Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health

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President Jimmy Carter's Presidential Commission on Mental Health was intended to recommend policies to overcome obvious deficiencies in the mental health system. Bureaucratic rivalries within and between governments; tensions and rivalries within the mental health professions; identity and interest group politics; the difficulties of distinguishing the respective etiological roles of such elements as poverty, racism, stigmatization, and unemployment; and an illusory faith in prevention all influenced the commission's deliberations and subsequent enactment of the short-lived Mental Health Systems Act. The commission's work led to the formulation of the influential National Plan for the Chronically Mentally Ill, but a system of care and treatment for persons with serious mental illnesses was never created.

Key Words: Jimmy Carter's Presidential Commission on Mental Health, Mental Health Systems Act, mental health policy, deinstitutionalization, mental illnesses.

SHORTLY AFTER ASSUMING OFFICE IN EARLY 1977, Jimmy Carter created a presidential commission on mental health. His action suggested the existence of deep-rooted problems in a mental health system that was fragmented, lacked cohesion, and often failed to meet the needs of many groups, notably those individuals with severe and persistent mental illnesses. The creation of such a commission also had an important symbolic element, for it indicated the president's awareness and concern.

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The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 425–456)
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Although presidential commissions are common, Carter's action was unique in one respect; there had never been one that dealt with the mental health system. An analysis of his commission provides an illustrative case study of the inner workings of such a body. More important, it demonstrates the manner in which social, political, and structural factors; interest-group pressures; and the sometimes invisible role of the federal bureaucracy all combine to shape mental health policy in unanticipated ways.

Background

During the previous three decades there had been determined attempts to change a system whose roots dated back more than a century. In the early nineteenth century, a faith in institutional care for persons with severe mental illnesses had led to the creation of a vast system of state mental hospitals that in 1955 admitted 178,000 individuals and had an average daily census of 559,000 patients. After World War II, however, mental hospitals began to lose their social and medical legitimacy. The experiences of the military during the war in successfully treating soldiers with psychiatric symptoms and returning them to their units led to the conviction that outpatient treatment in the community was more effective than confinement in remote institutions that shattered social relationships. The war also hastened the emergence of psychodynamic and psychoanalytic psychiatry, with its emphasis on the importance of life experiences and socioenvironmental factors. Taken together, these changes contributed to the belief that early intervention in the community would be effective in preventing subsequent hospitalization and thus avoiding chronicity. Finally, the introduction of social, psychological, and somatic therapies (including, but not limited to, psychotropic drugs) held out the promise of a more normal existence outside institutions for persons with mental illnesses (Grob 1991).

During the 1950s, the pressure for change mounted. The entrance of the federal government into the mental health arena following the enactment of the National Mental Health Act of 1946 and the creation of the National Institute of Mental Health (NIMH) in 1949 proved crucial. The NIMH was dedicated to bring about the demise of public mental hospitals and to substitute in their place a community-oriented policy. The passage of the Community Mental Health Centers (CMHC)

Act in 1963 culminated nearly two decades of ferment. The legislation provided federal subsidies for the construction of CMHCs, which were intended to be the cornerstone of a radically new policy (Grob 1991).

The CMHC Act, however, represented the triumph of ideology over reality, for it ignored the context in which persons with severe and persistent mental illnesses received care. In 1960, three-quarters of the more than 500,000 individuals in mental hospitals were unmarried, widowed, or divorced. The claim that such people could be discharged from hospitals and reside in the community with their families while undergoing psychosocial and biological rehabilitation was unrealistic (Kramer 1967a, 1967b). Nor was there any evidence that persons with serious mental disorders could be treated in clinics (Sampson et al. 1958). Such facts were largely ignored by those caught up in the rhetoric of community care and treatment.

CMHCs also came to serve a new and different set of clients who did not have severe disorders and thus were more appealing to their staffs (Langsley 1980). Equally significant, the CMHCs' mission was ambiguous. It was never clear whether they were social welfare or health agencies, as many emphasized social change and minimized patient care and treatment. The result was a sharp decline in the number of psychiatrists in CMHCs and a diminution in the role of those who remained. Between 1970 and 1975 the number of psychiatrists fell from 6.8 to 4.3 per center, even though the total number of staff nearly tripled during this same period (Fink and Weinstein 1979). Moreover, federal regulations governing CMHCs bypassed the state authorities and gave more power to the local communities, thus permitting many CMHCs to emphasize social concerns (*Federal Register* 1964, 29:5951–6). Not surprisingly, the result was deep and bitter divisions in mental health between state and federal officials, which lasted for several decades.

The creation of CMHCs had, at best, a minor impact on reducing hospital populations after 1965. Far more important were federal entitlements. The passage of Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act) in 1965 encouraged the construction of nursing-home beds, and the Medicaid program provided a payment source for patients transferred from state mental hospitals to nursing homes and to general hospitals. Although the states were responsible for paying the full cost of keeping patients in state hospitals, they now could now transfer them and have the federal government assume from half to three-quarters of the cost. This incentive encouraged a massive transinstitutionalization

of long-term patients, primarily elderly patients with dementia who were housed in public mental hospitals for lack of other institutional alternatives (Goldman, Adams, and Taube 1983; Gronfein 1985; Kiesler and Sibulkin 1987; Kramer 1977).

The states' use of entitlement programs to shift costs to the national government was a reflection of a federal system of government that divided authority and sovereignty. The existence of three distinct levels of government—federal, state, and local—often encouraged efforts to shift fiscal burdens and, at the same time, ignored policy. Intergovernmental rivalries, in other words, shaped policies and priorities in unanticipated ways (Grob 1994).

By the early 1970s, entitlements such as Medicaid, Social Security Disability Insurance (SSDI), Supplementary Security Income (SSI), food stamps, and housing supplements provided resources that enabled persons with serious mental disorders to reside in the community. Hospital populations declined rapidly. But the states' policy decisions to reduce their public mental hospital populations and to make admission to these hospitals more difficult, along with other changes in public attitudes, treatment ideologies, and social and economic factors, supported the development of a confusing array of organized and unorganized settings for treating persons with mental illnesses. Rather than improving organization, the result of these policy decisions was confusion and disorganization. By the 1970s the mental health system contained a bewildering variety of institutions: short-term mental hospitals, state and federal long-term institutions, nursing homes, residential care facilities, CMHCs, outpatient departments of general hospitals, community care programs, community residential institutions for the mentally ill with different designations in different states, and client-run and self-help services, among others. This disarray and lack of any unified structure of insurance coverage or service integration forced many patients with serious mental illnesses to survive in homeless shelters, on the streets, and even in jails and prisons.

Jimmy and Rosalynn Carter

As the governor of Georgia, Jimmy Carter had established the Commission to Improve Services to the Mentally and Emotionally Retarded, and his wife Rosalynn persuaded him to appoint her to the commission.

During Carter's term in office, the number of hospitalized patients fell by about 30 percent, and a large number of CMHCs were created. As early as 1974 Mrs. Carter decided that if her husband were elected president, she would continue to focus on mental health reform. Her hope was that the seemingly beneficial results of deinstitutionalization and the creation of CMHCs in Georgia could be replicated on a national level. Nevertheless, her knowledge of the mental health system was relatively limited. She accepted the prevailing assumption that CMHCs could treat persons with serious mental disorders more effectively than traditional mental hospitals could, a belief based largely on ideology rather than empirical evidence (Ayres 1979; Carter 1984; Gallagher 1974; Stroud 1977).

