Community Responsibility for Mental Health

JOHN D. PORTERFIELD, M.D.

THE OTHER night, as bedtime literature, I resumed reading in the Evans' Dictionary of Contemporary American Usage and ran across this bit of historiography stimulated by the words "incubus" and "succubus."

"In former times," they write, "when demonology was a more exact science, an *incubus* was a male demon which haunted the sleep of women and was responsible for their bearing witches, demons, and deformed children. The innocent maiden, however, plagued by his advances could protect herself with St. Johnswort and vervain and dill. The *succubus* was the female counterpart. The offspring of the union of a man and a succubus was demonic, but the proper prayers, spells, or charms recited by the man upon awakening would prevent its conception. These distinctions no longer hold in standard common usage, but the learned preserve them and delight in them."

After twinkling briefly over the sly dig at the learned class to which the Evanses inescapably belong, I made a mental note to inquire on the following day whether St. Johnswort, vervain, or dill had any medical properties either separately or in combination, and gave a less specific instruction to my subconscious to check on modern analogues of spells and charms.

I would consider with you for a few moments this question of spells and charms and the modern counterparts in what we now call mental health.

It should be understood that I am not a psychiatrist. My professional career has been devoted almost exclusively to public health administration. In my view this general term includes everything related to the establishment of communitywide health programs, of which, of course, mental health is an important component. In my pursuit of this specialty I have had a number of occasions to observe closely all of the aspects of programs for the detection, diagnosis, treatment, and prevention of mental illness and for the promotion of good mental health. Fortunately, I have been one of that growing number of people who have assailed the problem of integration of mental health and community health from both sides.

In the course of accumulating this experience I have developed some strong feelings and a few firm opinions about this matter of community mental health. From the vantage point of this experience I would like to consider a serious problem which is ours as citizens of the modern American community.

The Meaning of Mental Health

To discuss all of the bands in the spectrum of mental health would take too long. To be sure, the term "mental health" needs some definition.

We paradoxically include under this heading all the varied and difficult problems posed by mental illnesses and emotional disorders. We go quickly, sometimes too quickly, beyond this to a host of other problems perhaps because of the magnitude of the problems and the difficulties involved in attempting to develop measures to deal with them.

Beyond the frank psychoses and the psychoneuroses is a whole field of personality dis-

Dr. Porterfield is Deputy Surgeon General of the Public Health Service. *This paper is based on a talk before the 27th General Assembly, Council of Jewish Federations and Welfare Funds, at the Shoreham Hotel, Washington, D. C., November 14, 1958.*

orders which manifest themselves in problem behavior, such as drug addiction, chronic alcoholism, delinquency, and psychosomatic illness. Mental retardation and its effects on family and community are also the concern of mental health. Over and above these, however, is a broad range of problems which have become rather loosely incorporated under the term "mental health."

This range encompasses an almost bewildering array of failures in living. Examples can be drawn from practically every area of human activity and from every one of the "ages and stages" of man's growth and development. I need not spell them out. The problems of marital adjustment and divorce, of parent-child frictions and maladjustment to school, of absenteeism and failure in work, of the older person seeking a satisfactory way of life, the generalized unhappiness of individuals and families, the failures of people to cope with the world—whether because they are too weak or the stress of circumstances too great—all of these and more are the daily problems dealt with by both health and social agencies.

Increasing emphasis on prevention has further broadened the field of mental health. Many agencies have become concerned with what is termed building "positive mental health." This is an area of much complexity and more than a little ambiguity.

Some attempt at definition was made by Dr. Marie Jahoda in a monograph, Current Concepts of Positive Mental Health, the first in a series of publications by the Joint Commission on Mental Illness and Health, authorized by the Congress to conduct a survey of the national mental health problem. Dr. Jahoda starts with the assumption that absence of illness and presence of health overlap, but do not necessarily coincide. She analyzes the psychological content of the various criteria that have been suggested as indicators of positive mental health. Included are attitudes of the individual toward his own self, his sense of identity, the style and degree of his growth and development, the ways in which he uses his psychological resources, his autonomy, his perception of reality, and control of his environment.

All of these concepts, together with the question of how social adjustment can be made to coincide with individual independence and integrity, are familiar. These are the factors which all of us consider in planning a coordinated community approach to social needs.

The New Look in Care

As a physician and an administrator, however, I tend to proceed on the basis of practicality. My operational principle is that the promotion of health is tied to those preventive measures which reduce the likelihood of disease. As practical workers in community welfare services, we are vitally concerned with the prevention of mental illnesses and allied disorders. Before discussing the help we need from the community, let us look briefly at the problems we face and the gains recently made.

