mental health 

Interstate Cooperation in Mental Health

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ONLY a decade ago journalists, commentators, and other analysts were searing our newspapers with blazing portraits of inhuman conditions in the Nation's mental hospitals.

They indicated with passionate intensity the brutality and neglect, the barbaric use of physical restraints and seclusion, the unbelievable decay and deterioration of buildings, the terrible portent of jamming almost a half million people into hopelessly overcrowded facilities.

They portrayed bedlam and despair. They wrote that physicians were so encompassed with the burden of patients that little or no time could be given to active treatment. Lack of adequate therapeutic equipment intensified the tragedy. Lack of adequate funds meant low salaries, poor housing, exhausting working hours, and harassed administrators who could give little encouragement to research and to the establishment of a scientific environment. The relatively low recovery rate of mental patients induced defeatism and led to custody instead of treatment and cure.

Albert Deutsch summed it all up "as the tragic evidence of accumulated decades of neglect, public apathy, legislative penury, and administrative despair." But in October 1954, when Deutsch addressed the annual meeting of the National Association for Mental Health, he pointed to dramatic advances in recent years in State after State. He was aware of the sobering fact that too many mental hospitals still were being operated on a custodial and not on a therapeutic basis. But, after surveying the progress of the last decade, he felt no hesitation in predicting that "barring man-made cataclysms the next decade will see more advances in the war against mental disease than were registered in any previous century."

In this development, political leadership in the States has played, and will continue to play, a key role. With more than 85 percent of all mental patients in State mental hospitals, perceptive candidates for public office are sensitive to the most rapidly rising form of expenditure by State government. At this point they are alert to the proposition that a heavy investment in preventive techniques, personnel, training, research, intensive treatment, and rehabilitation, not custody, is the only effective alternative to continuing costly construction of hospitals for mental patients.

In addition, during and after World War II, mental illness gained recognition as a feature of the general social climate, and plans for its treatment emerged as a natural political phenomenon. I am reminded of a legislative district in which two competing candidates for a State election vied fiercely with one another in their promises of solving the problems of emotionally disturbed children. "Emotionally disturbed children" sounds so eloquent, so mellifluous and pear-shaped, and produces such favorable visceral reactions that I predict an

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intensive, perhaps excessive, concern for this one element of mental health.

The essence of progress in many fields at the level of concrete action in a democracy is the assumption of service responsibilities by political parties competing for electoral advantage. Out of this political ferment, which Deutsch, in his fine phrase, has labeled "a stirring in the States against mental disease," has emerged a glowing, intense concern for human welfare. The postwar convergence of political campaigns, costs, climate, and conscience led to a genuine humanitarian drive to treat the mentally ill and return them to productive lives as quickly as possible, to identify and treat mental illness early, to prevent unnecessary hospitalization, to educate for and promote mental health.

As a result, public leadership in State legislatures and executive departments is devoting more thought, time, and energy to mental health and related issues than at any time in our recent history. In many ways mental health services have become crucial tests of the survival of State government in a Federal system.

The long-term trend whereby the centers of important economic and political decisions move farther and farther away from the individual within his local government and toward higher levels will not be arrested by emotional slogans. They are rather directly related to the degree to which State governments assume their responsibilities and fulfill their obligations as responsive government units. As the Kestnbaum Commission on Intergovernmental Relations stressed in a basic document (*1*), the sinews of the Federal system can only be reinforced when State and local governments effectively and efficiently provide the services the people demand and raise on their own the financial resources to pay for these services.

A Decade of Progress

What then are some of the accomplishments of the last decade which, because of urgent, immediate unfulfilled needs, go too often unobserved?

Measured in dollars and cents, the States in 1954 spent for mental health care approximately 3 times the amount spent in 1945, and the sums for salaries and wages quadrupled. Within individual States the increases for salaries and wages were even more spectacular: Arkansas, almost 400 percent; Connecticut, about 400 percent; Delaware, 550 percent; Kansas, 650 percent; and North Carolina, 450 percent.

Figures for daily per patient costs for maintenance and operation of hospitals underline the same story. The average for the United States increased from $1.06 in 1945 to $2.84 in 1954. Here, again, within numerous individual States the increases were likewise spectacular: Connecticut, 230 percent; Delaware, 235 percent; Kansas, 450 percent; Nebraska, 275 percent; New York, 131 percent.

Of course, much of the rise resulted from an increase of some 50 percent in the general price level. But the average for the Nation came to 168 percent, or more than 3 times the price level increase.

Actually, however, the relative burden on the taxpayer did not change that much during the period since national income per capita also rose 105 percent from 1945 to 1953. The average person had more than doubled his income and was in a position to support public services.