During the presidential campaign, Peter Bourne, a psychiatrist who served as Carter's adviser on mental health and drug abuse policy, arranged a meeting between Thomas E. Bryant (president of the Drug Abuse Council, an organization funded by the Ford Foundation) and Mrs. Carter to discuss policy issues. Bryant recognized that his organization lacked the resources to launch a national effort to transform mental health policy, so he sought the counsel of John W. Gardner, former secretary of the U.S. Department of Health, Education, and Welfare (HEW) in the Johnson administration and the founder of Common Cause. Gardner suggested that the incoming president create a national commission. Because it would have taken a year or more to get congressional authorization, Carter decided to issue an executive order creating the commission. In retrospect, Bryant believed that it would have been wiser to seek congressional approval, which might have laid the foundations for a national consensus (T.E. Bryant, interview, April 11, 2003).

On February 17, 1977, Carter issued an executive order creating the President's Commission on Mental Health (PCMH). The very title suggested a fundamental shift in emphasis. Nearly two decades earlier, the Joint Commission on Mental Illness and Health (1955–1961) focused largely on the problems faced by individuals with serious and persistent mental disorders, many of whom were institutionalized (Grob 1991). The decision in 1977 to use "mental health" rather than "mental illness" in the commission's title indicated a policy shift, even though there was virtually no recognition of its implications. Rather, the change of terms was based on the application of a public health model that emphasized the role of the environment, social services, and prevention rather than

the traditional psychiatric focus on the diagnosis and treatment of severe and persistent mental disorders.

Mental health, of course, is a somewhat amorphous concept capable of being defined in a multitude of ways. Its imprecision and vague boundaries enabled a variety of advocates and organizations to claim that their concerns fell under its rubric. Serious and persistent mental illness, by contrast, was a much narrower designation; the population included in this category was more clearly identifiable. The concept of mental health also blurred important distinctions. Under these circumstances, persons with serious and persistent mental illnesses, who previously had been at the center of public policy, were forced to compete, often unsuccessfully, with other groups that now defined their needs in terms of mental health.

The commission was asked to deal with several issues. Were the "mentally ill, emotionally disturbed, and mentally retarded" being served or underserved? What were the projected needs for dealing with emotional stress during the next twenty-five years? What was the proper role of the federal government? How could a "unified approach to all mental health and people-helping services" be developed? What kind of research was needed? How could the educational system, volunteer agencies, and other institutions minimize "emotional disturbance"? Finally, how much would it cost to change the system, and how might the expenditures be allocated among the three levels of government?[1]

Organizing the PCMH

When Attorney General Griffin Bell raised doubts about the legality of making Mrs. Carter the chairperson, the president decided that Bryant, who was originally selected as the executive director, would become the chair and his wife an honorary chairperson (Bryant, interview, 2003).[2] The first task was to select twenty persons to serve as commissioners. Bryant appointed an ad hoc screening committee chaired by Gardner. The selection process proved to be anything but simple. A variety of constituencies (professional, ethnic, racial, and gender) wanted their interests to be represented. Similarly, members of Congress were anxious that at least one person from their state be appointed. Bryant responded tactfully to communications from members of Congress, noting that each of the various task panels (which were in the process of being appointed) included one of their constituents (Bryant, interview, 2003).[3]

Ultimately, more than a thousand names were submitted to the ad hoc committee by individuals as well as private and public organizations, of which forty-four were sent to the White House. Because Gardner and Bryant did not want psychiatrists to dominate the commission, they developed some general guidelines to direct the deliberations of the ad hoc committee and to ensure that people from diverse backgrounds and groups be selected (Bryant, interview, 2003).

The composition of the commission reflected in many ways the group consciousness that had become so pervasive by the 1970s. Gender, race, and ethnicity played major roles in the selection process. The twenty commissioners came from diverse backgrounds, and their interests revolved around the mental health of minorities and underserved groups rather than the specific needs of persons with severe and persistent mental illnesses. Indeed, some believed that mental health problems could be resolved only by dealing with such broad social problems as unemployment, discrimination, and poverty. The commission had twelve men and eight women, three African Americans, two Hispanics, and one Native American. Their occupational and professional backgrounds varied in the extreme and included psychiatrists, academics from several disciplines, lawyers, human rights and mental health activists, and a minister and a labor leader. Its members included Priscilla Allen, a former patient; three psychiatrists, Allen Beigel (Southern Arizona Mental Health Center), George Tarjan (UCLA Neuropsychiatric Institute), and Mildred Mitchell-Bateman (commissioner of the West Virginia Department of Mental Health); Jose Cabranes, general counsel and director of government relations at Yale University; John Conger, a child development expert at the University of Colorado School of Medicine; Thomas Conlan, a trial lawyer and an activist in problems of alcoholism; Virginia Dayton, a specialist in family systems theory and care systems; LaDonna Harris, a crusader for human rights and Native Americans; Beverly Long, an activist in mental health affairs in Georgia; Ruth B. Love, an educator concerned with disadvantaged and minority youth; Florence Mahoney, a nationally known advocate for the needs of the aged, a major promoter of biomedical research, and cochair of the National Committee against Mental Illness; Martha Mitchell, a psychiatric nursing administrator at Yale University; Harold Richman, a social welfare policy expert and dean of the University of Chicago School of Social Service Administration; Julius B. Richmond, the founder of Head Start and a noted pediatrician and child psychiatrist at Harvard University; Reymundo Rodriguez, a

health educator and urban planner at the Hogg Foundation for Mental Health, University of Texas at Austin; Franklin E. Vilas, an Episcopalian minister involved in pastoral counseling; Glenn Watts, president of the Communication Workers of America; and Charles V. Willie, a professor at the Harvard Graduate School of Education.[4]

With only a few exceptions, those persons appointed to the PCMH were generalists rather than specialists and had little direct contact with the mental health system. This is not in any way to insist that the PCMH should have been dominated by members of the psychiatric establishment. It is merely to suggest that as generalists, they would have been less quick to question claims that rested on ideology rather than empirical data and their agenda would have concentrated instead on broad social problems. Indeed, the composition of the PCMH reflected the emphasis on diversity and the incipient antiprofessional ethos that had become prominent during the 1970s. Consequently, some of the members of the American Psychiatric Association (APA) became concerned, and after meeting with Bryant, several APA representatives found his position to be "less than reassuring."[5]

The diversity of the commission's composition ensured that its deliberations would be wide-ranging if not diffuse. At the initial briefing in March 1977, some expressed their belief that economic cycles, war, racism, sexism, elitism, poverty, stigmatization, alcoholism, and an inadequate health system had contributed to the prevalence of mental disorders. Others emphasized the fragmentation of the mental health community, the need to develop new programs and services, the problems faced by rural populations, and the persistence of stigmatization. Toward the close of the meeting Bryant pointed out that the commission could not "remedy all social and economic problems," and he noted "the need for specific recommendations with a specific focus." A combination of pragmatism and idealism was required, and he suggested that presidential commissions that centered on specific problems and developed appropriate recommendations had a much better chance of success.[6]

The appointment of commissioners and the adoption of an agenda were only a beginning, which was complicated by conflicting bureaucratic forces. The White House staff was not always receptive to mental health initiatives because they felt it might detract from more important issues. The fact that Rosalynn Carter was determined to make sure that the commission succeeded, however, helped mitigate conflict because she had the full support of her husband. Joseph Califano, the secretary of

