mental diseases equal all physical diseases in subtracting from the total vigor, the total fitness of our population" and that half of all hospital beds were occupied by psychiatric patients. Yet psychiatry was a marginal and understaffed specialty, and expenditures for research were inconsequential. William C. Menninger (chief of the army's Neuropsychiatric Division during World War II) and others stressed the applicability of the lessons of war to civilian society. Francis Braceland (chief of the Navy's Neuropsychiatric Branch) emphasized the need for broad preventive programs. "In the same manner in which medicine has overcome such diseases as lockjaw and smallpox by prophylaxis," he observed, "psychiatry can do likewise by providing information and a public understanding which will prevent much unnecessary unhappiness."

War-related experiences led to innovative models of psychiatric practice that subsequently became the basis of postwar efforts to create a new mental health system.

Both Congressional subcommittees were sympathetic to legislation proposed by Felix and his allies. Concern about health care was widespread, and there seemed little reason to exclude mental illnesses from impending Federal initiatives. A tone of deference pervaded the hearings; there was virtually no disposition to probe or challenge psychiatric claims. Only Senator Robert H. Taft and Congressman Clarence J. Brown raised questions about Federal funding; they were assured that the proposed legislation would exclude support for patient care and treatment in state institutions. After favorable reports by both committees, the bill moved easily through both houses. Support by such conservative Republicans as Taft and Brown depoliticized the proceedings, and following the reconciliation of minor differences, the legislation passed Congress overwhelmingly and was signed into law by President Truman on July 3, 1946.

The National Mental Health Act, largely Felix's creation, incorporated three basic goals: first, to support



An exhibit on opportunities offered by the National Mental Health Act of 1946.

research relating to the cause, diagnosis, and treatment of psychiatric disorders; second, to train mental health personnel by providing individual fellowships and institutional grants; and third, to award grants to states to assist in the establishment of clinics and treatment centers and to fund demonstration studies dealing with the prevention, diagnosis, and treatment of neuropsychiatric disorders. The legislation provided for the creation of a National Mental Health Advisory Council to provide advice and to recommend grants and established the National Institute of Mental Health (NIMH) with an intramural research program. The initial authorization was modest: $30 million per annum for state programs and research and $7.5 million for a physical plant for the NIMH. Although the act was silent on the use of Federal funds for institutional care and treatment, Felix insisted that such expenditures were forbidden, and his interpretation prevailed.

The significance of the National Mental Health Act lay not in its specific provisions but rather in its general goals and the manner in which they were implemented. The Act's passage helped to create an organized mental health lobby that played an important role in subsequent policy deliberations. Federal policy was thus shaped not only by legislation and appropriations but by the outlook of officials responsible for creating and administering programs and their allies.

Following passage of the landmark 1946 legislation, the role of the Federal government slowly expanded. In its early years the NIMH budget grew at a slow pace. When the agency came into formal existence in 1949, its appropriation was $9 million; six years later that figure had reached only $14 million. From that point on, the rise was dramatic. By 1959, NIMH's appropriation was $50 million, and within five years it had tripled to $189 million.

Between 1949 and 1964 Felix and his associates played a more decisive role in shaping Federal mental health policy than either the executive or legislative branches of government. As the director of the NIMH, Felix developed close contacts with important Congressional leaders concerned with health issues. Year after year he appeared before congressional committees. Rarely was his testimony challenged or subjected to careful scrutiny; legislators shared the faith of that era in the ability of medical science to uncover the etiology of diseases and to develop effective interventions.

Felix's enthusiasm at times proved disconcerting to his NIMH colleagues, some of whom attempted to persuade him to modify exaggerated statements. Nevertheless, under Felix NIMH became an important component of the biomedical lobby that was successful in persuading the Federal government and the American people that the key to health and longevity lay in the discovery and application of new scientific knowledge. Indeed, its most important contribution was its role in helping to legitimize the importance of psychiatric and psychological services and to develop support for community-based mental health policies.

The political sagacity of Felix and his staff only added to their influence. In public they rarely criticized or offended those with whom they disagreed. They were particularly adept in building a variety of constituencies. NIMH support for training brought into the mental health professions thousands of sympathetic supporters. Funding of demonstration clinics and research enhanced the agency's influence and visibility, and its message to the American people was one of hope and optimism. The organization was also cognizant of the value of public relations, and by the early 1950s the Publications and Reports Section was active in disseminating materials for the general public, the press, radio, and television.

The influence of the Federal initiative can easily be exaggerated. By the 1950s, in fact, the expansion of health services was largely consumer-driven. To many Americans, the goal of ensuring the nation's physical and psychological health appeared within reach, and there was broad support for an expansion of funding and services. A favorable environment, therefore, provided the foundation for a remarkable expansion of funding for both research and services, and the leadership of NIMH was quick to exploit the situation.

NIMH was in a strategic position to promote alternatives to the prevailing institutional policy of the states. That severely and chronically mentally ill people might not benefit from new community institutions offering services to a broad clientele was never seriously considered. Nor were those who administered state hospital systems in a position to challenge the policies and actions of NIMH. The latter had a national forum and access to a sympathetic Congress; the former were responsible to 48 jurisdictions. Under such circumstances it was not surprising that responsibility for mental health policy slowly began to tilt from state governments to Washington.

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The passage of the National Mental Health Act of 1946 in the heady days that followed the end of World War II symbolized the pervasive faith that American society stood on the threshold of a new era that would end the segregation of the mentally ill in remote custodial hospitals, bring them the benefits of psychiatric progress, and integrate them into the mainstream of community life.

Yet beneath the heady atmosphere of these years lay a series of dilemmas. Was the faith in science, medicine, and technology justified? Would chronic diseases lend themselves as easily to the development of therapies such as antibiotics that had proved so effective against acute infectious diseases? Would community institutions be able to provide more effective care and treatment? Were administrative techniques equal to the task of managing a complex decentralized system, as compared with the traditional approach that integrated both care and treatment within closed institutional walls? Finally, would a community system be able to deal with large numbers of chronic mentally ill persons who often lacked families and supportive social networks? The answers to these and other issues would ultimately determine the success or failure of new policy innovations.

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