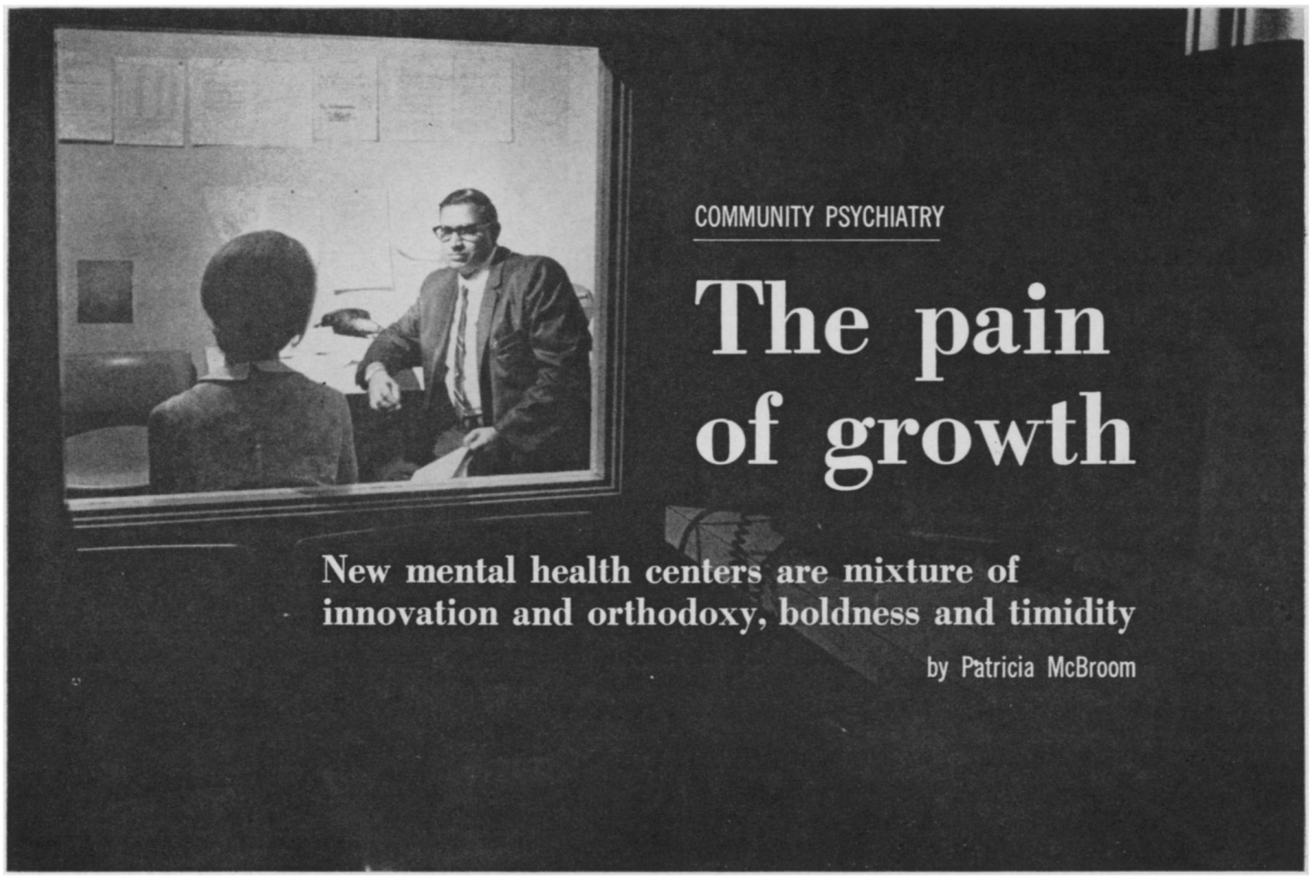


COMMUNITY PSYCHIATRY

The pain of growth

New mental health centers are mixture of innovation and orthodoxy, boldness and timidity

by Patricia McBroom

Ed Eckstein

At its best, the mental health center is a new kind of social agency, one geared to human not bureaucratic needs.

The first patient admitted to the oldest hospital in the country was—in 18th century terms—a lunatic. That was at Philadelphia's Pennsylvania Hospital, where the mentally ill were chained to the walls and surrounded by a moat. On Sundays, the hospital charged admission for anyone wanting to come in and gape.

Those same wards, substantially modified, still serve the mentally ill, but they now form part of a system holding as much meaning for future care of the mentally ill as it does grim memories of the past.

