Whatever happened
to
"community mental health"?

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Getting what one wants may be one of life's disillusionments, but it is also instructive. In October 1963, supporters of the "community mental health" approach to psychiatry got a good deal of what they wanted when President Kennedy signed the Community Mental Health Centers Act, authorizing $150 million for the construction of community mental health centers (CMHC's) over the next three years. The idea's supporters got even more of what they wanted in 1965, when $73.5 million in federal money was allocated for the additional purpose of hiring professional and technical staffs for the centers. By now over $900 million has been spent or obligated for the CMHC program, nearly 450 federally aided centers have opened, another 150 are already funded though not yet operational, and an estimated 86 million Americans live in the service areas of these 600 organizations.

The federal money was welcome because it seemed to make possible, as President Kennedy put it, "a wholly new emphasis and approach to care for the mentally ill." It would allow not only more equal access to mental health care but the provision of a broad spectrum of services-in-patient, out-patient, partial hospitalization, emergency, and education-consultation—to fill the enormous gap between the needs of those with only minor emotional tension and those
whose illness required full hospitalization. A CMHC could usually receive federal funds only if it provided a full range of services, at one site or within easy reach.

This broad-spectrum treatment was necessary, it was thought, to move psychiatry beyond its traditional one-to-one therapy and its emphasis on individual adjustment. As Dr. Leonard J. Duhl, then of the National Institute of Mental Health (NIMH), put it in 1961, “We need to utilize the larger political perspectives which might suggest institutional changes, producing practical changes in the mental hospital almost as a secondary consequence.” In Duhl’s view, the profession’s “total resources and responsibility” had to be reanalyzed and reallocated so that psychiatry could realize its potential as the “humanistic aspect of a technological society,” as “an alternative to the conformities and the well-defined structure that develops when a very complex society retreats to rigidity in order to handle the confusion of complexity.” Opponents of this grand view of psychiatry, in fact, could best be labeled as persons “paranoidally opposed to changes in society” who saw the discipline as a “threat” to the status quo.

**Formula for success**

Psychiatry, according to this understanding, could bring about mental health only by concerning itself with large numbers of people and with the social conditions around them. Such a view seemed to be supported by a good deal of research done in the 1950’s, research which both pointed to the need for broader psychiatric intervention and held out the promise of success through the new method. First, there had appeared new, higher estimates of the number of citizens needing mental evaluation and treatment. One of the most influential of these studies took place in a Canadian Maritime Province, where investigators concluded that only 17 per cent of the population was “probably well.” The rest ranged from “doubtful” to “most abnormal.” If figures like these held true in many places, there was an obvious need for many more mental health workers and for a broader attack on mental illness.

Furthermore, other research suggested that the broader attack could be successful. There was, it seemed, a firm link between environment and mental health, and at least the outlines of the kinds of interaction necessary for normal human development had been identified. Few claimed that answers were available in detail. But according to community mental health advocates such as Harvard’s
Dr. Gerald Caplan, what was most needed was to reform community organization, establish earlier and more thorough detection of mental illness, and provide treatment which would be more effective because it would be administered at an earlier stage. So the possibility that perhaps two-thirds of the population was emotionally distraught signified to community-minded mental health workers in the early 1960's the existence not of an intractable problem but of a gigantic opportunity for social progress.

There were few doubts about whether the new methods could ultimately succeed. In an address to the American Psychiatric Association in May 1963, its president exhorted:

We must remember that the support we have received is based upon an expectation that sooner or later we will be able to find answers to many social problems. . . . We are being handed the opportunity and we cannot afford to hand it to others or to put it down. As [novelist Philip] Wylie said, "You can inherit the earth. The only question is, 'How soon?' . . . Never was chaos so great; never was Paradise so near the reach of common folks—like you and me."

Advocates acknowledged that their method was "in part a political movement," but they often overlooked the possibility of a genuinely political opposition. Too often, they ascribed disagreement to simple ignorance or even emotional illness in their opponents.

This was the faith which welcomed federal funding for the CMHC's; in retrospect, its rhetoric is a considerable embarrassment. The federal subsidy today is a target for elimination by the current Administration. But more than that, it is a subject of serious internal professional dispute as well. The program is criticized for distorting psychiatric training and research, for embodying the arrogance of social engineering by euphoric experts, for making and breaking extravagant promises to poor and distraught communities, for being primarily an ambitious power play by federal mental health bureaucrats. The story of the program's rise and fall in esteem is partly the story of the Great Society's rise and the subsequent suspicion of federal activism in general; it is partly the story of a profession's climb to power in the federal government. But just as important, it throws light on both the persistence and the recent wavering of the American faith in the power of social environment and in mental health experts as manipulators of that environment.

Psychotherapy and the American creed

If the community-approach advocates showed a remarkable faith in their discipline's ability to work environmental changes, they were
not voicing anything foreign to psychotherapy in America. Psychotherapy—treatment for mental tension or illness through personal communication—began to gain adherents and some popularity in the United States around the turn of this century, even before the introduction of Freudian psychoanalysis, Adlerian individual psychology, or Jungian analysis. The indigenous American psychotherapy movement was distinct from the older, more pessimistic psychiatry of the late 19th century, which saw the roots of mental illness in often-intractable organic causes. The new movement, by contrast, offered the possibility of using modern psychological treatment to achieve real cures for the mentally ill. Enthusiasm for the new psychotherapy emerged, not surprisingly, during the period of Progressive social reform and of the general growth of social services based on professional expertise. Belief in the possibility of personal cure accompanied belief in the possibility of social remedies.

When the Continental psychologies came to America, they were quickly incorporated into the armamentarium of Progressive reformers—but not without considerable distortion. Freud, for instance, approached the mind as a scientist seeking understanding; he certainly did not expect immediate or even rapid social change through psychological insight or therapy. The Americans adopted Freud with enthusiasm but ignored his caution; they wanted simpler explanations, more rapid cures. Ironically, while no other country has welcomed or fostered psychoanalysis as much as the United States has, none has been so willing to ignore Freudian restraint in order to apply psychological theory directly to public policy.