HEW, wanted the commission placed under his jurisdiction, but Bryant managed to maintain its independence (Bryant, interview, 2003).[7]

Bryant's staff consisted of twenty-four persons, of which eight were from HEW, which paid their salary. He knew that the commission would have to direct its work not only to a professional audience but to a broad public and political constituency as well. To edit and remove the professional and technical jargon from its reports, he hired Paul Danaceau, who had both a journalism and a political background. Danaceau's role was to make sure that all the PCMH's reports were written in a clear and literate manner and were accessible to a broad public (P. Danaceau, interview, December 12, 2003). Bryant also recognized that Congress would play a key role, so he solicited the views of many legislators.[8]

The basic work that would presumably serve as the foundation for the final report was to be done by a series of task panels that drew on the expertise of individuals from a variety of backgrounds and disciplines. Such panels enhanced the PCMH's legitimacy. Using private foundation funding, Bryant hired two deputy directors, both of whom were psychiatrists. Beatrix (Betty) Hamburg, who had just moved to Washington, D.C., from Stanford University's School of Medicine, oversaw the task panels dealing with community support and minority groups (B. Hamburg, interview, November 25, 2003). Gary Tischler, from the University of California at Berkeley, oversaw the research and finance panels. Dr. Steven Scharfstein, then at the NIMH, also worked with the commission. All helped find appropriate people to serve on the task panels and subsequently worked with them (Bryant, interview, 2003).

Each task panel had as many as fifteen members, one of whom acted as the coordinator, with a staff member assigned to research and support (G.L. Tischler, interview, November 3, 2003). Ultimately nearly two dozen task panels were formed, with some having several subpanels. They were organized thematically and covered such subjects as the nature and scope of mental health problems, community support systems, service delivery, personnel, cost and financing, the mental health of families, special populations (minorities, women, physically handicapped), the elderly, Vietnam War veterans, rural mental health, legal and ethical issues, research, prevention, the role of the media in promoting mental health, the arts in therapy, and the states' mental health issues. More than 250 individuals representing the professions, academia, and the public served on these panels, and their work was to serve as the basis of the commission's final report.[9]

In the months following its establishment, the commission met periodically to lay out an agenda. The specific purpose of its first official working meeting, on April 19, 1977, was to define the scope of its deliberations, create the task panels, and review the development of the CMHC program. Outside some desultory discussions dealing with definitions of mental health and mental illness, prevention, and the relationship of the commissioners to the task panels, the group tended to concentrate on the needs of persons with serious and persistent mental illnesses and the role of the CMHCs. Allen, a former patient who had previously expressed her reservations about the problems of community care in California, insisted that the most important task was the development of an integrated system that linked psychiatrists with a range of services like housing, vocational rehabilitation, and nutritional advice (Allen 1974). The discussions suggested that the problems of individuals with severe and persistent mental disorders had the potential to take center stage. But it also was clear that other concerns could steer the commission in quite different directions.[10]

Aware of the need to develop a broad base of support, the commission held four public hearings in different parts of the country, each lasting a day. Such hearings were designed to enlist the assistance of professional and paraprofessional groups, consumers, volunteers, and citizens, in addition to providing valuable information. Bryant also arranged press briefings in order to build public interest in the PCMH's work. The goal was to have a preliminary report by September 1977 and a final report by the following April.[11]

The first two hearings took place in Philadelphia and Nashville in late May, followed by meetings in San Francisco and Tucson a month later. Rosalynn Carter and Bryant were present at all the meetings, and they usually were joined by more than half the commissioners. Because the format permitted a variety of organizations and individuals to testify, the meetings had no particular focus. To be sure, some of the testimony revolved around the needs of persons with serious mental illnesses. But the overwhelming majority of the witnesses were preoccupied with concerns that were far removed from serious mental disorders.[12]

At the Philadelphia meeting, Dr. Leon Soffer, deputy health commissioner of the city's Office of Mental Health and Mental Retardation, emphasized the need for adequate aftercare services for the chronically mentally disabled who resided in the community. Soffer's concerns were echoed by others. But the majority of presenters, by contrast, were

preoccupied with different issues. Some spoke on behalf of the mental health needs of children, women, the aged, the mentally retarded, the Hispanic community, and the Pacific Asian community; others emphasized the need for prevention, research, manpower and training, advocacy, and counseling services; and still others spoke about mental health on the job, renewal of the CMHC legislation, alcoholism, and legal and ethical issues.

The concerns of those who testified at the next three hearings were similar to those expressed in Philadelphia, with the differences reflecting dissimilar regional interests. In Nashville, for example, the initial presenter emphasized the inadequacies of the service delivery system and its impact on rural Americans with mental and emotional difficulties, and the failure of those in policymaking positions to recognize them. In Tucson, the mental health of Native Americans, Mexican Americans, and Spanish-speaking migrants occupied center stage. In San Francisco, Kenja Murase, the principal investigator of the Pacific/Asian Coalition (an NIMH-funded national organization), spoke about the historic discrimination faced by his multiethnic constituency and the fact that many were immigrants who were at high risk for mental health problems.

The varied nature of the testimony presented by individuals and organizations, each representing different interests, did not result in a clear agenda to guide the PCMH's work. There was a consensus that the fragmentation within the mental health system and the absence of links between clients and services were serious problems. But there was little effort to distinguish among the needs of various groups; instead, the discussion centered on underserved groups without in any way prioritizing them. Privately, some commissioners talked about the mental health needs of children and adolescents; ethnic, racial, and geographic minorities; the importance of better management; a greater emphasis on prevention; the lack of services in jails and correctional facilities; and the stress and mental disorders caused by unemployment, inadequate education, poor housing, racism, sexism, and elitism. All the commissioners implicitly accepted the claim that effective therapeutic advances and preventive interventions existed and that new systems of financing and administration could facilitate their deployment. Finally, they agreed that deinstitutionalization was the preferred policy and that CMHCs were "the most beneficial and accessible of present service delivery systems."[13]

One issue that proved particularly troublesome was the question of boundaries. How could mental problems that were medical in origin be distinguished from those that were societal? Willie, for example, believed that the PCMH could not avoid dealing with unemployment, inadequate education, poor housing racism, and sexism, all of which produced stress and served as barriers to effective services, a view endorsed by Beigel. Allan, by contrast, saw a real danger in broadening the concepts of mental health. She argued that the survival of individuals with severe disorders ought to determine prioritization, and she feared that the commission's deliberative sessions and emphasis on prevention and early detection would deflect attention away from dealing with their pressing needs. Indeed, the internal discussions suggested that the majority of members accepted a public health model that emphasized prevention and social action, thus implicitly minimizing the importance of treatment and care.[14]

In July and August 1977 the commission met to receive briefings on the work of the various task panels. Their lack of focus, however, made it difficult for the commissioners, particularly some of the lay members, to assimilate the many claims and recommendations. "Most of the papers we have received," observed Cabranes, "tend to be rather discursive and . . . even in those papers where there is a quite clearly delineated conclusion, or recommendations section, the recommendations tend to be rather hortatory in nature. . . . I think generally . . . we have to move from the big picture to narrow, boring, pedestrian, but presumably significant recommendations." The reporter who covered the July meeting for the APA wrote that the commission was somewhat impaired by "inexperience." Its members seemed to ignore strictly psychiatric issues such as treatment and adopted a working definition of mental health that included "all sorts of social and even economic dysfunction."[15] In this respect the PCMH reflected the antiprofessional ethos so prominent in the 1960s and 1970s.