We are all acutely aware of the mental institutional problem in this country. Despite the fact that the population of mental hospitals has begun to decline slightly within the past year or two, some three-quarters of a million people are still confined to institutions. It has not been long since the certification of an individual for and his admission to one of these public institutions characteristically marked his permanent departure from the family and the community. The walls around these institutions were high, and the people inside, staff as well as patients, had practically no communication with the world outside.

Three things have happened to these institutions in recent years.

First, a much more dynamic program of treatment has been initiated in most of them. Such new therapies as the tranquilizer drugs, which have curbed symptoms and made patients more amenable to other types of definitive treatment, have given impetus to this program.

Second, various forces have helped to tumble down the walls, so that the institutions have become a much more active part of their communities.

Third, the communities themselves have begun to grope toward efforts at preventing or at least retarding the hospitalization of those people who show signs either of aberrant behavior or of aberrant thinking.

There are other promising developments in mental hospitalization. We are learning that

huge institutions, overcrowded and understaffed as they are, tend to defeat the purpose for which they were established. Leaders in the field of psychiatry have suggested that mental hospitals hold from 200 to 500 patients only. But this requires many more trained professional workers, as well as new buildings.

The relatively new idea, in this country at least, of the "open" hospital, in which patients are helped to use their own resources for independent and responsible activity, requires more than merely throwing away the keys to the doors. Custodial care is relatively simple. In an open hospital, trained people are needed to plan and conduct active treatment. We need more personnel, too, to staff the "day" hospitals, where patients who live at home can get treatment during the day, and the "night" hospitals, where patients who hold full-time jobs return for treatment at night. For these groups, as well as for recently discharged patients, there should be more halfway houses, sheltered workshops, convalescent homes, foster home care, and help with legal and personal problems. Perhaps more than anything else, a sympathetic community is needed—a community that will accept the former patient as relative, friend, neighbor, and fellow employee, without prejudice or discrimination.

But what of the problem of mental illness outside the hospital? Surveys have estimated that about 6 percent of the population, or close to 10 million people, are seriously enough disturbed to need treatment. The percentage appears to be even higher in overcrowded, economically depressed areas in some of our larger cities. It has also been estimated that 50 percent of the patients seen by general practitioners for physical complaints are suffering from some form of mental disorder, and that their complaints are at least partially psychogenic.

The magnitude of the problem of maladjustment in children, as evidenced in school problems and in a demand for outpatient clinic services that far exceeds the supply, is well known today. So is the extent of juvenile delinquency and divorce and broken homes. In addition, some 3 percent of the population, or close to 5 million individuals, are mentally retarded.

In the face of this almost overwhelming array of problems, we find ourselves singularly handicapped in terms of resources. For one thing, we are desperately short of trained, professional personnel in mental health. Surveys in different parts of the country have shown that we need 3 to 5 times as many psychiatrists and psychiatric social workers as we now have, 4 to 7 times as many psychologists, and 5 to 7 times as many psychiatric nurses.

The number of outpatient psychiatric clinics has increased considerably during the past few years. But the total number, about 1,200, only half of which operate on a full-time basis, is far short of the need. Only a handful of residences are currently available for inpatient treatment of psychotic children. The result is that these children either lack treatment or are thrown together with adult mental patients.

Search and Research

Fortunately, we are beginning to see some progress. I have already mentioned some of the recent gains in care and treatment. A great deal has also been done to help meet the need for trained personnel. During the past decade, a considerable number of psychiatrists, clinical psychologists, psychiatric nurses, and psychiatric social workers have been trained with funds made available under the National Mental Health Act. The Public Health Service's National Institute of Mental Health also provides funds to include psychiatric training in the curriculums of medical schools and collegiate schools of nursing. Research fellowships and other grants have helped to train some of the people needed to do research in mental health.

Research into the cause, treatment, and prevention of mental diseases is a long, complicated, and expensive undertaking. Here, too, the Federal Government provides support and stimulus. Investigators in research centers throughout the country are conducting a wide range of biological, psychological, and sociologic studies with Federal aid. In addition, NIMH conducts mental health research in its own laboratories and clinical facilities.

Out of this work, new knowledge is emerging about the structure and functioning of the

brain and central nervous system, about techniques for treating the mentally ill, and about preventive measures. Special emphasis is being given to such key problems as schizophrenia, alcoholism, mental retardation, and the use of psychopharmacologic agents in treating mental disorders. In a relatively new program, the Public Health Service makes funds available for demonstrations in new methods of treating and caring for the mentally ill.