The applications came soon enough. By the 1920's, the juvenile court clinics, begun in 1909 to apply psychological principles to wayward youth, had given birth to Child Guidance Clinics which treated any child with emotional problems. These clinics usually employed treatment teams, in a new division of specialized labor similar to that not only of the Mayo Clinic but also of Henry Ford's assembly line. The team—with a psychiatrist as leader, a psychologist to conduct tests, and a social worker to provide knowledge of family setting and environmental resources—attempted to predict future maladjustment or treat current difficulties.

The establishment of these Guidance Clinics in the 1920's was prepared by a series of demonstration projects across the United States, funded by the Commonwealth and Rockefeller Foundations. In these clinics, treatment teams sought to fight mental illness in the same way that public health workers had effectively fought public health menaces like tuberculosis—through early identification and
quick treatment. This public health approach to mental illness had been proposed as early as 1909 by the founders of the National Committee for Mental Health (now the National Association for Mental Health). The 1920's also saw the founding of the American Orthopsychiatrie Association, a group of professionals—including psychologists, social workers, and lawyers, as well as psychiatrists—who, encouraged by the promise of the Child Guidance Clinics, believed that widespread application of mental health principles, especially to children, would substantially improve society, reduce crime and poverty, and aid in reforming the criminal justice system, the schools, and other institutions. The mental health profession's entry into the public arena, in short, had been an early and optimistic one.

The limits of growth

The day-to-day experience of the various clinics provided sobering evidence that could have been weighed against the early optimism of their advocates. Predictions about adult adjustment and screening programs to detect misfits turned out to be of little value: Without better knowledge about the causes of mental illness, such preventive efforts were impossible. As for treatment, the results were sometimes helpful but certainly not dramatic. Practitioners did have some success in making the courts appreciate the environmental complexities of behavior, and treated families were perhaps less inclined to punish children for the sake of punishment. But in general, training parents in approved child-rearing practices—one of the clinics' chief goals—proved a frustrating failure; and treating the emotionally disturbed children themselves frequently proved not less time-consuming than treating adults, as had been expected, but even more lengthy. These experiences, however, did not end faith in the eventual value of prevention, early detection, and early treatment of mental illness. Usually, failure was ascribed to inadequate technique and lack of manpower and funds, but not to flaws in the ultimate goals. What limited the further application of the new faith was not discouraging empirical evidence but the attitudes of the federal government.

Psychiatric hospital care had been primarily a state responsibility since the 19th century. Attempts to involve the federal government in providing direct patient care for the indigent mentally ill failed repeatedly. One early attempt by Dorothea Dix came close to success in 1854, when both Houses of Congress passed a measure grant-
ing federal lands for the construction of state mental hospitals. President Franklin Pierce, however, vetoed the measure, stating:

I cannot find any authority in the Constitution for making the Federal Government the great almoner of public charity throughout the United States. To do so would, in my judgment, be contrary to the letter and the spirit of the Constitution, and subversive of the whole theory upon which the Union of these States is founded.¹

This strict constructionist philosophy prevailed until the 1930's, and the keen vigilance of the American Medical Association (AMA) against the first signs of socialized medicine helped it to do so. From the beginning of the 20th century, the federal government began providing small matching grants to state and local communities for health services, but AMA opposition kept such efforts from growing larger. When the Public Health Service in 1930 acquired a Division of Mental Hygiene, it was not only federal economizing but the opposition of organized medicine to federal expansion in the health field which kept the Service's efforts minimal.

The uses of adversity

Two things helped change the balance of opinion about federal health activity. First, the Depression established a general precedent for large-scale federal intervention to meet major domestic problems. Just as important, though, World War II both seemed to provide an impressive demonstration of the value of the mental health professionals, and gave the professions themselves almost all the precedents they later drew upon in establishing postwar mental health programs. At the outbreak of the war, most full-time psychiatrists worked in mental hospitals, while the few clinical psychologists primarily gave mental tests. The war instantly increased the demand for professionals. Psychiatry, clearly the dominant discipline in the therapeutic professions until the late 1960's, thereby received long-awaited large-scale recognition.

Military leaders were astonished to find almost two million draftees rejected from the services for mental disorder or deficiency; the admirals and generals had had no idea that there were so many mentally unreliable persons. Even though rejection rates before training significantly constricted the supply of able-bodied service-

¹ Senator Stephen A. Douglas of Illinois concurred. The measure, he said, "opens a door to the extension of power of this Government and its jurisdiction, in derogation of the rights of the States, to a wider and more fearful extent that any bill or proposition which I have ever known to be presented."
men, the military accepted the psychiatrists' judgments in these cases and thus enabled psychiatry to expand its role and authority in the medical services. Psychiatrists proved valuable at the front as well. They had an admirable record for returning a high proportion of "battle-fatigued" servicemen to the front after brief therapy, and they were impressive at providing explanations to the line command for the bizarre and irritating symptoms exhibited by the emotionally disturbed.

As with the Child Guidance Clinics, there is reason to question the scope of these accomplishments that both psychiatrists and the military accepted so unreservedly. For one thing, the high rejection rates at induction centers seem to have been in large part the result of the psychiatrists' oversensitivity to any hint of mental disorder. Thus, while the U.S. rejection rate for mental problems was six times higher than at British induction centers, the British rate of discharge from active duty for psychological reasons was no higher than the American one. And even the "battle-fatigue" successes were not necessarily of broader significance. Breakdowns under extreme battlefield conditions, though they may appear similar in their expression to civilian neuroses, can apparently be relieved much more easily once the extraordinary specific stress is relieved. Thus there was no necessary connection between the wartime successes and the ability to treat more chronic emotional disturbances.

These, however, were not the conclusions drawn at the time. After the war, Brigadier-General William C. Menninger, head of army psychiatry, spoke of its lessons for the future of American psychiatry in general, citing early detection, referral to a psychiatrist, and "team" treatment as key factors in the phenomenally high wartime recovery rate. Above all, he believed, the war taught that psychiatry should be allowed to stand on its own feet rather than be considered merely a subfield of medicine. All too often, he claimed, commanding medical officers, ignorant of, or unfriendly to, psychiatric treatment and theories, made regrettable decisions involving psychiatric care.