The Preliminary Report

The varied makeup and sometimes competing interests of the commissioners and the members of the task panels made it difficult to come to clear and definitive recommendations. Bryant, who had to deliver a preliminary report to President Carter in mid-September, noted that

the drafting of such a document was "a real hassle . . . with staff versus Commission and Commissioners disagreeing among themselves and with me." He had to take into account not only the deliberations that accompanied the task panel briefings but also the views of the individual commissioners. Nevertheless, the preliminary report was completed and delivered to and discussed with President Carter on the morning of September 15, 1977. Bryant reported that the president "was very pleased and enthusiastic about the Report and our work."[16]

The preliminary report noted that mental health problems were not limited merely to those with mental illnesses and psychiatric disorders but also included people suffering the effects of various societal ills such as poverty and discrimination based on race, sex, class, age, and mental and physical handicaps. Four problem areas required attention. The first was the delivery of community-based mental health services. The report recommended the creation of an interagency group within the federal government to coordinate these programs; the encouragement of states and localities to develop more group care housing; adequate funding for CMHCs; and manpower training programs for professionals and minority mental health personnel to work in community programs. The second problem area was financing. For this the report supported the inclusion of mental health benefits in public and private insurance plans and studies that assessed the costs of providing services in different settings and organizations. The third problem area was the need to expand the general knowledge base, so it urged more funding for a number of federal agencies. Finally, the report proposed that greater efforts be made to identify strategies that would help prevent mental disorder and disability.[17]

Even before the preliminary report was issued, the commission's work had begun to receive criticism. In early August the National Coalition of Hispanic Mental Health and Human Services Organizations sponsored a conference attended by CMHC directors and organizations representing ethnic minorities. Bryant agreed to attend and answer questions. According to some participants, the PCMH was flawed in its composition as well as the manner in which it addressed ethnic concerns. It also had not "adequately considered the relationship between unemployment, education, economic class divisions, and other societal factors as causes of mental illness." "Nothing is going to be done for us," observed Rodolpho B. Sanchez, national director of the coalition. "We've got to seek other avenues."[18]

The Task Panels' Reports

Between October 1977 and January 1978 the commission held three two-day meetings during which they received and discussed the reports of the various panels. The reports and deliberations revealed that its members were confronted with extraordinarily complex problems that grew out of both a global agenda that had no clear boundaries and the involvement of multiple interest groups with concerns that were not easily reconciled. Indeed, it was questionable whether any group, professional or lay, could absorb the findings and recommendations of two dozen task panels and then develop a coherent final report. Further complicating the commission's deliberations was the fact that panels sometimes offered contradictory advice.

The October meeting was revealing. Six task panel coordinators provided interim reports dealing with community support systems, the family, public attitudes and the media's promotion of mental health, the CMHC program, legal and ethical issues, and manpower concerns. Each report offered complex and numerous recommendations. The December meeting was similar; six panels provided detailed summaries of their deliberations. The report of the Task Panel on Organization and Structure of Mental Health Services was in many respects typical. Its members attempted to develop a model that looked at the clustering of organizationally related structures in connection with three constituent groups: consumers, providers, and social institutions. In so doing they created a series of theoretical categories. In the ensuing discussion Allen asked, "How do you get from a theoretical place to what we have in reality?" Her pragmatic concerns stood in sharp contrast to the panel members' theoretical emphasis. The reports of the other task panels (which included planning, media promotion, legal and ethical issues, and rural mental health) posed similar problems because of their breadth. The same was true of the report on prevention. "How do you avoid the criticism," asked Cabranes, "that the expansive definition of mental health used by the Commission and the interest in prevention combine to make the Commission one that in effect would restructure society and speak not to physical but to social, political, and economic health?" He insisted that they develop a clear sense of what was meant by "prevention," the agencies involved, and the limits of the mental health system's functions. The January meeting was even more frenetic. Over a two-day period the commission listened to briefings by

no fewer than twenty-two task and subtask panels, each providing several recommendations.[19]

By early 1978 the task panels had completed their work. Their reports filled 2,140 pages in three large volumes included as appendices to the commission's final report. Nor were the reports necessarily consistent. The constraints of time and the commissioners' additional obligations raised doubts about their ability to absorb the findings and recommendations of so many diverse groups.

The first report, "The Nature and Scope of the Problems," was based on data and emphasized the importance of epidemiological research to framing health and mental health policies (President's Commission on Mental Health 1978, 2:1–138). The report dealing with special populations, covering nearly 400 pages, was by far the longest and most exhaustive. It discussed women, Asian/Pacific, Black, Hispanic, and Indian Americans, as well as Americans of European ethnic origin and those with various handicaps. These groups were selected because they were both overrepresented in mental health statistics and under- or inappropriately served. The report also noted that most of those who provided services and conducted research did not share "the unique perspective, value systems and beliefs of the group being served." Subpanels dealing with each group issued their own reports, which tended to stress the presence of discriminatory barriers and the need for policies that took into account unique group characteristics. Four other task panels dealt with the elderly, migrant and seasonal farmworkers, Vietnam War veterans, and rural residents. By breaking down the population into such groups and emphasizing the role of discrimination, the need for social reforms, and the importance of positive mental health policies, the task panels implicitly lost sight of individuals with severe and persistent mental illnesses. Rather than constituting a single identifiable group, they were placed into groups whose distinguishing characteristics had little to do with specific diagnostic categories (President's Commission on Mental Health 1978, 3:730–1358).

The panel dealing with legal and ethical issues offered 42 recommendations. Above all, its members insisted on building a strong patients' rights and consumer perspective into any changes in the service system. Its specific recommendations covered such diverse subjects as compensatory education for handicapped children, employment, housing, guardianship, confidentiality, right to treatment issues, experimentation, commitment, and mental health issues affecting individuals

accused or convicted of crimes (President's Commission on Mental Health 1978, 4:1359–1516).

Several reports were general and vague. The panel dealing with organization and structure, for example, urged the creation of active programs that promoted mental health, prevention, early identification, crisis stabilization, and the restoration or maintenance of mentally impaired persons at their maximum level of functioning. Similarly, the reports dealing with community support programs, access and barriers to care, and deinstitutionalization, rehabilitation and long-term care were brief and superficial. Even the panel dealing with costs and financing—surely critical issues—conceded that the divergent views of members "limited the possibility that . . . [their] report would present agreements on the causes and cures for the problems of mental health financing." Hence it simply identified areas that required attention (President's Commission on Mental Health 1978, 2:139–235, 275–311, 340–75, 497–544).

The panel assessing the CMHCs was strongly supportive and rejected criticisms that they had played a limited role in prevention, services to populations at special risk, and services to the previously institutionalized. Conceding the existence of serious problems, its members noted that relatively meager funding had produced important positive results. Unless the commission wanted to change the distribution of funds, nothing the panel could recommend regarding the CMHCs would make a difference (President's Commission on Mental Health 1978, 2:312–39).