The growth of community mental health facilities represents another great area of progress. Partly as the result of Federal and State encouragement, communities have begun new programs and services. Voluntary agencies and welfare groups, at all levels, have contributed substantially to this new look at mental health services.

But the task ahead is still a staggering one. Our basic knowledge is far from complete. We are not able to apply even the limited knowledge we do have. It is not likely that we will have all the psychiatrists and other professional personnel we need for many years to come. It is fairly certain that, for a long time at any rate, we will have to "make do" with facilities that are inadequate, in terms of both quality and quantity. All of these areas point up the extent to which the entire community must be involved.

Preventive Possibilities

As a nonpsychiatrist I am afraid I must confess to you that I am rather skeptical about much of what the psychiatrists hold out as effective psychotherapy or as effective prevention. I have unfortunately seen too many instances of exclusive and complete dependence on these resources and too many failures as a result. It is my own private opinion that the ultimate solution of the problems of mental illness lie more within the realm of biochemistry and psychopharmacology. At least in therapy I consider the analyses, the psychotherapeutic interviews, and all the other current techniques to be partially effective, much in the same way that a crutch or a cane is helpful to a person with a fractured leg bone and not much more likely to produce a permanent and successful cure.

As to prevention, I must admit I am not quite so strongly biased. I can accept the analogy which describes individuals as having varying amounts of insulation or protection surrounding the development of their "normal" thought processes and their "nerves." It is quite possible that this insulation can be strengthened by the provision of a wholesome mental milieu or environment for the individual, by the removal from the environment of those toxic factors which would eat away the insulation. Hence, just as a cane or a crutch is useful in preventing a broken leg when one is not quite as steady on his feet as most people or when one is forced to tread a precarious and slippery path, so improvement of the mental environment may be of significant benefit to the borderline individual or others faced by hazards.

The path can be smoothed, straightened, and made passable. This is the job of the community and its various agencies. If you were to draw a circle around the area which contains most of the factors affecting an individual's mental health, you would probably draw the circle around his community, recognizing, of course, that there are certain regional and national forces at work too. The community is the basic element in the mental health effort and even State and national agencies work best when they work closely with community mental health groups.

In only a few communities, however, are attempts being made to do a coordinated job in spite of the fact that lack of coordination means wasted time and effort. Bradley Buell and his associates a few years ago found that 6 percent of the families in a midwestern city were utilizing more than 40 percent of the community's social and health services of all types. For years Buell and his associates have been arguing for a unified effort by community health and social agencies. They suggest that only one agency assume primary responsibility for each family which presents multiple problems, and that this agency then coordinate the services of other agencies in a well-planned rehabilitation effort. To my knowledge this approach has not yet been fully tried anywhere.

Coordinated, long-range programs are essential if we are ever to control mental illness in

the same way that we now control tuberculosis and other diseases. Such programs become more crucial when we consider the effects of improved methods of treatment and the increased emphasis on returning partially recovered patients to the community. For example, many patients may be able to return to the community in the first year or two after hospitalization, and many may be treated on an outpatient basis without ever being hospitalized. This depends, however, on the development of community resources, which are for the most part latent or nonexistent. As we in public health view it, the mental hospital is one of a whole complex of community agencies available to deal with mental and emotional disorders. It can provide professional assistance to other agencies, but needs their assistance to carry out its own mission successfully. The new trends make the community a key factor in the management of mental illness and should dramatically sharpen community awareness of the need for effective preventive work.

What then is the community like? How is it organized and how does it function?

The basic unit, in relation to our problem, is the family. Over and over again it is said that mental health efforts need to be directed to the family—its interpersonal relations, its child-rearing practices, its external attitudes. Families can be reached in a number of ways. We know, for example, that such communication media as newspapers, magazines, radio, and television reach many families at the same time. We also know that families coalesce in neighborhood groupings and in various groups around the school, the church, health agencies, and social and work interests. We know that families need help in child rearing, and that key agencies like the school, church and synagogue, Scouts, and Y's give this help.

Our knowledge of how communities build or retard sound mental health is still inadequate. But we have enough information to warrant trying out various preventive techniques. And it seems reasonable to presume that children, and families in relation to children, would be the most productive starting point in any long-range mental health program.

