MENTAL HEALTH

By HENRY DAVIDSON, EDITOR 'MENTAL HYGIENE'

WHEN IT comes to seeking psychiatric help, America is largely divided into two economic classes: those who can afford private psychiatric care and those who cannot. Usually, a privately-practising psychiatrist in the USA receives from 25 to 35 dollars per patient appointment. For psychoneurotics, most American psychiatrists ask for at least two psychotherapeutic sessions a week —at a cost to the patient of 50 to 70 dollars a week. This, of course, is beyond the reach of most Americans. However, the minority who *can* afford these fees keep the private psychiatrist so busy that he does not have time for the patient he never sees—the one who cannot afford his fees.

Three months wait

Theoretically, some clinics are available, at low cost, or free, for those who cannot afford private outpatient care. However, nearly all these clinics have long waiting lists so that the person tormented today by a crippling phobia or hag-ridden by a severe anxiety may have to wait three months before his name comes to the top of the clinic waiting list. Because of the pressure of new applicants, most clinics have to limit visits to one a week and some to one visit a month.

Clinic salaries in the USA average 75 to 100 dollars a day—which works out, on the traditional 8 hour day, to from 9 to 13 dollars an hour—less than half of what the psychiatrist can earn in private practice. Characteristically, the clinics are staffed by young and relatively inexperienced psychiatrists, usually just starting private practice. As that practice grows, they tend to leave the clinics for the greener-backed pastures of private enterprise. Thus, the clinic system does not meet the basic problem because of long waits, infrequent visits, and inevitable rapid turnover of therapists.

Serious efforts in the USA have been made to meet this problem. Some medical schools and graduate training programmes in psychiatry have their students doing therapy at clinics, thus fulfilling their obligations to society and giving their students experience. Some prosperous private practitioners do contribute some time each week to service to clinics or community agencies; but this small, and unpredictable, contribution does little to close the gap.

Hospitalised psychiatric patients are faced with a similar problem. The USA is dotted with several hundred 'private' mental hospitals, usually small, with a superior staff, but handling in total only about 10 per cent of the hospitalised psychotic patients. About 90 per cent of patients are in public (i.e. tax-supported) mental hospitals, usually operated by the State governments. A few are run by Counties or by the Federal Government. Here, especially in state hospitals, large case loads are the rule, with an average 150 to 250 patients per physician. Overcrowding (seldom more than 50 square feet per patient in the dormitories) is the custom. Most patients in public mental hospitals are certified, and the hospital therefore cannot control its own admission rates.

By contrast, private mental hospitals have a comfortable amount of space per patient, a reasonable case load (typically 10 to 20 patients per doctor) and intensive drug and psychotherapeutic treatment programmes. But most private mental hospitals charge 200 or more dollars a week so that few families can afford this for very long.

Insurance helps

Insurance offers some assistance, particularly at the hospital level. The commonest type of hospital plan insurance (generally called Blue Cross) has limited coverage for patients in psychiatric facilities. In some states this is limited to, perhaps, two, three or four weeks—in a year, or even in a life-time. For patients over the age of 65, the Medicare Programme will pay all private hospitalisation for up to 30 days in a life-time but only when the patient is getting active therapy.

One way of alleviating this has been the development of the 'comprehensive mental health centre' a new and imaginative approach to the problem

The 'comprehensive community mental health centre' (CMHC) has, indeed, been the most dramatic feature of the 1968 mental health scene in the USA.

The community mental health centre is a programme of services, not just a building. The 'centre', if it solicits Federal support, must make available a place to which a patient in anxiety or distress may go on short notice for immediate psychiatric attention. It must operate a psychiatric outpatient unit (a 'clinic') for the prolonged therapy of chronic or subacute emotional disorders. It must have available, either in its own buildings or by contract with a larger and not too-distant mental hospital, a place to which patients can be sent if they do not recover sufficiently in the centre's own inpatient installation. It must make diagnostic provision for the mentally retarded.

The Federal Government offers money grants to communities that will set up these centres and conform to Federal standards. The grants cover a large part of both construction costs and staffing costs during the first year. Thereafter, the Federal contribution diminishes each year until after, perhaps 10 years, the local community must support the programme. The role of the Government is thus to stimulate the establishment of CMHCs, set high standards and provide financial support during the early stages of each centre's operation.

The Government estimates that a population of about 200,000 will support one CMHC. So the USA, with its population of 200 million, can support, in theory, some thousand such centres. But the movement towards establishing these CMHC's has run into several roadblocks. To begin with is the wretched problem of staffing. If each CMHC is to have the services of only 4 psychiatrists, the nation would need 4000 psychiatrists for these centres alone leaving only, perhaps, 10,000 or 15,000 psychiatrists to handle all the demands of private practice, universities, public and private hospitals, research and the military.

Another problem is that the CMHC can attract psychiatrists only by offering salaries that would compete with private practice even at the lower (25 dollars an hour) level. If they offer less, practitioners will not want to give up lucrative private practice incomes. But if they do offer 25-dollar an hour stipends (and corresponding salaries for social workers, psychologists and psychiatrically trained nurses) they will drain off the staffs of existing public mental hospitals and clinics.

The typical public mental hospital in the USA offers salaries of from 13,000 to 20,000 dollars for experienced staff doctors. However, a psychiatrist who earns 15,000 dollars in a State Hospital could resign that position and, at 25 dollars an hour in a community mental health centre, work only half a day, earn 100 dollars a half day; or 25,000 dollars a year for working only 5 days a week. Thus, the more ambitious or better qualified staff physicians in public mental hospitals would soon be lured to community mental health centres, and earn more money for less work. Of course, the unambitious and poorly qualified staff doctors would remain in the public mental hospitals. A similar raid would take place on the psychologists, social workers and psychiatrically trained nurses.

The CMHC would also drain off the interesting and more treatable cases. The acutely sick patients would first go to the community centre and, under intensive treatment would, presumably, never get to the State Hospital. Indeed, under the CMHC plan, the public mental hospital is described as a 'back-up hospital'—being frankly set up in this scheme as the place where the failures go. The State Hospitals thus see themselves reverting to the transitional custodial or warehouse function from which they had painfully extricated themselves only a few decades ago.

Uncertain sponsorship

Other unanticipated problems have developed. The Federal programme has purposely made flexible the details of the CMHC enterprise. This has left some uncertainty in communities over the sponsorship of a mental health centre. In some places, special boards of trustees have been created to sponsor a mental health centre. In others, existing general hospitals have become the core of such a programme. Occasionally, a social agency, child guidance clinic, university, religious organisation, or county government has taken the lead. This has produced a wide variety of sponsorships and organisations which has either lent richness to the programme (say those who admire it) or provided confusion and lack of standardisation.

Among the thousand anticipated CMHCs, some 200 had been 'funded' (an Americanism for provided with funds or subsidised) by the first quarter of 1968.

While the establishment of CMHCs has been the most spectacular development of American psychiatry over 1967 and 1968, it has not been the only one. The inventiveness of biochemists has led to the synthesis of many complex drugs which can influence behaviour—either elevate the mood or tranquillise the patient. Some of these medications seem to help the patient recover from delusional thinking. While psychoanalysts (who have always been popular and prosperous in the USA) generally look down on the use of the newer drugs, some of them reluctantly accept medications for the 'control of symptoms'. They then depend on analytic interpretations for the basic cure of the mental illness.