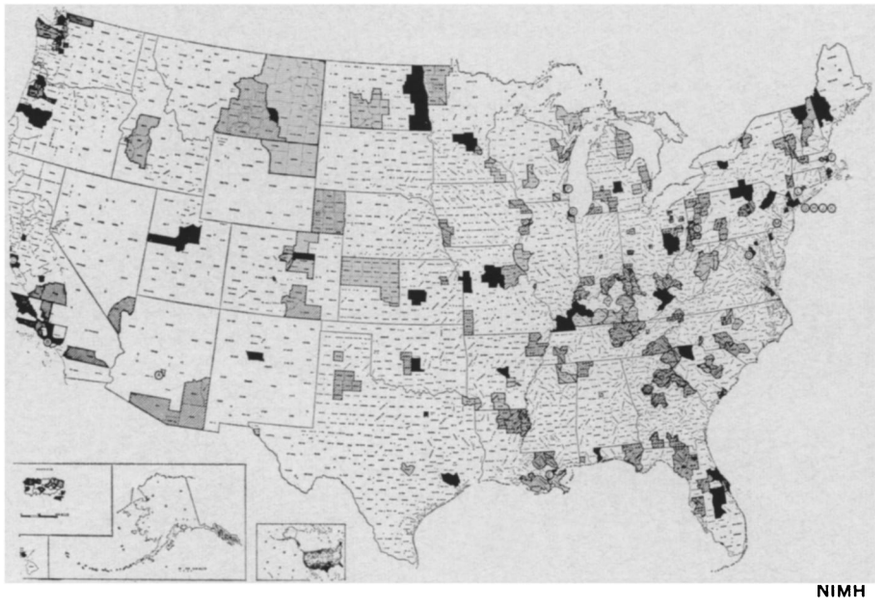
Pennsylvania Hospital runs one of Philadelphia's six functioning community mental health centers, and in terms of community psychiatry—social commitment, flexibility and a unified service network—is among the few, set up by a three-year-old Federal program, that is cementing links to the community.

Philadelphia has a lead over other urban areas in covering its population with mental health services. Besides the six centers, another five are gradually coming into service. Each is responsible for a territory housing some 200,000 people.

Not all of them have so far grasped the concepts of community psychiatry. But three which have made an impressive start in that direction serve rock-bottom populations.

The nation's oldest slum, for instance, falls into Pennsylvania Hospital's territory, where last year there were 5,000 arrests for alcoholism.

Two miles to the north, Hahnemann Medical School runs a center that serves The Jungle, a poor section known for its high rates of crime, suicide and acci-



NIMH

Shaded areas represent construction and/or staffing grants as of January, 1968.

. . . less a center than a network

Pennsylvania Hospital

Pennsylvania Hospital: diversification along the lines of modern industry.

dent. The mental health clinic is located in a hotel, once the haunt of local prostitutes. But the hotel's tattered appearance and disreputable past do not embarrass the Hahnemann people, who have left the well-known name "Philadelphia Hotel" blaring from the building's marquee. As one observer put it, "Area residents would probably rather be seen entering a bawdy house than a mental health clinic."

Still further north, Temple Medical School operates mental health services from a series of drab row houses. Renovated inside, the center facilities still blend well with the surrounding community, which in terms of living standards is a notch above The Jungle.

These are three of Philadelphia's most successful centers, and they compare favorably with any in the nation.

- Temple has a daring experimental program going in therapy which challenges some basic psychiatric assumptions (SN: 10/5, p. 345).
- Hahnemann has extended lines into the surrounding area by setting up satellite centers in churches where community workers do such things as teach mothers how to sew and find homes for burned-out families.
- Pennsylvania Hospital has taken still another tack—diversification along the lines of modern industry. Besides its therapeutic services, the center has subcontracts with existing agencies—a halfway house, an alcoholism unit, a child study center—in a network which it has expanded and blended into a single system. The mental health staff also advises public housing officials and engages in community action. They work with gangs and organize tenants.

"The big problem of social agencies in the past is that they became specialized," says Robert Fishman, director of program development at Pennsylvania Hospital's mental health center. "There should be nothing to limit us from getting into any field of endeavor. . . . If we don't get involved, we can endlessly treat the mentally ill," without reaching root causes.