Dr. Menninger further argued that psychiatry must contemplate the possibility of applying its wartime lessons in the broader civilian arena. And if there were to be such application, he wondered whether there was any justification "for some of our best psychiatrists limiting their practice to the same eight or ten patients every day, in many of whom they invest hundreds of hours." Dr. Menninger saw the "handwriting on the wall for some of the future trends in this field":
As yet we have not begun to reach the average man on the street. We must conclude that to date psychiatry has fallen far short of its potential contribution and its service must be tremendously expanded.

The profession had emerged from the war with its faith in community treatment strengthened and its self-confidence raised.

**Institutionalization of the faith**

In the last months of the war, Representative J. Percy Priest of Tennessee introduced a bill to establish a National Neuropsychiatric Institute as one of the National Institutes of Health (NIH). Surgeon-General Dr. Thomas Parran and Dr. Lawrence Kolb, Sr., of the Public Health Service's Mental Hygiene Division had been planning for such an Institute from the late 1930's, and the idea's time had finally come. The National Mental Health Act of July 1946 created the body as the National Institute of Mental Health (NIMH). In 1946, Dr. Robert H. Felix, soon to become the NIMH's first director and eventually to oversee the passage of the CMHC program through Congress, spoke of his hopes for federal activity in the area. The "cornerstone" of the new program, he said, was "the concept of mental health and mental illness as a public health problem and utilization of the strategy which has proved most successful in coming to grips with health problems in other fields."

In addition to federal support for training, research, and education, Dr. Felix foresaw, as in the campaign against tuberculosis, "an easily applied and reliable screening method . . . to bring to light and study many cases of personality disorder which would not come to the attention of the psychiatrist until the symptoms were more advanced. We would then have a real opportunity to try preventative measures." The major locus of treatment would be "properly staffed out-patient clinics," which might postpone or prevent hospitalization, permit earlier hospital discharge, and educate the public. Dr. Felix cited the need for one mental health clinic for every 100,000 citizens "to provide a well-rounded and integrated program for the whole community. . . ." Some hopes that were later expressed for the 1963 Act were missing from the 1946 speech: Dr. Felix did not speak of completely abolishing the state-controlled hospital system or of reordering social conditions to alleviate mental illness. But many of the assumptions of the 1963 Act were already in place by this time, as indeed they had been in place since the turn of the century.

Despite Dr. Felix's vision, the legacy of strict constructionism and
AMA opposition had by no means been completely obliterated by the Depression and the war. The NIMH's origins coincided with intense debate over President Truman's plans for federal compulsory health insurance. In this atmosphere of controversy, the NIMH had ample incentive to proceed traditionally and cautiously; indeed, its annual budget did not reach $12 million until 1954. More important, the prohibition against direct federal aid for patient care was still in force. The only major exception was the Veterans' Administration, which remained the primary center of federal activity in mental health. The VA provided strong support for medical school training and research and established psychiatric hospitals and out-patient clinics of a quality rarely available before except in private institutions.

The VA's effort was widely accepted because of the special responsibility the federal government owed to ex-servicemen. In state-supported institutions the care provided to hospitalized mental patients had been deteriorating since the 1930's. The number of patients in these dismal hospitals increased yearly. By 1955 they totaled about half a million and accounted for half of all the hospital beds in the United States. By 1960, the VA psychiatric hospitals had a patient care cost of $12 per day, while state, city, and county psychiatric hospitals spent only $4. The idea of community treatment was popular, but the state hospitals could not be phased out or improved unless the prohibition against direct federal aid for patient care was overcome. (The federal government appeared to be the only source of enough additional money to care for these patients properly.) Although the state hospitals were largely hidden from public view, mental health workers were aware of them, and in the early 1960's they seized the moment when the federal government finally decided to allocate significant funds to the direct care of the mentally ill. If some of the promises made to get that money were excessive, one can sympathize with the motivation to improve these lamentable conditions in any possible way.

The last mile is the hardest

Beginning in the 1950's, a succession of public bodies tried to formulate a new federal mental health policy. In 1955, Congress authorized a multidisciplinary re-evaluation of all aspects of mental illness, with a view to formulating "comprehensive and realistic recommendations" to meet the problem. The Congressionally established Joint Commission on Mental Health and Illness submitted its
report in 1961; the report recommended that President Pierce's veto of the Dorothea Dix plan be reversed, and that the federal government begin to give significant amounts of money for the care of the mentally ill. The federal money would be given in mounting increments to the states beginning at $100 million a year, to reach an appropriation of $1 billion annually in 10 years. Local participation was to be encouraged through further federal matching grants, bringing the annual total of federal contributions to $1.75 billion after 10 years. The Commission also recommended a wide variety of additional services—clinics, training, research, public education.

What the Commission did not do was to suggest virtual abolition of the state mental hospitals; instead, it called for a system of minimum standards and upper limits on numbers of patients. Also, the Commission made a firm decision not to emphasize prevention of mental illness, because the effectiveness of preventive methods had not been proved to its satisfaction. Generally, the Commission showed a certain restraint: "In the absence of more specific evidence of the causes of mental illness," it said, "psychiatry and the allied mental health professions should adopt and practice a broad, liberal philosophy of what constitutes and who can do treatment. . . ."

While the Commission was at work, another study was begun on the problem of increasing and coordinating federal aid in the mental health fields. In 1959 the Surgeon-General appointed a committee of state health authorities to work with the Public Health Service in drawing up guidelines for comprehensive state mental health planning. The Committee's report stressed the need for many of the services that the Commission had mentioned, and favored even more stringent limits on the size of state mental hospitals. The federal legislation contemplated by the Committee also featured (as the Commission plan did) federal funding through the states, presumably for construction rather than staffing. Increased aid to the mentally ill themselves was to come through the public assistance provisions of the Social Security Act. The Committee recognized the shortage of mental health professionals but pointed to the rapid growth in their numbers and claimed that good facilities in rural areas had proved helpful in attracting competent medical personnel.

These reports were not comforting to the mental health professionals at the NIMH. Although the report of the Surgeon-General's Committee had led to an appropriation to the states to prepare state mental health plans, the NIMH had less involvement in this planning process than it would have liked. It feared that the result-
ing approach would be too cautious, too dependent on state funding, too much associated with already-existing health facilities, and too hesitant to demand federal staffing grants as a necessary element in the program.