Almost all children go through the school system, where there is ample opportunity to observe and influence their behavior. If the school is well staffed and equipped, its influence can be in the direction of better mental health. Most schools examine the child's health and confer with parents regarding illness or behavior problems. Some school systems employ psychologists, social workers, and other trained personnel to help in dealing with emotional problems that can best be handled within the school setting. Anyone who has worked in schools and in parent-teacher groups has felt the great striving toward mental health which parents have for their children and for themselves. The school is a powerful focus for mental health efforts.

There are other counseling and guidance services, including the courts and welfare agencies, which should be viewed as resources for mental health work. Even more important, perhaps, for basic preventive efforts are churches and synagogues, places of work, and social and neighborhood groups.

Opinion Leaders and Caretakers

In all communities there are two overlapping groups of people, called by some the "opinion leaders" and the "caretakers," who can contribute much to mental health efforts. The opinion leaders are those whose influence molds the opinions and behavior of a great many people. Political, religious, business, and professional leaders are in this category.

The caretakers are the people who are called on in time of psychological stress, such as bereavement, illness, and changes in job or social role. These situations can be quite critical for people who may need help to function normally. Caretakers who can administer such psychological "first aid" are, among others, physicians, clergymen, police, social workers, nurses, and teachers.

If it were possible to provide some kind of mental health training for the opinion leaders and the caretakers, these key people might be able to do a more effective job. Ultimately they might create a kind of therapeutic environment in the community and spread a "contagion of health." In the long run, such environments would tend to reduce the incidence of mental illness and permit the management and treat-

ment of the less seriously ill right in the community.

Incidentally, we also need to locate the foci of infection in the community—individuals in places of influence who exercise a detrimental effect on the mental health of others. Unfortunately, these people also tend to be caretakers and opinion leaders.

Obviously, more work is needed to identify the key people in the community and to discover the type of training that is best suited for them. This approach, however, is worth pursuing. For one thing, we do not now have nor are we likely to have in the future enough professional mental health workers to do the preventive job that is needed. On the other hand, most communities contain a great reservoir of healthy, well-motivated people who are potential resources of preventive measures. These are the people who keep the wheels turning in the community and keep our complex social system working smoothly. They need to be alerted to spot incipient problems, to help prevent these problems if possible, and to handle deviant behavior in a constructive way.

We need also to deepen our understanding of the social significance of deviance. In a period of rapid change, certain kinds of nonconforming behavior are desirable. If everyone behaved according to expectations, we would very shortly stagnate. Community leaders and caretakers need to know how to deal effectively with the constructive deviant, with the gifted child or adult who can enrich our life, different though his behavior may be. Sometimes it is difficult to distinguish between such a person and someone whose behavior is likely to lead him in a vicious circle toward mental illness. The healthy community will give understanding and help to both types of deviants if it is to avoid becoming overburdened with an increasing number of frustrated, sick individuals.

The Cultural Climate

Finally, the size of the problem requires a great deal of self-help, that is, public education and guidance in sound mental health principles. Casefinding programs aimed at highlighting the individuals with specific emotional difficulties depend upon the dissemination of mental health information and education for the community at large. Then, community mental hygiene clinics could serve as the focal points for anticipating and adjusting conflicts which may arise in normal relationships in the home, the school, and the workplace.

If the emphasis is on prevention, we can be spared from a situation such as one in Ohio where, as part of its program, the State helped support the establishment of community mental hygiene clinics. Far too often, in my opinion, the clinics, organized around a psychiatrist-director, viewed their primary function as diagnosis and therapy of mental illness on an outpatient basis. Within a matter of weeks, the directors were swamped with patients and could not accept new referrals. What is more important, they could reserve very little time for the more important job of providing psychiatric consultation to courts, welfare agencies, schools, and other agencies which deal with people and could use this kind of guidance in preventive and health promotional activities.

What we needed in Ohio—and what we need now throughout the country—are more mental health centers which are devoted exclusively to the work of prevention. Such centers are part of the community's total resources for better mental health, resources which include a great many agencies and groups. These resources need to be known, assessed, and used in a coordinated community undertaking.

I cite once again an experience in Ohio, this one in Franklin County. About a year ago the Franklin County Mental Health Association enlisted all the major elements of the community in a survey on the availability of community resources for mental health. One of the main findings of their survey report was that "good community mental hygiene is not the responsibility of specific mental health services alone, but is also a responsibility shared in part by all and especially by all agencies and individuals who work with people and provide services for people."

This, then, is our modern answer to spells and charms. It will take determination and hard work to exorcise the demons, even of our own day. But the job can be done and must be done if we are to create a healthier world for ourselves and the generations to follow.