Measured in personnel, the number of physicians in State mental hospitals almost doubled; psychologists increased 574 percent; social workers, 165 percent; graduate nurses, 107 percent; attendants, 112 percent. General staff-patient ratios, despite a 17 percent rise in resident population and a 39 percent increase in first admissions, also climbed 76 percent.

With respect to organization and administration, mental health departments have been reorganized and revitalized in many States for a more effective, coordinated approach toward preventing mental illness and promoting mental health. Twelve States now have formal departments of mental health or hygiene: California, Connecticut, Kentucky, Massachusetts, Michigan, Montana, New Hampshire, New York, Ohio, South Carolina, Tennessee, and Virginia.

About half the 48 States have consolidated mental hospital and mental health services within one department, either a department of mental health or welfare or institutions. A distinct trend in the last decade is the centering

of administration of all State hospitals in one department under a single commissioner appointed by the governor. Also discernible is a pattern of integration of community services with the mental hospital agency, whether the agency be a department of mental health, welfare, institutions, or, as in two instances (Idaho and Indiana), a department of public health.

Even more important, however, is the mature recognition that many agencies of government at all levels—health, welfare, corrections, education—are heavily engaged in mental health services, and that cooperation and coordination are far more urgent than simple structural centralization.

Measured in discharges of patients to active community life, progress is significant. In some hospitals at least 80 percent of first admissions are discharged within a year, and a return of 60 percent to the community is becoming common. As a matter of fact, my impression from traveling in the various States is that hospital populations are leveling off or lessening. State after State is issuing reports and statistics indicating surprise and delight at the trend. What the reasons may be, whether the trend is meaningful or not is still too early to determine.

With respect to the legal framework of mental illness, States are adopting modern codes in line with the concept that a mental patient is a medical problem, not merely a subject for legal action pointing to institutional isolation. In this connection, particular tribute should be paid to New York State's Joint Legislative Commission on Interstate Cooperation, which initiated the development last year of the Interstate Compact on Mental Health, and which joined Connecticut this year in adopting the compact.

Interstate Compact on Mental Health

I believe that the Interstate Compact on Mental Health, formulated and approved by the Northeast State Governments Conference on Mental Health, is a milestone in the history of improving the conditions of the mentally ill. Wide adoption of the compact by all States would put an end to the arbitrary shipment of mental patients around the country.

For the first time, it is recognized and asserted on an interstate basis that a person's eligibility for hospitalization does not primarily depend on length of residence in a particular State or on archaic, complicated legal definitions. It is mainly a function of a patient's medical disability. Under the compact a person needing hospitalization for mental illness or mental deficiency is eligible regardless of residence requirements. Where the patient will be ultimately hospitalized or transferred will also be a question for medical determination in his best interest. The compact also provides for supervision of a patient on convalescent status who may have to be sent to another State in order to be with relatives or close friends.

There has been real progress in the States, and a new hope for the mentally ill is born. But this is no time merely to consolidate gains. I have been concerned about the feeling among some States, which in recent years have invested large sums in attacking mental disease, that it is time to consolidate financially and stabilize. Other functions press forward and compete for limited resources. The cycle of interest may have hit its peak in some instances.

Despite the foregoing catalog of continuing progress, all of us are only too painfully aware that we have hardly reached the crawling stage in the field of mental health. To begin to cite the figures on personnel needs alone is to make the situation look hopeless. To set down realistic estimates of building requirements produces figures of prohibitive, well-nigh fantastic proportions.

Faced with problems of such magnitude, the States are joining forces in attempting a common solution through regional cooperation. Regional cooperation permits each participating State to obtain maximum benefit from the total resources of an area rather than rely upon facilities within its own limited geographic boundaries.

If resources would permit, each State individually might choose to provide centers for the training of all persons in each of the mental health specialties. However, it is sheer folly for every university and for every State to build and maintain its own medical school with training in every specialty or its own school of public health, of nursing, of social work, or of psychology. Rising costs—and the coming

rise of student enrollments—and especially the scarcity of magnetic teaching staff suggest that the goal of complete self-sufficiency in higher education is a delusion.

"Few institutions and few States," declared Harold Enarson, director of the Western Interstate Commission for Higher Education, "can do first-class teaching and research in all fields of knowledge. The only sensible approach is for each State and each school to do what it can do best, and beyond that, to pool resources."

It is preferable by far that a group of States support one teaching or clinical training center which can achieve accreditation and prestige than that each individual State maintain an isolated unaccredited center lacking the financial resources for adequate training.

Southern Regional Education Board

The most advanced example of interstate cooperation in mental health is the Southern Regional Education Board's pooling of the mental health resources of the southern States. The board was created in 1948 by the Southern Governors' Conference through an interstate compact of 14 southern States. Action by West Virginia and Delaware in 1955 brought the total membership of the board to 16 States: Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

The Southern Regional Education Board is authorized to enter into agreements with States, educational institutions, and other agencies in providing adequate services and facilities in graduate professional and technical education. Under its aegis a student does not pay out-of-state fees when he goes out of State to school. The sending State pays an additional fee to the receiving school.