In other words, from the NIMH's point of view both the Surgeon-General's Committee and the Joint Commission suffered from an excess of tradition. The Public Health Service staff which had led the Surgeon-General's Committee were those involved with hospital construction under the Hill-Burton Act, and had estimated that only about $50 million a year would probably be available from federal funds for community mental health facilities. To NIMH leadership, the construction background of the PHS bureaucrats was auspicious for a dramatic change in the federal approach, and the budget that the PHS anticipated was too small for producing the changes required with the necessary speed. The Joint Commission had called for more money, but failed to call for the uprooting of the state hospital system or to express faith in the possibility that community psychiatry could reform society and thereby reduce the incidence of mental illness among the citizenry as a whole. NIMH leadership, in short, was impatient with what it saw as bureaucrats doing business as usual.

NIMH leaders also were troubled by something else in these reports—the question of control. If federal mental health policy were to make the required major departures, it was necessary that only NIMH psychiatrists, rather than conventional bureaucrats, have control over planning, budgeting, and operation of the national community mental health program. This kind of centralized professional supervision over both services and research represented a departure for the National Institutes of Health; the NIH usually conducted research and supported other training and research activities, while the PHS and other parts of the Department of Health, Education, and Welfare dealt with the states and with the actual delivery of treatment. Dr. Felix, however, now NIMH Director, saw mental health as unique: One need not conform to the usual custom in this area, but on the contrary must get the emerging program away from the doubting, conservative bureaucrats and let his experts carry the ball.

**The NIMH victory**

So by late 1961 the NIMH staff had prepared its own plans for mental health centers. Staying within the Joint Commission guide-
lines for the amount of federal funding, the NIMH report projected the goal of 2,000 mental health centers in existence by 1980. The report deviated from its predecessors by insisting that the federal money should be used not only for construction but also for staff salaries.

At first this NIMH vision seemed to have little chance of being accepted, since the King-Anderson bill providing for broader health care through Social Security had just met defeat at the hands of the Health Insurance Institute and of the AMA, which adamantly opposed the bill's proposal for federal funding of physician services. The Surgeon-General's Office and the Director of the NIH, Dr. James A. Shannon, took note of this controversy and of the traditional federal role in mental health when they criticized the NIMH scheme. The question of federal payment of medical staffs, they said, should be decided not by NIMH alone but at higher levels of government. NIH's Office of Planning stated that before NIH could support the NIMH proposal, the latter would have to give persuasive reasons for such a departure in policy and present a "corroborative statement justifying such action by the Federal Government in providing support for the care of the mentally ill and not for other chronically ill persons of the nation." President Pierce's century-old criticism was still alive.

At this point, though, the White House intervened to provide encouragement for the NIMH plan. President Kennedy wanted to make a major contribution to the problems of mental retardation and mental illness. He read the Joint Commission Report, and he and his health appointees decided that implementing it would be one of the Administration's higher priorities. On December 1, 1961, he appointed an interagency committee to decide how this implementation should take place and to prepare for a Presidential message to Congress on the subject early in 1963. The interagency committee report that emerged strongly resembled the vision of the NIMH. Continuous care within the community was preferable to refurbishing the state hospital system, the committee said, and therefore a network of CMHC's should be constructed throughout the nation through federal aid in the Hill-Burton tradition. State hospitals were to be aided, but with the understanding that an ongoing transition to CMHC's would ultimately reduce the need for these hospitals.

The CMHC's would emphasize the general promotion of mental health and the prevention of mental illness. By 1980 they would require a tripling of the number of mental health personnel, whose
salaries would be met through direct federal aid during the first few years of operation only, as opposed to the NIMH plan for an open-ended subsidy. The committee thought that health insurance programs could eventually play a more decisive role in mental health services and relieve government costs for them.

The President decides

President Kennedy's optimistic message to Congress on mental illness and mental retardation, on February 5, 1963, incorporated his committee's recommendation: "If we apply our medical knowledge and social insights fully," he declared, "all but a small portion of the mentally ill can eventually achieve a wholesome and constructive social adjustment." He was confident that "a concerted national attack on mental disorders is now both possible and practical."

The key to success would be the Community Mental Health Centers, where it would be "possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society." There would be major emphasis on mental illness prevention, which was "far more economical and... far more likely to be successful." The centers, "ideally... at a community general hospital," would receive federal construction funds; and as a compromise between full, permanent payment of staff costs and no payment, the President recommended federal aid beginning at 75 per cent of staff costs and phasing out in about four years. The state hospitals, destined to play a "valuable transitional role," should receive $10 million in federal aid to improve existing care; and professional manpower had to be increased from the 45,000 existing in 1960 to 85,000 in 1970.

Neither the funding level envisioned in the Kennedy message nor the idea of federal staffing grants survived the Congress of 1963. First, the House Subcommittee on Public Health and Safety cut the Senate's proposal for overall funding levels from $657 million to $284 million, and then the full House Committee on Interstate and Foreign Commerce eliminated the federal staffing grant proposal altogether. The committee seems to have been strongly influenced by the AMA leadership. The CMHC Act that President Kennedy finally signed on October 31, 1963, specifically provided for a three-year construction program of $150 million, to make possible the funding of about 145 centers between July 1964 and July 1967. Planning could go forward within the states while the Administra-
tion made further attempts to get staffing grants. The staffing grants finally did emerge—but not until the summer of 1965, when President Lyndon Johnson signed amendments to the CMHC Act authorizing $73.5 million for this purpose.

Despite its omission of staffing grants, the Act of 1963 provided significant victories for the NIMH advocates and paved the way for future victories. For one thing, the goal of prevention—and the assumption that one knew how to prevent mental illness—had been endorsed in the Presidential message. To Dr. Felix, this endorsement suggested possibilities far beyond the words of the message itself. Two weeks after the passage of the 1963 CMHC Act, he described the tasks of the mental health center as including:

...not only the reduction of those factors which tend to produce mental and emotional disturbances, but also the provision of a climate in which each citizen has optimum opportunities for sustained creative and responsible participation in the life of the community, and for the development of his particular potentialities as a human being.