Other panels emphasized the importance of the states and expressed the hope that a partnership could be forged to overcome the mistrust and confusion among various levels of government. Panels on prevention, research, personnel, alternative mental health services, family support services, media promotion of mental health, and learning failures all contributed to an agenda with no definite boundaries. Finally, three liaison panels reported on issues relating to mental retardation, alcohol-related problems, and the use and misuse of psychoactive drugs (President's Commission on Mental Health 1978, 2:236–74, 376–496; 3:545–729; 4:1517–1924, 1991–2140).

The Final Report

With the task panels' reports in hand, the commission now faced the seemingly herculean task of absorbing their findings and recommendations and preparing a final report by April 1978. The writing of the

report was complicated by the fact that most of the members had their own agendas (Bryant, interview, 2003; Danaceau, interview, 2003). Initially a draft document was prepared before the February 1978 meeting by three dozen individuals who had met for three days at Wingspread in Wisconsin to discuss the delivery of services. Participants agreed on two broad themes: the necessity of fulfilling the federal commitment to community mental health services with full citizen participation and the need for a new place and a new priority for the chronically disabled.[20]

The multiplicity of voices complicated the preparation of an acceptable final report. The commissioners' comments on the first drafts ranged so widely that Danaceau suggested to Bryant that all of them be deliberately incorporated into the document, which would then be "unbelievably long and confusing." When presented with this draft, the commissioners agreed that Bryant and his associates should assume responsibility for preparing a coherent report, which would then serve as the basis for discussions. At the February and March meetings Bryant proved adept in working out language acceptable to all the commissioners. The result was a unanimous report without minority dissents (Danaceau, interview, 2003).[21]

The report avoided the task panels' excessive details and innumerable recommendations. Although Bryant and his colleagues did not ignore their work, they chose to present their case in a way that would make it accessible to as wide an audience as possible. Despite the progress made during the previous twenty-five years, the report noted that many groups continued to receive inadequate care, notably persons with chronic mental illnesses, children, adolescents, and older Americans. Rural areas in particular lacked services (President's Commission on Mental Health 1978, 1:3–4).

The plight of persons with chronic mental illnesses was illustrative. Most areas lacked a broad range of services that provided food, shelter, social supports, and psychiatric and general health care. Furthermore, those services that did exist all but ignored the differing cultural and linguistic traditions of minorities, including African Americans, Hispanics, Asian and Pacific Island Americans, Native Americans, and Alaskan Natives. The 5 million seasonal and migrant farmworkers, many of whom belonged to racial minorities, were almost entirely excluded from mental health care. Children and adolescents as well as the 23 million Americans over the age of 65 suffered from "neglect, indifference, and abuse" and lacked access to services. Moreover, perhaps 25 percent of the population suffered from mild to moderate emotional disorders, including

depression and anxiety, to say nothing of the 40 million handicapped Americans. Nor could the damage that resulted from poverty, unemployment, and discrimination that occurred on the basis of race, sex, class, age, and mental or physical handicaps be overlooked (President's Commission on Mental Health 1978, 1:4–9).

The report affirmed a commitment to the goal of making high-quality mental health care at reasonable cost available to all who needed it. Personal and community supports had to be strengthened, and a responsible mental health service system had to be created that provided the most appropriate care in a least restrictive setting. The report endorsed a federal program designed to encourage the creation of new community mental health services, particularly in underserved areas. It was imperative, therefore, that a "National Priority to Meet the Needs of People with Chronic Mental Illness" be established. The report urged HEW to develop a national plan for phasing down and, where appropriate, closing large mental hospitals and allocating more resources for comprehensive and integrated systems care that included community-based services and the remaining small state hospitals (President's Commission on Mental Health 1978, 1:16–28, 64–5).

The report also supported reforms in both the public and private financing of mental health services. Any future national health insurance program and all existing private and public programs had to include benefits for emergency, outpatient, and inpatient care. Since persons with chronic mental illnesses required decent housing, adequate nutrition, and other supportive services, the commission maintained that any new system be required to recognize the need for social welfare, as distinct from medical, expenditures (President's Commission on Mental Health 1978, 1:29–34).

Federal policy, the report continued, had to encourage mental health specialists to work in underserved areas, to increase the number of minority personnel, and to ensure that the training and knowledge of such personnel were suitable for the needs of those they served. Implementing these and other goals required federal resources and moderate increases in funding for training and planning (President's Commission on Mental Health 1978, 1:35–41).

The document also dealt with legal and human rights. Given the social ferment of the 1960s and 1970s, this subject could hardly be avoided. The commission supported a series of actions: (1) the creation of an advocacy system to represent mentally disabled individuals; (2) the

prohibition of discrimination; (3) a requirement that the states review their civil commitment and guardianship laws to ensure that they contained procedural protections; (4) affirmation of the rights to treatment in the least restrictive setting, rehabilitation, and protection from harm, as well as the right to refuse treatment with appropriate procedures under which this right could be qualified. Finally, it asked that individuals caught up in the criminal justice system be given access to relevant mental health services (President's Commission on Mental Health 1978, 1:42–5).

The final recommendations dealt with research, prevention, and the improvement of public understanding. In regard to research and training, the commission supported an increase in funding, but in regard to the problems posed by stigmatization and discrimination, its members conceded that they did not know how to resolve them. Better data about how people actually viewed mental illnesses and emotional problems were needed (President's Commission on Mental Health 1978, 1:46–50, 55–7).

In its "A Strategy for Prevention," the commission noted that the history of public health during the past hundred years provided "ample evidence that programs designed to prevent disease and disorder can be effective and economical." Possible avenues of study were the reduction of the stressful effects of life crisis experiences "such as unemployment, retirement, bereavement, and marital disruption due to death or other circumstances." It was equally important to understand the nature of social environments. The first priority, however, was the mental health of children, and the report underscored the importance of appropriate prenatal and perinatal care, day care programs, and foster care as ways of preventing mental disability in later life. The commission also supported the creation of a center for prevention within the NIMH, with primary prevention (the elimination of the causes of mental disorder or disability) as its first priority (President's Commission on Mental Health 1978, 1:51–4).

The final report also included more than 100 other major recommendations that affected not only the relations among federal, state, and local governments but also public and private agencies and such federal programs as Medicare and Medicaid. In many ways the heterogeneous character of the commission's work was influenced by a political climate in which debates and agendas were shaped by the demands of groups that defined themselves in terms of class, ethnicity, gender, and race.

By that time, neither the state mental hospital system nor individuals with serious and persistent mental disorders were at the center of the policy debates; the number of competing voices and advocates for other groups had increased exponentially. The final report was neither a blueprint for legislative action nor the expression of a specific group. The diversity of its recommendations could not easily be translated into legislation. At best, it was a document, as Sharfstein observed, that had the potential to create some sort of consensus that would eventually result in legislation (Foley and Sharfstein 1983). The commission, Tischler recalled, "sought a political middle ground and its attempt was to honor the various constituencies through recommendations that provided something for everyone" (Tischler, interview, 2003). The inclusiveness of the report was thus a source of strength as well as weakness.