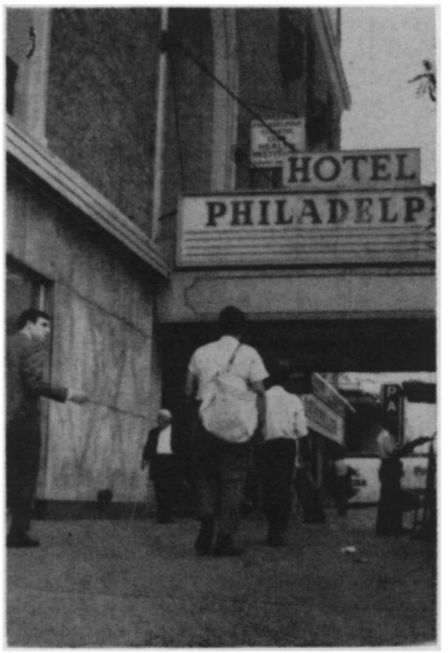
The community mental health program, of which each of these is a sample, is a massive system with tremendous potential. Community psychiatry is feeling its natural growing pains, says Raymond Glasscote, who heads the joint information service of the American Psychiatric Association and The National Association for Mental Health. "There is thrusting in all directions to find out what a center can and should do."

About 100 centers have been established so far through the National Institute of Mental Health, state, local and private agencies; an additional 230 have been funded. These represent a commitment of money on the order of $600 million from all sources, with the Federal portion accounting for something less than 30 percent. The target by 1970 is to establish 550 centers throughout the nation serving some 82 million people in urban and rural areas.

Besides Philadelphia, cities partially covered include New York, Los Angeles, Denver, Milwaukee, Washington, Boston and San Francisco. Dallas, Houston and Atlanta have made a start. Kentucky is almost completely covered.

At its best, the mental health center represents a new kind of service institution in the United States—one geared to human rather than organization needs. Ideally the mental health center can handle on the spot a wide range of problems—schizophrenics in reaction, alcoholics with DT's, depressives ready to commit suicide, marriages on the point of breaking up. . . .

Diversification of the services and



Hahnemann Medical School

A new scene in mental health clinics.

their deployment into the community through satellite centers are key concepts underlying community psychiatry. With its lines out and links established, a mental health center is less a center than a network.

But these are difficult aims to achieve, and in actual fact, most of the centers now in operation have a long way to go in reaching them. All centers, for instance, are required to have 24-hour emergency services, but most are still relying on general hospitals for this function. Mental health personnel are physically present only during the day.

By contrast, the Temple crisis center, located in a row house, is manned around the clock and has beds for six people who may stay up to three nights if they have no place else to go. The crisis center is an important screening point from which a patient is turned over to one of several treatment teams or, if necessary, hospitalized.

Some obstacles in community psychiatry arise from theories shaped by years of individual-oriented psychiatry.

One theory, for example, holds that a patient must be internally motivated before he can be helped. He must want therapy badly enough to seek it out whatever the difficulty.

Among deprived populations, the concept of internal motivation fails.

Few middle-class Americans know how circumscribed the lives of the poor may be. Many are born, live and die within the space of a few blocks. They may not cross into unfamiliar territory to reach a hospital partly because they distrust public institutions, partly because their range of experience is so limited. The Hahnemann area has people who have never been to downtown Philadelphia, two miles away.

But the poor will make use of services "if they are really accessible and suitable," says Dr. Elmer Gardner, director of the Temple program. He blames the psychiatric profession for long-standing prejudice against poor patients. The idea, for instance, that poor people lack insight or the ability to express themselves and cannot benefit from talk therapy is a myth, he says.

In August, Glasscote completed a survey of eight centers (none of which were in Philadelphia) and found only two of them fully in shape. The majority had not achieved a sensible pattern of service, he says.

Typically, people were falling through gaps, says Glasscote. An alcoholic, for instance, would come into an emergency center asking for help and be told, "We don't take alcoholics here, but there's a place across town. . . ."

In handing him on that way, he is counted as having been served, which is not true, says Glasscote. The center has no link with the unit across town; as a result, the patient passes through the same multiplicity of services and diagnostic workups that are characteristic of old-line agencies.

The locations of many centers also lack common sense because states failed to plan adequately. In one section of Kansas, a single center serves 22 counties, an area of several thousand square miles.

In a total of 11 centers that Glasscote has visited, only six were deploying services and those covered the smallest geographical areas. It was the middle size towns and urban areas that were not deploying anything. In Glasscote's opinion, five of the 11 had made an impressive start on community psychiatry.

Some were failing principally out of nervousness. Reluctant to advertise their new services for fear of being swamped with hordes of the sick, they failed to sink roots into the community, and their services were underutilized.

These failings are not inherent in the system, Glasscote points out. The centers are very young, most of them less than a year old, and there is a remarkable degree of public enthusiasm.

"I believe in the program," he says. "It is so important and so sensible. . . . It represents the best pattern for delivering services that the best people in the field can come up with. But its success will depend on basic changes in training for all mental health professionals."