In short, the centers would not limit themselves merely to preventing abnormalities but would also promote positive self-fulfillment.

Securing the beachhead

Furthermore, the CMHC program was a means through which the NIMH could achieve victory in its power struggle within the federal government to win more autonomy and appropriations, and in its battle within the states to wrest power from the hospital superintendents who influenced the control of state funds—about $1 billion a year—appropriated for patient care. First, if the NIMH directed a national delivery system and funds were allocated to the NIMH budget, rather than to the PHS Bureau of State Services, a good case could be made for elevating the NIMH to bureau status. Second, the program’s goals meant that state hospitals would be by-passed while new local institutions would provide complete community services. Meanwhile, other power centers in the mental health professions—academic departments of psychiatry, psychology, and social work, and various professional organizations—would get additional training, faculty, and building funds and increased status in their communities as they cooperated in creating the CMHC program.

At least some of these possibilities were indeed realized. After the 1963 Act was signed, it was the NIMH, rather than the PHS
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Bureau of State Services, which won primary control over the planning and design of the centers. Only a psychiatric agency, the NIMH successfully argued, could evaluate these services properly. In 1964, new regulations for the centers mandated that only psychiatrists be directors of clinical services and named the NIMH as the evaluator of proposed CMHC's. In 1966, the NIMH attained its goal of becoming a bureau; reorganization, placing it on an equal footing with its parent, the NIH, took effect on January 1, 1967.

The assumptions which underlay the 1963 Act and which permitted the NIMH rise to power did not receive, and were not likely to receive, much criticism from within the mental health profession. Even those with doubts often benefited in some way from the total program, and the NIMH argument that division in the ranks might lead to no new program at all also helped to quiet the skeptics. But the NIMH advance was not merely the creation of strategists aiming at greater power and others hoping to share in that power; it was consistent with one of the lines of the most advanced serious professional speculation. Analysis of group and social behavior in the 1950's had concluded that communities as a whole should be the object of concern because their often ineffective or destructive patterns of interaction appeared to cause higher levels of mental pathology, and these destructive patterns could be corrected under expert guidance. The CMHC program would be one of the federal government's first attempts to raise national mental health by improving the quality of general community life through expert knowledge, not merely by more effective treatment for the already ill. The enormous potential contribution of the mental health professions to national betterment had at last been recognized. These were, then, exciting times for the NIMH; the difficulties of creating the "bold, new approach to mental illness" would appear only later.

Faith versus works

The first practical problem that beset the NIMH as it began creating its network of centers was how to obtain the large numbers of properly motivated professional and non-professional personnel needed to run them. The problem with the professionals was to persuade the typical private-practicing, one-to-one therapist to get the faith and turn his eyes away from the individual patient toward the community.

Various forms of persuasion were used. First, there were general exhortations to the profession. In 1965, the chief of the NIMH's
planning office admitted the difficulty of transition to the “foreign world” but insisted:

Nevertheless, it is the real world where basic decisions are made... It is the world in which the future of mental health services will be decided, even more markedly than by psychiatrists... Thus we must begin to work with the politicians and with other planners and on all levels.

Many professionals actively entered into the state-wide and local planning processes, anticipating an exciting experience in improving their communities. To those who had not caught the vision, the enthusiasts would not only speak of “proof” that they could reform communities but warn that Congress or “the community” demanded that the mental health professions perform their task without dawdling—although the goal of “community reform” had in fact been the planners’ own inspiration and favored emphasis.

The NIMH worked not only with the profession in general but with professional training centers in particular. For example, the new program’s goals and needs were delivered directly to the nation’s medical schools through a series of Regional Institutes on Training in Community Psychiatry, from October 1963 to February 1964. The need for a strong emphasis on community psychiatry, an element then lacking in two-thirds of all psychiatry departments and very new in most of the other third, was presented as President Kennedy’s “demand,” his “call to action” for a “completely new approach.” Dr. Gerald Caplan, one of the most influential theorists and educators in the new field, described the community psychiatrist as different from his traditional colleagues in having to provide services for a large number of people with whom he has had no personal contact, and of whose identity and location he has no initial knowledge. He cannot wait for patients to come to him, because he has equal responsibility for all those who do not come. A significant part of his job consists in finding out who the mentally disordered are and where they are located in his community, and he must deploy his diagnostic and treatment resources in relation to the total group of sufferers rather than restrict them to the select few who ask or are referred for help.

Certainly this new role required an enormous change in perspective for both academic and practicing psychiatrists. But there would be trouble for the profession if it did not obey the new federal “demands”:

Will it be worth the effort involved? This question implies that we have a choice. I do not believe we have. The demands of the legislators are
no passing fad. . . . They are in line with other governmental planning developments in the public health, social welfare, education, and urban renewal fields. . . . We are today witnessing a major trend. If we do not wish to accept the community leaders' mandate, we will undoubtedly be pushed aside and replaced by others. If psychiatry rejects the preferred roles in community programs for the prevention and control of mental disorders, these will be offered to other professions. . . . To retain our leadership we must accept the legislators' offer and rise to the challenge of adjusting our professional theories and practices to the new situation which confronts us. . . . Perhaps we will be strengthened in overcoming the inevitable obstacles by the realization that we have no reasonable alternative.

The vast majority of training programs, lured by additional funds, the thrill of the undertaking, or the fear that its psychiatrists would be by-passed if they rejected the "mandate," did just what was asked by the NIMH. The result in many training centers was enormous growth in the number of residents, the creation or great growth of community services, and the establishment of training programs for "psychiatrist-administrators." There was also considerable emphasis on the training of "indigenous workers" or "aides," who perhaps had little formal education but who could presumably communicate better with the neighborhood or were simply needed to fill out the huge number of psychotherapists that the anticipated centers would require "to lower the level of pathology in a total community."

The CMHC's and the local communities

The NIMH has also scored an apparent success in getting patients out of mental hospitals and back into their communities—an important goal of the CMHC program. Year by year, the average census of state mental hospital patients has been dropping. A large chart showing this decline is the inevitable background to an NIMH press conference or Congressional hearing.