In April 1978 the commission's final report was delivered to President Carter. At a press conference Carter spoke of his support for the commission's recommendations and his appreciation that the report had called for only modest increases in funding and had not recommended the creation of new programs.[22]

The Aftermath

The hope of every modern presidential commission is to turn the public's attention to an important problem while providing new policy initiatives designed to mitigate the prevailing difficulties. Unlike the commissions that had dealt with urban violence, assassinations, and racial friction, however, the problems posed by mental illnesses and health appeared less immediate and hence less pressing. Indeed, the public's reception of the PCMH's final report was relatively subdued. A few urban newspapers and professional journals provided summaries. The APA's response was somewhat mixed. Jack Weinberg, its president, wrote to President Carter hailing the report "as an important step toward forging a national policy and commitment for adequate care and treatment of the mentally disabled." At its annual convention in May the APA's ad hoc committee on the PCMH sponsored a special session that gave panel participants a chance to offer their own critiques. The general consensus was that the report "could have been worse."[23]

That the report drew little attention did not mean that it would be ignored. Shortly after receiving the report, President Carter directed HEW

Secretary Califano to draft a law that would implement its recommendations. Califano in turn created an internal task force to identify and analyze the implications of the report and to propose legislation. On the advice of his staff, he directed that the proposed legislation concentrate on revising the CMHC Act and categorical mental health services. His staff believed that if the draft law tried to address the comprehensive needs of persons with severe mental illnesses, Congress would be unlikely to act (Foley and Sharfstein 1983).

By this time, it was clear that the decentralized and uncoordinated mental health system was not providing integrated and comprehensive services to those with the greatest needs, namely, persons with severe and persistent mental illnesses. Hence there was increasing interest in a systems approach that would forge links between the mental health system, on one hand, and other health and human services, on the other. The presumption was that people with severe and persistent mental disorders required a range of life and social supports. In this context the HEW task force on implementing the PCMH report began composing its recommendations, which took nearly eight months to complete. It offered a draft of a community mental health systems act as the means of implementing the letter and spirit of the PCMH's recommendations (Foley and Sharfstein 1983; *Report of the HEW Task Force* 1979).

Even before completing its work, the HEW group was sharply criticized.[24] Nevertheless, in March 1979 a draft bill was sent to the White House. Bryant, who was asked to review the draft, found it "not exciting." He characterized it as a sort of "fix-things-up" bill. Nor did it deal with the care of the chronically mentally ill, the "deinstitutionalized" population (Foley and Sharfstein 1983). The bill was returned to the HEW task force, which sent a revised and acceptable version to the White House in April 1979.

Following in the footsteps of John F. Kennedy, President Carter sent a message to Congress the following month accompanied by a draft of a mental health systems act (House 1979). The introduction of a draft law, however, was just a beginning. Indeed, passage of the final bill took nearly a year and a half. Congressional inaction was by no means a result of disinterest or preoccupation with other issues. Rather, there was no consensus on mental health policy. Deinstitutionalization—whatever its meaning—was coming under widespread criticism by a variety of interest groups, each with a different agenda. The concerns of CMHCs, for example, differed from those of state officials. In fact, the

role of CMHCs in the mental health system remained an open question. Moreover, the proliferation of the mental health professions had created other constituencies with either a tangential or no relationship to persons with serious and persistent mental illnesses. To forge a consensus that would result in new legislation was not an easy task.

In late May 1979 the draft bill submitted by HEW to President Carter was introduced in the Senate (S 1177) and the House of Representatives (HR 4156). That the concept of mental health had the ability to attract a variety of constituencies was evident in the deliberations of the House, which introduced a second piece of legislation (HR 3986) amending the CMHC Act to provide further research on and services to victims of rape. In May and June both the Senate and House subcommittees held public hearings on the draft legislation, and the latter also included in its deliberations the bill dealing with rape.

The hearings in both Senate and House subcommittees in the spring of 1979 revealed broad policy disagreements. The testimony of many individuals and organizational representatives was critical of the draft bill. Supporters of CMHCs were disturbed by the absence of a firm commitment to the program. Others believed that the draft did not address the problem of creating a coherent working relationship among the three levels of government. Some argued that states—which supplied more mental health dollars than did the federal government—did not have an adequate voice in determining how federal dollars were spent. Civil rights advocates were disturbed by the absence of a patients' bill of rights. And many decried the bill's failure to address many of the needs of racial and ethnic minorities (House 1979; Senate 1979).

The bill that emerged in the Senate was quite different from the original HEW draft. It promised a sharp expansion of services and resources, even though its provisions were diffuse and sometimes contradictory. The House draft was somewhat more modest in scope than its Senate counterpart, although it by no means rejected the administration's bill (Foley and Sharfstein 1983; House 1980; S. Rep. 96-712, 1980).

In the summer of 1980 the Senate and House passed different bills,[25] setting the stage for both chambers to reconcile the differences. Members from both branches of Congress managed to resolve several major differences, including provisions that protected hospital employees facing the loss of their jobs (Foley and Sharfstein 1983; H. Rep. 96-1367, September 22, 1980). The principal dispute concerned the patients' bill of rights. In the end, the weaker Senate version was accepted by members of both

bodies, but only after deleting the section penalizing those states that failed to protect the rights of patients. In general, the bill reported out by the conference committee on September 22 was, with some exceptions, closer to the more expansive Senate version. Within days both chambers accepted the conference report and approved the legislation, which was signed into law on October 7, 1980 (S. Rep. 96-980, September 23, 1980).[26]

Mental Health Systems Act

The provisions of the Mental Health Systems Act reflected the ambiguities and contradictions that had been characteristic of mental health policy during the preceding two decades. The act reaffirmed the priority for community mental health services, particularly for such underserved groups as individuals with chronic mental illnesses, children and youth, the elderly, ethnic and racial minorities, women, the poor, and rural residents. It emphasized planning and accountability and mandated "performance contracts" as a condition for federal funding, the creation of new intergovernmental relationships, and closer links between the mental health and the general health care systems.

The legislation provided grants for a variety of purposes: to CMHCs that had not received federal funding; to state mental health authorities, CMHCs, or other entities providing services to persons with chronic mental illnesses, severely disturbed children and adolescents, elderly persons and other priority populations; to health care centers to provide mental health services; to training and retraining programs for displaced employees; to programs for the prevention of mental illness and promotion of mental health; and to state mental health authorities to plan and develop mental health services programs and coordinate them with other federal programs providing services to persons with mental illnesses (e.g., the various titles of the Social Security Act as well as legislation dealing with other disabled groups). Some of its provisions were designed to restore the balance that the original CMHC Act of 1963 lacked. The states' mental health authorities were given more power to review applications for community services. The NIMH was required to create a mental health prevention unit. Funds were dispensed through "performance contracts" in order to ensure accountability. The law included a relatively weak provision dealing with a patients' bill of rights

and advocacy programs, as well as titles dealing with rape prevention and the control and protection of employees adversely affected by the introduction of new policies (Public Law 1980).

While assigning the highest priority to individuals with chronic mental illnesses, the legislation also recognized the claims of various other groups whose needs were quite different, including children and adolescents, the elderly, rural residents, and victims of rape. The absence of new resources and vague generalizations about the kinds of services required, however, raised doubts about the legislation's effectiveness.

Since the legislation mirrored the demands of multiple interest groups, it was hardly surprising that it offered prescriptions for action that reflected quite different concerns. As Sharfstein noted, in order to make it through the congressional gauntlet, the legislation "had to give a little something to everyone and as a result became unusually complex" (S.S. Sharfstein, interview, October 24, 2003). Older CMHCs were criticized because they had not responded to the needs of vulnerable populations, yet the act authorized the programs to continue in order to permit funding for areas that had not received grants. Although the legislation anticipated the creation of an integrated effort at the local level, it created ten new categorical programs, each with its own constituency (Foley and Sharfstein 1983).

