REMARKS OF HONORABLE JOHN E. FOGARTY, M.C., SECOND DISTRICT OF RHODE ISLAND AT THE EMMA PENDLETON BRADLEY CONFERENCE TO BE HELD ON OCTOBER 5, 1959, AT THE SQUANTUM CLUB, RIVERSIDE, RHODE ISLAND

# THE CHANGING RELATIONSHIP BETWEEN COMMUNITY MENTAL HEALTH PROGRAMS AND THE MENTAL HOSPITAL

Dr. Laufer in his preliminary letter about this conference said that the participants were being selected "on the basis of professional background and personal contribution." In a medical sense this would bar me from addressing this distinguished conference body. I suspect, however, that my long record of interest in and support of those activities designed to provide for the people of this country better health through expanded medical research is the principal reason for my being invited to participate in this meeting.

As part of my duties as Chairman of the Subcommittee of the House Appropriations Committee for Labor, Health, Education, and Welfare, I have had an opportunity to observe the total set of events in mental illness. It is in this context that I wish to speak with you today. Much that is happening in this total overview has significance, it seems to me, in the specific areas of your interest -- namely, "function and roles in an institutional setting for children with emotional disturbances and relations to social processes and factors in the larger community."

The care of the mentally ill, both adults and children, has changed markedly within the last decade. Until recently, community resources consisted primarily of an inadequate number of practitioners in the field of psychiatric treatment, augmented by a few specialized persons such as marriage counselors and other individuals able to give

some assistance with respect to psychological difficulty. These out-patient resources, usually inadequate in number if not in quality, provided the only possible means of treatment for the person -- adult or child -- who began to develop a psychiatric or psychological disorder. In the event that such treatment was not available or inadequate for the degree of illness, the victim ultimately entered a mental hospital. Usually State-supported, it was characteristically located fairly far from any urban center, probably a great distance from the patient's home community.

The care in such hospitals was primarily custodial for a variety of reasons. One of the major causes was economic in that hospitals had insufficient funds to hire a staff to give each patient intensive treatment. In addition, because of the lack of adequately trained personnel it was impossible to hire adequate staff even when funds were available.

The situation was further compounded because practically nothing in terms of transitional arrangements was worked out to re-integrate the patient into his family and work situation. There also was practically no aftercare or continuing professional service available to the patients, and the probability of relapse and re-entry into the hospital was high. While there were happy exceptions at favored places in this country to the somewhat stark situation described above, it was certainly generally characteristic in the mid-1940's.

Despite the preponderance of custodial care and near-absence of specialized treatment, a fairly large number of patients recovered and were returned to their communities.

Not all of the problems have been solved in recent years, but we do see important and hopeful developments which are based not only on professional advances but upon a new concept of the whole cycle of treatment and rehabilitation of the psychiatric patient.

In the first place, community resources over the last ten years have been greatly improved in terms of quantity and quality. Outpatient care through private practitioners and community psychiatric clinics, for both adults and children, has increased, thus diverting many patients who previously would have been committed to a mental hospital.

Another development has been the great increase in the number of psychiatric wards in general medical and surgical hospitals during this period of time. It is well known that the best time for treatment of the psychiatric patient is at the very onset of his illness. Communities that have had long experience with intensive early treatment have ample proof that a large number of the patients need never enter a mental hospital. The increase in the number of general hospitals with psychiatric wards has had a twofold impact:

.... it has reduced the number of people finding their way into mental hospitals, and

.... It has lifted the stigma often attached to mental illness

because treatment is given under conditions not unlike those encountered by the person with a medical complaint or a surgical need.

Another heartening development over the last several years has been the trend to incorporate what one may call the indigenous structures of the community into the defensive system against serious mental illness. Many of these important efforts are still in the exploratory, pilot, and even experimental phases. One of the most promising examples is the tendency for the schools to shift away from a case-finding approach to mental illness. Instead of waiting to identify children already in psychiatric difficulty, the trend is toward a more encompassing point of view in which efforts are being made to find out the effects on personality development and mental health generally of the entire way in which the school is administered and conducted. Through this new approach the school makes a contribution of a positive nature to many children who are not sick and identifies just as effectively as ever those who are already in difficulty. As the fruits of the projects, such as those being conducted by the FHE in Florida and the case investigation of school mental health at the Bank Street College of Education in New York, become available and integrated into educational thought and philosophies, one may at least hope for a substantial improvement in the developmental events of childhood in the mental health field.