But one should not be too quick to take this drop as proof of CMHC effectiveness. Although the average census in state mental hospitals dropped from a high of 557,000 in 1957 to 249,000 in 1973, a team of NIMH investigators, speaking only on their own behalf, reported to the 1973 meeting of the American Psychiatric Association that "evidence as to the impact of the Centers Program on the use of state mental hospitals is equivocal. . . . No large consistent relationship appears between initiation of federally funded centers and change in the in-patient rate in state mental hospitals." The
CMHC's might be performing other valuable services in their communities, but they simply could not claim primary credit for the drop in the hospital census.

But even if the CMHC's could properly claim a major portion of this credit, it is not so clear that they should want to. The hospital census has been reduced by means ranging from hospitals' abundant use of drugs to the massive discharge of patients, many of them elderly, to proprietary nursing and foster homes. In these domiciles, the discharged patients too often receive care worse than in the average state hospital. It is, as critics put it, merely a move "from the back yard to the back alley." After inadequate or nonexistent "community care," many of these individuals are soon readmitted to the hospital, in a process described by Murray Schumach of the New York Times:

... thousands of the released patients who were supposed to be getting treatment that would rehabilitate them had become part of a vicious "revolving door." This meant that many patients, denied treatment and adequate facilities, drifted from state institution to sleazy hotels, to the street, to such city institutions as Bellevue, and back to the state institutions.

This situation helped to produce the drop in the average census and the average length of hospital stay; it has also produced, because of the "revolving door," an enormous rise in the number of annual admissions to the state hospitals, from 200,000 in 1956 to 400,000 in 1972. Seen in this light, the omnipresent NIMH chart does not appear quite so impressive.

The CMHC's encountered much greater difficulties in their attempts to establish fruitful relationships with the "total communities" around them. The centers began operating just as many local communities, particularly those mired in poverty and given priority as CMHC targets, were seething with overt anger against the Establishment. The early centers tried various ways of intervening in this collision with troubling and even harrowing results for CMHC staffs.

Some of the most dramatic confrontations occurred at those centers which involved themselves in their communities by enrolling local residents in training programs that promised a career in the mental health field. The experience of New York City's Lincoln Hospital, afflicted in the late 1960's by a variety of local problems, dramatically revealed the effects of this unwarranted raising of expectations. Lincoln Hospital's mental health service, aided by both OEO and NIMH grants, recruited 140 black and Puerto Rican
"indigenous workers," who became increasingly restless when significant jobs did not materialize for them after their training. In March 1969, they took over the mental health service entirely and threw out the professional staff. Other confrontations of this sort befell the CMHC's as they first presented themselves to poor and angry local citizens as a source of substantial help for the community as a whole, and then found that they had stirred up feelings and expectations they could not fulfill.

Even apart from the hopes which the centers themselves stirred up, the CMHC's found that mental health expertise could do little to quiet rioters or diminish social unrest as the turmoil of the 1960's continued. Some of the professionals trained in community psychiatry concluded that the centers should not try to defuse or mitigate community anger through "environmental manipulation," but should instead join with the community in demanding better social conditions and equal justice through political activity, demonstrations, and, at times, violence.

Other centers forged ahead with a more specifically psychiatric approach, but even they found themselves in a difficult position. In the tense atmosphere of urban disorder, each side at times saw the mental health center as an outpost of the enemy. The institutions funding the CMHC's generally wanted peace and quiet, and were disappointed by the disorder that came to surround CMHC activity. But these pressures from above seemed mild compared to the demands of angry communities for jobs, social reform, and power. Amid these fierce buffetings, the CMHC's gradually moved toward the more traditional activities of individual and small group care and consultation on request. Optimistic forecasts of what community psychiatry could do for social reform in the "total community" declined, as did the claims made for Great Society programs as a whole. Justification for CMHC programs shifted from social reorganization to the provision of customary services to alleviate individual deprivation and illness.

Finding out what happened

By September 1974, a total of 591 centers had been funded under the CMHC Act, and 443 were actually operating. Some hard data about their operations are available: The centers' services, for example, are primarily directed towards the poor and the young. In 1972, less than four per cent of the persons served were 65 or over, though such persons made up 9.7 per cent of the total population;
42 per cent of those served came from families with incomes of less than $2500, an overrepresentation by about a factor of three. But in many respects, it is hard to generalize about the CMHC's. They vary widely in character, from components of university medical centers to simple associations of pre-existing services in small rural towns. They also vary in quality of leadership, fiscal responsibility, style of treatment, and quality and kind of professional training. Depending on which edge of the spectrum one examines, the program can appear a nightmare or a success. Furthermore, the data on the centers are fragmentary, have been kept only for a short time, and are of varying reliability.

One major reason why it is difficult to speak systematically about the CMHC's is that the NIMH has, until recently, strongly resisted evaluating their performance. On the surface, this hesitancy is surprising. Testing and evaluation formed a leitmotif of the NIMH's community psychiatry proposals from World War II until the campaign for the centers was won, and federal requirements stipulated that each center must devote a small portion of its budget to program evaluation. But NIMH administrators seemed to reason that in the early years of the new program attention should be focused on bringing the centers into operation; only later could research into performance be meaningful. Perhaps also the extraordinary rush to build centers in the first years of funding left the NIMH with the not unreasonable fear that evaluation might only serve to damage the centers' public image and the strong support that they enjoyed in the Congress.

The evaluations that have been made, usually prepared by a center's professional staff with an understandable interest in perpetuating their programs, are often based on subjective impressions. These self-evaluations tend to conclude that more needy individuals are reached by services, and that ex-patients are more able to function in society, better able to hold a job, or "happier." Evaluating the impact of mental health services is of course a very difficult thing. A recent and carefully controlled study of English children with school problems, for instance, found that of those treated, 65 per cent showed remission of the disorder within two years; of those untreated, 61 per cent had remission within the same period. One might well reply that the treated child might have a better future prognosis or that family and school disruption had been lessened during treatment. To a critic, however, those qualifications could easily seem like rationalizations for the lack of significant difference that the "hard data" showed. A growing unwillingness to accord
mental health evaluation the "benefit of the doubt" has undermined claims of effectiveness which some years ago went virtually unchallenged.