Some of the legislation's provisions reflected ideology rather than empirical data, notably the provisions dealing with the prevention of mental illnesses and the promotion of mental health. Their popularity reflected in part a faith in human agency, that disease was not inevitable and could be avoided by conscious and purposive actions. In fact, the prevention of mental illnesses and the promotion of mental health were little more than attractive slogans. Given that neither the etiology nor the pathology of mental illnesses was understood, how could strategies be developed that would prevent such disorders and promote health? The absence of any data demonstrating the effectiveness of preventive and promotion strategies did not, however, act as a deterrent.

Even more important, how could individuals with serious mental illnesses in the community negotiate with programs administered by independent agencies? To be sure, the act implicitly recognized the critical role of federal entitlement programs. Yet it made no systematic provisions to ensure that individual needs would be addressed by the agencies administering these programs, each of which had different missions and concerns. Despite paying homage to the need to integrate services and

to strengthen the regulatory role of state mental health authorities, the act did little to overcome the fragmentation characteristic of the mental health field.

The Mental Health Systems Act had hardly become law when its provisions were rendered moot. The inauguration of Ronald Reagan in January 1981 led to an immediate reversal of policy. In the summer of 1981 the Omnibus Budget Reconciliation Act became law. Under its provisions, the federal government provided block grants to the states for mental health services and substance abuse, although at levels of about 75 to 80 percent of what they would have received under the Mental Health Systems Act. The states had considerable leeway in expending their allocations. With a few exceptions—notably, the patients' bill of rights—the Mental Health Systems and CMHC Acts were repealed, thus diminishing the direct role of the federal government in mental health (Public Law 1981). The transfer and decentralization of authority merely exacerbated the existing tensions, as federal support was reduced at precisely the same time that the states were faced with social and economic problems that increased their fiscal burdens.

By 1981 it had become clear that the effort to create a more coherent and integrated mental health system for persons with serious and persistent mental illnesses had fallen short of its goals. The PCMH's report might have laid out a blueprint for the future, but the very composition of its membership led to deliberations that focused on the needs of multiple interest groups. In the judgment of David Mechanic, coordinator of the Task Panel on the Nature and Scope of the Problems, the PCMH failed to face "the tough question of financial priorities. . . . In endorsing everything, the report offered no clear course of action" (Mechanic 1999, 98–9).

In the short run the PCMH appeared to have relatively little influence on the evolution of mental health policy. Yet serendipity is often an unrecognized force in human affairs. This is particularly true of the section in the final report calling for the establishment of a national priority and a national plan to meet the needs of individuals with chronic mental illnesses. As a result of this recommendation, the HEW task force charged with drafting a law proposed that the secretary of the agency appoint a group to develop a "national plan for the chronically mentally ill" (President's Commission on Mental Health 1978, 1:22–3; *Report of the HEW Task Force* 1979). Completed in December 1980, the plan laid out a blueprint for future action (Koyanagi and Goldman 1991a, 1991b; U.S.

Dept. of HHS 1980). Despite the political conservatism of the 1980s, a number of recommendations in the national plan that emphasized the use of federal entitlement programs were implemented incrementally in the federal bureaucracy, thus lessening the impact of the Reagan administration's efforts to reduce the role of the national government. The use of federal entitlement programs materially assisted persons with severe mental disorders and helped improve their lives. Nevertheless, care and treatment in the community for such individuals continued to pose challenges. In the community (and particularly in large urban areas) successful management depended on bringing together needed services administered by a variety of bureaucracies, each with its own culture, priorities, and preferred client populations. But only a small number of communities succeeded in integrating psychiatric care and treatment, social services, housing, and social support networks. The overwhelming majority of persons with severe and persistent mental illnesses continued to face a difficult future.

Less obvious but also important was the PCMH's stimulus to the development of a psychiatric epidemiology that, for better or worse, created a whole new set of issues. Daniel X. Freedman, an important figure in American psychiatry from the 1960s until his death in 1993, believed that the PCMH had created a "climate of informed concern" by focusing on the underserved and the need to bring "the mentally ill and disabled into undisputed full entitlement to professional and social services and gains from new knowledge." Its report highlighted the need for a sound and useful knowledge base, which required a vigorous expansion of psychiatric epidemiology. "Diagnosis, prognosis and special social practices or behavioral and biomedical treatment," he insisted, "require the data that sophisticated epidemiology can create." Published in the prestigious *Archives of General Psychiatry*, his editorial was followed by two articles emphasizing the potential contributions of psychiatric epidemiology to administrators and policymakers (Freedman 1978, 675–6; Regier, Goldberg, and Taube 1978; Robins 1978).

Conclusion

The history of the PCMH and the abortive legislation that followed illustrates the impact of social and political change on mental health policy. Between the 1940s and 1960s, relatively few, strategically located

individuals were able to reshape policy. But by the 1970s, quite a different situation prevailed. The receptivity of the 1960s to innovation was followed by a decade of consolidation and retrenchment. Carter's fiscal conservatism constrained the PCMH's work. More important, the rise of groups that defined themselves in terms of race, gender, and ethnicity helped change the configuration of American politics. In many respects this transformation created the foundation for a sustained attack on discriminatory practices that had marginalized minorities, women, and individuals with disabilities, all of whom benefited to some degree. The demands for services by new groups were not in any way intended to detract from the needs of individuals with serious mental disorders. Nevertheless, the rise in consciousness of neglected social groups created demands for mental health services by those not mentally ill. At the same time the elevation of many behaviors to the status of distinct pathological entities, perhaps best symbolized by the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980, as well as a dramatic increase in mental health personnel less concerned with serious mental disorders, contributed still more to the tendency to shift services away from individuals with more serious mental illnesses (American Psychiatric Association 1980).

Can the history of the PCMH offer policy guidance? The answer to this ostensibly simple question is extraordinarily complex. Admittedly, history offers few concrete lessons, but it does suggest some broad themes that are useful to keep in mind when developing policy. At the very least, history teaches us that there is a price for implementing ideology ungrounded in empirical reality and for making exaggerated rhetorical claims. The PCMH's experiences also illuminate many of the difficulties that American society faces in dealing with health policy. Bureaucratic rivalries within and between governments; tensions and rivalries within the mental health professions; identity- and interest-group politics; the difficulties of distinguishing the respective roles of such elements as poverty, racism, elitism, stigmatization, and unemployment in the etiology of mental disorders; and an illusory faith in the ability to prevent mental disorders all contributed to the commission's deliberations and the subsequent enactment of the Mental Health Systems Act.

The issues and dilemmas confronted by the PCMH have not become obsolete. Should priority be given to individuals with serious and

persistent mental illnesses, compared with those with less serious problems? Is it possible to minimize efforts to shift costs within a federal system composed of three levels of government? Should legislators and policymakers concentrate on incremental changes, or should they seek a systemwide change? Can strictly health concerns be distinguished from broad environmental and social determinants? Should mental health policy remain independent of or part of our general health policy? These questions remain as relevant in the present as they did a quarter of a century ago.