For example, Mississippi since 1949 has purchased places for 269 students in regional schools of medicine, veterinary medicine, and dentistry. Mississippi contributed almost $1 million to professional education outside the State, but it would have cost the State at least $8 million to build and operate the necessary schools during the period from 1949 to 1956. Thus the State estimates a saving of $7 million in these professional fields alone through the regional compact.

Interstate cooperation in the south has obtained needed services for the States without duplication and at minimum cost. The facilities of a $2- or $3-million school are provided for professional students at a cost of a few thousand dollars annually. Qualified students are assured of schooling without having to pay out-of-state fees. Participating universities have broader financial support to provide stronger faculty and better facilities.

The program has made sense to governors and legislators. The whole concept has been not to erect new regional schools but to strengthen and improve existing institutions, building upon them and making better use of them.

Southern regional cooperation in professional education was expanded by the Southern Governors' Conference in 1953 to include training and research in the field of mental health. With a grant of $50,000 from the National Institute of Mental Health of the Public Health Service, the Southern Regional Education Board formed the Commission on Mental Health Training and Research, headed by the Governor of Tennessee and composed of public health and university officials, legislators, administrators, and representatives of the various mental health professions.

In addition, the governors each appointed State committees, with similar composition, in order to bring new and powerful proponents into the movement and to undertake surveys of resources and needs in each State. A great regional conference, held in 1954, afforded persons from all areas an exceptional opportunity to organize for concerted action. The organizing conference was followed by a legislative work conference in Houston the same year. A report was made to the Southern Governors' Conference in November (*2*).

The governors authorized the creation of the Southern Regional Council on Mental Health Training and Research, to be supported by annual contributions of $8,000 from each State.

Mental illness is not a problem to be solved; rather there are continuing tasks to be undertaken.

The council will serve to expand and improve mental health programs in the south and will

be an agency for consultation, stimulation, and problem solving that no individual State could undertake alone. If the south is successful, it will have gone a long way toward meeting a most pressing obligation.

Western and Midwestern Developments

A similar major effort is being made in the far west. At a meeting of governors' representatives in San Francisco, called March 25, 1955, by the Council of State Governments, a resolution was adopted to the effect that the Western Interstate Commission for Higher Education undertake an appraisal in the west of preventive efforts and training and research resources in mental health.

Again, as in the south, official committees were appointed by each governor to assist in this regional effort. A total of 262 persons serve on these State survey committees. The composition of the Colorado committee is typical of the western and southern groups. A State senator who is a former governor and lieutenant governor is the chairman. The other members are legislators, psychiatrists, psychologists, social workers, and university heads.

The National Institute of Mental Health again granted funds to finance a mental health survey. More than 26,000 people in the west were questioned as to where they stand on prevention and treatment. Here is an effort to pool the entire knowledge of a region in order to produce bold, imaginative ideas for full utilization of all skills in preventing mental illness and promoting mental health.

A successful regional conference was held in June 1956 to analyze the regional data and the State reports and to prepare recommendations for State and interstate action, with especial reference to the supply of trained personnel. One recommendation of the conference proposed that the Western Interstate Commission establish a regional council on training and research in the mental health fields in order to encourage cooperative interstate programs in this area. The findings and recommendations were presented to the Western Regional Meeting of the Council of State Governments in September 1956. The conference approved the report and called for immediate steps to establish the Western Council on Mental Health. The National Institute of Mental Health granted $171,000 for a 3-year period for this purpose. All this should result in more effective research, better training programs, an increase of well-qualified personnel, and an ever-growing concern of the public with problems of mental health.

A similar survey was also undertaken in the midwest in 1954, climaxed by the Midwest Governors' Conference on Mental Health in Chicago. It duplicated on a regional basis the National Governors' Conference on Mental Health held at Detroit in 1954, and adopted a series of resolutions for implementing the 10-point program of the national conference (*3*). One proposal suggested that an additional 10 percent of total State funds for mental health ought to be appropriated for training and research. This became a real, and practically realizable, objective for the midwest.

Northeastern States' Interest

In the northeast a somewhat different, but equally significant, interstate pattern has developed. For many years an exceptionally valuable conference of State mental health authorities has met annually in this region under the leadership of the Public Health Service. At its meeting in Hartford, Conn., in 1954, the conference decided to expand its purpose and membership in line with the recommendation for regional conferences included in the 10-point program adopted at the National Governors' Conference on Mental Health (*3*). The group altered its name to the Northeast State Governments Conference on Mental Health and requested the Council of State Governments to cosponsor its meetings and to expand participation by inviting budget officers, legislators, representatives of governors, and other State administrators.