Dr. Caplan, a community health advocate who insisted upon the importance of evaluation, repeatedly asked that such evaluation be done and met with NIMH opposition on the grounds that there existed as yet no evaluation techniques without obvious flaws. Eventually, the American Psychiatric Association appointed a task force to consider how this research could be stimulated. The task force's 1971 report was openly critical of the NIMH record in this regard:

While it has been the policy of the NIMH to give high priority to research support, it must be acknowledged that in the area of community mental health this policy has not been implemented with the attention required by the newness of the programs and their scope. The time is propitious to correct this imbalance.

The decline of the faith

Research was indeed needed—not just for new knowledge, but in order to defend the centers or to improve them so that they could withstand the growing attacks of critics who favored more comprehensive health centers or contended that the "bold new approach" had nothing much to offer after the hoopla of its introduction and the sequestering of federal health resources. One of these critics has been the present Administration. Currently HEW publicly maintains that the decision to build and maintain CMHC's should be a local matter, and that the federal government should not support additional centers.

The proposal for a cut-off, contained in the President's January 1973 Budget Message to Congress, was based on the fear that federal aid to the centers would be endlessly perpetuated by repeated extensions. HEW's criticism of the little and late evaluation of CMHC's may not be a fair one. It may be, as some CMHC advocates contend, a political attack that cannot be met no matter what kind of information is supplied, and it may be that the contribution of the CMHC's is no less valuable for being the kind of service that can be described only through intangible, subjective impressions. It is ironic, though, that CMHC advocates scoffed in the early 1960's at the "intangible" considerations cited by some of their opponents, such as the possibility, since borne out in the New York State mental hospital system, that the large-scale release of patients
from mental hospitals might have bad rather than good effects on the patients and their families.

The Administration is not the only critic of the CMHC’s. In 1971 and 1974 the General Accounting Office sent to Congress reports full of detailed criticisms of the CMHC’s and concluded that substantial improvements were required in a list of rather crucial areas: “planning related to the area to be served (catchment area) and services provided, a center’s ability to operate without continued Federal assistance, monitoring and evaluation, coordination of center activities and use of construction resources.” The 1974 Nader Report on the NIMH, *The Madness Establishment*, put the matter even more strongly: “The community mental health centers have been neither accountable backward to the NIMH, which established them, nor forward to the consumers and citizens in the community they allegedly serve.”

Other criticisms have come from radicals opposed to the very idea of mental health expertise. The early community mental health planners cannot be accused of any particular insensitivity to the idea of individual rights and liberties. During the past decade, however, the general preoccupation with rights and liberties grew to the point where every restraint on freedom was thought presumptively worthy of suspicion or active rejection, and mental health planning was no exception. The original CMHC strategy was a “public health strategy,” to be applied as it had been applied to tuberculosis—entering a sick community and locating and treating the diseased, who might be recalcitrant or ignorant of their condition. It was to be a professional decision which designated an individual as “sick” and in need of treatment. This kind of intervention is one of those external restraints that have now fallen into disrepute. The leading edge of legal thought once embraced psychiatry as a guide to the causes of crime and to its reduction through treatment and rehabilitation. Today, the leading edge questions the value of psychiatry in the courtroom and condemns sentences for psychiatric treatment as a cruel extension of incarceration without benefit to the defendant or the public. “New drugs” were originally part of the CMHC strategy to empty state hospitals and permit community care; by now, at least one jurisdiction has refused hospital psychiatrists the right to give such medication to a legally committed patient against his will.

The anti-professional animus is not merely a legal one; it has beachheads within the mental health professions themselves. Dr. Thomas Szasz, of course, has called the whole concept of mental illness a “myth”; and, ironically, the very training programs of the
1960's which were intended to produce community psychiatrists added members to the anti-psychiatry movement within the profession. In some communities, “anti-psychiatrist psychiatrists” have adopted confrontation tactics ranging from defamation to physical attack to block the construction of a CMHC, viewing it as nothing more than an attempt to “control” a community. These children of the CMHC movement are merely the mirror image of their parents. A good number of leaders in each camp hold that individual disorder is inescapably linked to social environment, believe in the primary goal of new community awareness and organization, accept psychiatry as powerful enough to influence this awareness and organization, and reject individual therapy as not only old-fashioned but essentially immoral. The battles which erupted in some communities between the two groups and which considerably harmed the CMHC idea were so intense and dramatic precisely because both sides shared the fantasy of an omnipotent and omniscient mental health technology which could thoroughly reform society; the prize seemed eminently worth fighting for.

Neither of these groups represented more than a small fraction of all practicing psychiatrists, but by now criticism of the program has also been voiced by a more broadly representative organization, the American Psychiatric Association (APA). The same 1971 APA task force report that criticized NIMH’s evaluation procedures raised more general questions about the Emperor’s clothes which had appeared so elegant in President Kennedy’s message to Congress. The breakthroughs, the “new knowledge and new drugs” which made the CMHC proposals both “possible and practical” appeared somewhat less remarkable to the APA authors:

Therapeutic claims have often been unsubstantiated by experience and experiment. Our current knowledge of the nature, causes, and treatment of mental illness, while significantly advanced over previous decades, is still inadequate to validate comprehensive programs of prevention and treatment.

Congress for the defense

Very little of this criticism, however, seems to have penetrated the halls of Congress. The CMHC program has been continued by repeated Congressional extensions and amplifications of the basic 1963 Act. In 1967, the original construction and staffing programs were extended to 1970. And in 1970, Congress substantially increased and extended federal assistance to the centers, having been persuaded
that its earlier optimism that states and localities would eventually step in had been excessive. Centers could now receive aid for eight years; centers in poverty areas could receive more than others. Further aid was allocated for child mental health, for community programs, and for alcoholism and drug addiction. In 1973, HEW Secretary Caspar Weinberger tried to persuade the Congress that it was time to phase out federal aid; he was rebuffed, though funding was extended only for one year at existing levels. Congress still believes that the reduction in the state mental hospital census is indeed a powerful symbol of CMHC success; Congressional response to public fear and anger over the massive discharge of mental patients into communities has been to propose that a new service, that of halfway houses, be added to the CMHC program.