Endnotes

1. White House Press Secretary Release, "Executive Order, President's Commission on Mental Health," February 17, 1977, box 25, Presidential Commission on Mental Health Papers, record group 25, Carter Presidential Library (hereafter cited as PCMH Papers).
2. *Psychiatric News*, March 18, 1977, 14; *Psychiatric News*, May 6, 1977, 1, 12; Office of the First Lady's Press Secretary, Fact Sheet, April 19, 1977, box 25, PCMH Papers.
3. See, for example, T.E. Bryant to Senator John Melcher, April 28, 1977; Bryant to Representative Bill Alexander, October 28, 1977, box 22, PCMH Papers.
4. Detailed résumés of each can be found in boxes 20 and 21, PCMH Papers.
5. *Psychiatric News*, May 6, 1977, 13.
6. Notes on Briefing of Commissioners-Designate of President's Commission on Mental Health, March 29, 1977, 1–12, box 1, PCMH Papers.
7. Bryant to Margaret McKenna, April 5, 1977; Joseph A. Califano Jr. to Bryant, April 28, 1977; Bryant to James Dickson, April 29, 1977, box 22, PCMH Papers.
8. Bryant memo to Margaret McKenna, April 5; Bryant to James B. Rielly, April 26; Bryant memo to Ben Heineman Jr., May 3, 1977, box 22; Bryant to Hugh A. Carter Jr., February 22, 1978, box 24; Vic Pfeiffer to Bryant, June 9, 1977, box 22; Congressional Responses to Letter Sent by PCMH, n.d., box 22, PCMH Papers.
9. President's Commission on Mental Health—Task Panels Announced, June 16, 1977, box 25; Information Bulletin, July 20, 1977, box 25; Richard A. Millstein to Paul R. Friedman, November 15, 1977, box 23, PCMH Papers; *Psychiatric News*, July 15, 1977, 1, 6.
10. Bryant to Priscilla Allan and other commissioners, April 12, 1977, box 22; Meeting of the President's Commission on Mental Health . . . April 19, 1977, 19–21, 25–9, 48–53, 60–64, 74–83, 89–99, box 1, PCMH Papers.
11. Gathering Information and Data: Staff and Panel Work Plans, April 19, 1977, box 1; Dr. Bryant's Remarks at the June 16, 1977, Press Conference, box 25, PCMH Papers.
12. Verbatim transcripts are in President's Commission on Mental Health. Philadelphia, Pennsylvania, May 24, 1977, box 10; Public Hearing before the President's Commission on Mental Health [Nashville, May 25, 1977], box 12; A Public Hearing before the President's Commission on Mental Health . . . Tucson, Arizona . . . June 20, 1977, box 14; President's Commission on Mental Health. Public Hearing, San Francisco, California . . . June 21, 1977, box 17, PCMH Papers.
13. Public Meeting, Commissioner's Meeting . . . June 22, 1977, passim, and Summary, 1–3, box 1; Virginia Dayton to Bryant, May 27, 1977; Rev. Franklin E. Vilas Jr. to Bryant, May 31,

1977; Charles V. Willie memos to PCMH, June 24, 1977, box 21; John Conger to Bryant, July 15, 1977, box 20, PCMH Papers; *Psychiatric News*, August 5, 1977, 1, 9–11.

14. Public Meeting, Commissioner's Meeting . . . June 22, 1977, 9–10, 26–8, 52–5.
15. Meeting of the President's Commission on Mental Health, July 11–12, 1977 . . . Summary, box 1; Transcript of Proceedings . . . Meeting on Prevention . . . 3 August 1977, 5–10, 47, 50–1, box 3; Meeting of the President's Commission on Mental Health . . . August 2–3, 1977 . . . Summary, 1–3, box 2; Transcript of Proceedings . . . Meeting on Mental Health Manpower . . . August 2, 1977, 23–4, box 3, PCMH Papers; *Psychiatric News*, August 19, 1977, 1, 10–11.
16. Bryant to Peter Bourne, September 8, 1977, box 23; Beverly Long to Beatrix Hamburg, July 16, 1977; Long to Bryant, August 17, 1977; LaDonna Harris to Bryant, August 26, 1977; Thomas L. Conlan to PCMH, July 1, 1977; Conlon notes telephoned to Bryant, August 9, 1977, box 21; Bryant to Priscilla Allen and other commissioners, September 15, 1977, box 23; Washington Press Club—September 15, 1977, Mrs. Carter's Remarks, box 25, PCMH Papers.
17. Preliminary Report to the President from the President's Commission on Mental Health September 1, 1977, box 2, PCMH Papers.
18. *Psychiatric News*, September 16, 1977, 1.
19. Meeting of the President's Commission on Mental Health . . . October 14–15, 1977 . . . Summary, 1–6; Meeting of the President's Commission on Mental Health December 9–10, 1977 . . . Summary, 1–2, box 4; Transcript of Proceedings President's Commission on Mental Health . . . December 9, 1977, 4–52; Transcript of Proceedings of the President's Commission on Mental Health, December 9, 1977, 53–60, 103–11, 133–8; Meeting of the President's Commission on Mental Health December 9–10, 1977 . . . Summary, 2–11; Transcript of Proceedings President's Commission on Mental Health . . . December 10, 1977, 177, 183, 199–200, 202–18, 226–7, box 5; Memo from Richard H. Millstein to George Albee, December 12, 1977, box 24; Transcript of Proceedings President's Commission on Mental Health . . . January 16, 1978, 5–20; Transcript of Proceedings President's Commission on Mental Health . . . January 17, 1978; Meeting of the President's Commission on Mental Health January 16–17, 1978 . . . Summary, box 6, PCMH Papers.
20. Thomas L. Conlan to Bryant, March 9, 1978; Conlan to PCMH Commissioners, n.d. (Suggestions for consideration in setting the tone . . . of our Report); Charles V. Willie to Bryant, February 2, 1978; Beverly B. Long to Rosalynn Carter and Bryant, February 11, 1978, box 21; Allan Beigel to Bryant, December 15, 1977; Priscilla Allen to Mildred Starin, December 2, 1977; Allen to Gary Tischler, February 20, 1978, box 20; Martha Mitchell to Bryant, March 20, 1978, box 21; memo, Bryant to all commissioners, February 7, 1978, box 9; Transcript of Proceedings President's Commission on Mental Health . . . February 17, 18, 1978, 3–18, box 7, PCMH Papers.
21. The commission's deliberations and debates over the wording of the final report can be followed in Transcript of Proceeding President's Commission on Mental Health . . . February 17, 18, 1978, box 7, and Transcript of Proceedings President's Commission on Mental Health, March 6, 7, 8, 1978, box 8, PCMH Papers.
22. Office of the White House Secretary, Remarks of the President upon Receiving Final Report of the President's Commission on Mental Health, box 25, PCMH Papers.
23. *Psychiatric News*, May 19, 1978, 8; *Psychiatric News*, July 7, 1978, 1, 8–9, 35; *Hospital & Community Psychiatry* 29(1978): 342–3.
24. *Psychiatric News*, November 3, 1978, 3, 9.
25. *Congressional Record*, 96th Cong., 2nd sess. 126, part 15, pp. 19472–524, and part 17, pp. 22692–734; *Psychiatric News*, February 1, 1980, 1, 4.
26. *Cong. Rec.*, 96th Cong., 2nd sess., 126, part 20, pp. 26511–28, and part 21, pp. 28382–7, 28412.

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Acknowledgments: I should like to thank David Mechanic, Edward Berkowitz, Steven S. Sharfstein, and Howard H. Goldman for reading the manuscript and offering valuable comments.