The conference is held twice a year. The spring meeting is composed primarily of professional workers in mental hospitals and community service programs. The fall meeting spreads participation to legislators and executive officials. An extremely interesting meeting in Asbury Park, N. J., in March 1956 dis-

cussed inpatient services for children, problems of mental retardation, and the training of leaders for community mental health programs. The areas of consensus and of difference freely arrived at in this conference were examined in the fall by representatives of politics, government, and the general public for possible concrete action on an interstate or intrastate basis.

Listing the Achievements

Each of these regional developments has been particularly effective in bringing about an unprecedented community of interest on a regional basis, a community of interest not only within and among professions—a feat in itself—but among governors, legislators, laymen, and others. The area of participation and decision making in a previously somewhat closed family unit has widened into the harmonious working together of professional people and laymen.

A second achievement is the discovery that no State can go it alone, that one of our greatest resources is the concept of regional planning to which definition has been given by the interstate compact device. Here is a major new form of permissive governmental organization ready for further development.

A third result was the happy environment which brought forth a problem-centered, rather than a profession-centered, approach. Conspicuous among these regional movements is a concern for problems, rather than prerogatives. This, in the field of mental health or elsewhere, is no mean accomplishment.

Fourth, the regional plans are having a great impact on individual State programs. No factor is more influential in the improvement of State government than that of comparison and emulation. The voice of a whole region has stamped the needs of the mentally ill upon the conscience of the public, professional, and political leadership in each State.

Finally, these regional movements, the discussions at each of the last 6 or 7 governors' conferences, the information supplied by such organizations as the National Association for Mental Health, the National Institute of Mental Health, the American Psychiatric Association, the American Medical Association, the Council of State Governments, and the numerous other agencies in this field have paid off in legislative action.

Throughout the Nation, 1955 was a record year as far as financial investment in mental health is concerned. One survey showed that 38 out of 42 States had increased appropriations, thus attracting more personnel to State mental hospitals (*2*).

Several States provided funds for community services for the first time, and many expanded their funds beyond any previous appropriations. Still, the amounts are negligible, except in New York State which has approached the problem in a somewhat realistic manner.

But the most conclusive measure from our point of view is the funds made available for training and research. In these twin focal points of national and regional action in 1954 and 1955, accomplishments are evident. States that had never dreamed of investing in training and research did so—and spectacularly. Of the 12 State legislatures meeting in the south in 1955, 8 gave special attention to training and research. Nine out of ten State legislatures in the midwest, 4 out of 10 in the northeast, and 1 out of 11 in the far west, where the movement really has just begun, likewise emphasized training and research. Funds available in 1956 for training and research were about 2 to 2½ times the amount made available in 1953.

Actually, I have felt that we may be embarrassed today not so much by the lack of funds for research as by the inability to spend productively what we already have. Our major problem is one of competition for the brilliant researchers and the magnetic teachers who will know how to use existing funds wisely.

This dramatic pattern of regional cooperation in every section of the country touches all 48 States. Still a crawling movement, its progress has probably been overstated. This development is not a one-shot affair. Continuing mechanisms are being formulated to keep the momentum going and accreting. In this way, it is hoped that the States can join actively and boldly in solving their problems in the field of mental health. Mental health programs devised, financed, controlled, and operated by the

States constitute a positive demonstration of meeting responsibilities and of executing rights.

REFERENCES

(*1*) Commission on Intergovernmental Relations: A report to the President for transmittal to the Congress. Washington, D. C., U. S. Government Printing Office, 1955, 311 pp.

(*2*) Southern Regional Education Board: Mental health training and research in the southern States. A report to the Southern Governors' Conference, Boca Raton, Florida, November 11–13, 1954. Atlanta, 1954.

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Back to Work Movement

To help restore mental patients to homes, jobs, and family life, mental hospitals should be small, open, and close to the hometown. Clinical facilities should also be extended to facilitate the care of patients in their hometowns and social services strengthened for the mentally ill.

When a family has to travel 600 miles to visit a patient, as some do, they tend to lose touch. As for locks and other restraints, Dr. T. P. Rees, director of an outstanding open hospital at Warlingham Park, England, has found that unruly behavior of mental patients is often the result not so much of the disease as of the conditions under which patients are detained. Such hospital practices stigmatize the patient and place gratuitous blocks in the way of recovery and rehabilitation. Thomas A. C. Rennie and others have given practical demonstrations of rehabilitation, and M. J. Rockmore and R. J. Feldman have found that discharged mental patients are less likely than members of the general population to commit serious offenses. Confusion of the legal process of commitment with legal competence is another obstacle to recovery of the patient.

—GEORGE S. STEVENSON, M.D., *consultant for the National Association for Mental Health, addressing the 1957 National Health Forum.*