Congressmen remain enthusiastic over the CMHC’s, both because they retain their faith in mental health experts and because voting against the idea of mental health seems as difficult as voting against motherhood. Their opponents as well as their supporters admire the political finesse of the NIMH and CMHC lobbyists in cultivating such Congressional enthusiasm. CMHC advocates have until now succeeded in using the state hospital census reduction as a shield behind which they can try to reform a hastily developed program, preserve funds for the mentally ill, and maintain as well the jobs now dependent on federal subsidies.

Nevertheless, one can begin to see signs that the Congressional support for separate, categorical grants to mental health facilities may not last forever. The bill that the Senate Committee on Labor and Public Health drew up to replace the expired 1973 authorization encourages the centers to increase their reliance on general health funds from Medicare and Medicaid. A more general change in attitude is also perceptible. In the early 1960’s, up-to-date Congressional aides often fought for more mental health care as avidly as Dr. Johnson thought gentlemen should acquire lace and Greek. Within the last few years, however, a new generation of Congressional staff has come to question the value of psychiatry and psychotherapy. Congressional aides are increasingly inclined to believe, for instance, that the lack of hard evidence for the effectiveness of long-term out-patient psychotherapy is good reason to limit severely the provision of such services in any national health insurance plan that may come about. This new skepticism, accompanied by demands—even within Congress—for proof of effectiveness, is perhaps the most serious obstacle that the CMHC’s and the mental health profession will have to face.
The pains of integration

The experiment with community mental health, then, has placed its advocates in a position where they are increasingly unable to make a convincing case for special funding consideration as a unique tool for the betterment of society as a whole. CMHC's were one of the earliest federal civilian health systems; they had time to organize and consolidate their own constituency while those working for general medical care were still fighting for federal participation. Now, however, other special needs have been acknowledged and funded, and the attention of health planners is being directed to the question of how to organize this very costly system in the most efficient way. The pressure to justify the expense and show the effectiveness of various mental health treatments is increasing, and in this new climate CMHC advocates are finding it hard to justify their continued funding as separate organizations. Even those convinced that mental health treatment is of value have suggested that the CMHC's be integrated with social service agencies or with broader health care systems (such as general hospitals or health maintenance organizations), instead of continuing to ask for what their critics call special privileges through categorical grants.

American psychiatry has resisted such integration with the rest of the medical profession; it fought actively for its independence beginning in World War II and had fairly well achieved it by the 1960's. The reason for this resistance may be found in the nature of American psychiatry's goals. In Britain, for example, psychiatrists were integrated into a national health system without any apparent damage to their effectiveness or morale; but in Britain there has been no dominant opinion among psychiatrists that the profession might be able to make society well and happy. By contrast, the American mental hygienist, as sociologist Kingsley Davis portrayed him in 1937,

... will continue to be unconscious of his basic preconceptions at the same time that he keeps on professing objective knowledge. He will regard his lack of preventive success as an accident, a lag, and not as an intrinsic destiny. All because his social function is not that of a scientist but that of a practicing moralist. . . .

The American mental health professional has believed and has been supported in the belief that his expert insight and technology could achieve a better social day; perhaps this view has received such broad support because it promised to achieve social goals more painlessly than programs calling explicitly for economic and political change.
The *hubris* with which some American psychiatrists have approached, and have been encouraged to approach, mental and social problems may well have been a significant cause of their difficulty in integrating with other medical specialties. Since World War I, leaders among American general practitioners have tended to praise rugged individualism and private enterprise, while their counterparts among American psychiatrists were increasingly likely to stress social interdependence and perhaps even national social reform through psychological insight. The American mental health workers' optimism has often elicited strong, negative reactions from other professionals. Psychiatrists who wanted no subordination to other medical specialties correctly sensed the incompatibility between themselves and other American physicians in the style and the assumptions with which they approached individual as well as the largest of social problems. The psychiatrists seemed to have gained their independence with the passage of the 1963 CMHC Act; criticisms of the program pose a serious threat to that independence.

**A chastened future**

Along with the problematic performance of the CMHC's, other changes have occurred in the psychiatric profession since 1963 that may make its integration easier than it would have been before. Calls from within the profession for social change under psychiatry's guidance have declined, along with the value placed by others upon its opinions on every conceivable issue. The "community psychiatry" training of the 1960's "thinned" psychiatric education and at the same time brought it closer to the concerns of social agencies and management consultants. The actual operations of the CMHC's taught that psychiatrists, as opposed to social workers, psychologists, or administrators, did not necessarily possess all the skills necessary for leadership of such an effort. Federal programs directed at increasing the numbers of mental health workers, both professional and non-professional, held out one vague goal for all—namely, securing "community mental health." There are now tens of thousands more workers, but they are enmeshed in confusion over professional boundaries and rivalries, as each discipline sees itself as the natural guide to mental health in the community.

The future of the mental health service delivery system will be determined by the form of national health insurance that emerges in the next few years, but it is unlikely that a much closer integration between psychiatry and other health services can be long de-
layed. CMHC's and their experiences have pointed to its desirability. At the same time, the prospect of that integration is becoming less painful. The difficulties that psychiatrists have had in working with other specialties have been reduced by, among other things, the development of pharmacological treatments, psychiatrists' increasing experiences as part of general hospital teams and, indeed, psychiatry's beneficently constricted feelings of omniscience and omnipotence.

A fundamental question raised in this period of transition for the mental health professions is how to maintain without interruption their real strengths. Fifteen years ago policy error was likely to be on the side of expecting too much from these then exuberant professions; now the danger exists that the mental health professions will suffer as a result of indiscriminate and exaggerated denigration.

Psychiatry and the allied professions offer essential services not only to troubled individuals but to our general society as well, ranging from informed and persevering advocacy on behalf of children—a constituency easy to ignore—to patient biochemical research designed to understand and hopefully to alleviate severe depression and schizophrenia. The validity of their role within our institutions cannot be eliminated by the invective of their shrillest opponents. The persistence and effects of behavioral problems are not greatly altered by rhetoric—no more than "sick" communities could be reformed through homilies on community psychology. By endorsing and funding psychiatry's more grandiose claims, the CMHC program's most enduring contribution may have been to lead the profession to a clearer sense of reality and of its own areas of greatest competence.