Today both management and labor are looking at the impact of the work situation upon the mental health of employees, which of course affects the family situation and the psychological robustness of the entire population. Perhaps the developments in these areas are even less advanced than the developments in the schools, but they are beginning on a research and demonstration basis at Yale University, the University of Michigan, and at other places in a variety of other settings.

The developments which I have briefly described give a cross-section of some of the emerging measures, many of which did not exist ten years ago, that may resolve adjustment problems before a person reaches the status of a psychiatric patient. It is true, of course, that the mental hospital is still the most effective place for the care and treatment of many who are mentally ill. Here, too, the last decade has seen gratifying developments. Concepts of effective treatment have shifted from psychosurgery to shock therapy, group therapy, and other types of intensive treatment. One of the great advances, of course, has been the development of psychopharmacological techniques which have made much more intensive treatment possible. These new methods hold a vital key in the effort to decrease the length of stay in the mental hospital and to increase the rate of release from the hospital.

While there is still an acute manpower shortage, the support given through Federal and State resources in the last ten years for the training of people in the mental disciplines has done much to make personnel available to those hospitals fortunate enough to have budgets allowing payment of adequate salaries and provision of good working conditions. Many States have recognized the need to improve professional standards in their hospitals and to initiate teaching research programs which previously were practically nonexistent. The program of the Emma Pendleton Bradley Hospital is an outstanding example of this trend.

There can be no doubt that the quality of care in increasing numbers of mental hospitals has risen sharply in the last ten years. For example, comparative studies of release rate by age, sex, and diagnosis covering 45 or 50 years of experience show that a psychiatric patient entering a mental hospital today has a much higher probability of release alive than was the case 20 or 30 years ago. It must be said in all honesty that the improved prognosis does vary with respect to the patient's status upon admission (that is, diagnosis, age, etc.) The essential point is, however, that mental hospitals today are demonstrating that they are and can be true treatment centers with differential treatment for specific disorders and with a fair prospect of returning an increasing number of their patients to the community. These are the fruits of increased activities in training and research in the

mental health field coupled with vigor, enthusiasm and wisdom in the administration of the single most costly component of our inpatient health resources.

Finally, to bring us full circle, the road back to the community has been greatly improved in the last decade. These developments are certainly as significant as those already described. The patient who is judged able to leave the hospital is not the same person he was before he got ill, nor is he necessarily able to cope with the demands and needs of the outside world as well as the normal person who has never undergone a psychiatric episode. To return him to his community with no special arrangements is to invite a second, perhaps more profound, disaster in his life span. Much thought has been given to this problem over the last few years, and some significant developments have occurred. There are some half-way houses, sheltered workshops, day hospitals, night hospitals, and other facilities which help make the return of the mental patient to the outside community a transition and not a sudden re-immersion into the hectic everyday life of the world. Coupled with these transitional devices there are programs of aftercare which provide follow-up and guidance for the ex-mental patient through continued contact by out-patient facilities of the State and local health departments. There are clear indications that such interested follow-up by professional personnel, usually psychiatric social workers, can do much to assist the returned patient to deal with the problems with which he must cope as well as to orient his family and his employers with respect to the

special needs and problems faced by him. Thus the difficulties of re-entry into society may be minimized and the person's possibility of success maximized.

In summary, then, the mental hospital and the general hospital with specialised facilities no longer stand as the isolated institutions to which those who have become ill in a psychological or psychiatric sense are relegated. Today we see an emerging specialized treatment center, integrated with cooperating community resources, working toward minimizing the patient load, and aiding in the rehabilitation of the discharged patient. The results are obvious: we must continue to improve all of these resources; and we must do our utmost in increasing the communication between the institutions and those resources for the community preventive programs, transitional arrangements, and aftercare programs. Concerted efforts by persons of good faith working in all these fields give promise of a brighter future for those who have experienced psychiatric illness.