

JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH

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Joint Commission on Mental Illness and Health Study and Report

Date(s): Established 1955 (Mental Health Study Act); Report published 1962

Location(s): United States (National Scope)

1. Summary

The Joint Commission on Mental Illness and Health was established by the **Mental Health Study Act of 1955**, passed by the U.S. Congress. Its mandate was comprehensive: to thoroughly assess the mental health needs of the American populace and formulate precise, actionable recommendations for a national program designed to achieve "adequacy." The culmination of this multi-year effort was the landmark final report, published in 1962 under the evocative title, "**Action for Mental Health**." This document quickly transcended its role as a governmental study, becoming a profound "**call to arms**" that galvanized professionals, policymakers, and advocates to launch an unprecedented national offensive against what was identified as the country's most significant health problem. The report provided irrefutable evidence of the failure of the existing custodial care system and laid the foundational blueprint for the subsequent transformation of psychiatric care in the United States, emphasizing community treatment and deinstitutionalization.

The core thrust of the Commission's findings was the necessity for a radical paradigm shift away from isolated, underfunded state hospitals toward integrated, community-based care models. It identified pervasive **public indifference and stigma** as the primary sociological barrier preventing the effective application of already-developed treatments. The recommendations spanned clinical care, demanding short-term hospitalization in general community hospitals and the immediate establishment of outpatient clinics; professional development, calling for massive recruitment and training programs across all mental health professions; and research, requiring significant federal investment in long-term, basic research to achieve fundamental breakthroughs comparable to those in other medical fields. The report's aggressive financial strategy proposed doubling expenditures within five years and tripling them within ten, marking a pivotal moment in the history of American public health policy.

2. Legislative Background and Institutional Crisis

The impetus for the creation of the Joint Commission stemmed from a growing national awareness of the desperate conditions and inherent failures of the state mental hospital system following World War II. Despite technological and pharmacological advances that offered hope for effective treatment, institutional practices remained largely custodial and geographically isolating. The **Mental Health Study Act of 1955** acknowledged that sporadic local efforts were insufficient to address the scale of the crisis, mandating a thorough, national investigation to guide federal policy. This legislative action recognized that mental illness affected a significant portion of the population-

-estimated at the time as one out of every ten people suffering from some level of emotional or mental disturbance--and that institutional responses were proving inadequate for the millions incapacitated by severe illness.

The state of care documented by the Commission highlighted a profound disparity between available medical knowledge and practical application. While effective treatments existed that could lead 60 to 80 percent of schizophrenic and other serious cases to improve sufficiently for community life, these treatments were tragically underutilized. The fundamental crisis was financial and systemic: state hospitals, often housing millions of patients, were typically located far from population centers, fostering a sense of social exile for both patients and medical staff. Furthermore, the financial commitment was grossly insufficient; these institutions spent a meager \$4.44 per day on each patient, a stark contrast to the \$31.16 spent daily in community general hospitals, and alarming trends showed that the proportion of state expenditures dedicated to mental patients was actively declining, illustrating systemic neglect.

3. The Findings: State of American Mental Health Care

The Commission's investigation delivered a sobering assessment of the prevailing mental health landscape, providing quantitative evidence of structural failure. A critical finding emphasized the custodial nature of institutions, noting that fully 80 percent of the country's 277 state hospitals were essentially warehousing facilities, prioritizing segregation over therapeutic recovery. This custodial approach perpetuated the idea of chronic illness rather than treatable conditions, trapping approximately two million severely ill persons in debilitating institutional environments. The geographic isolation of these large facilities exacerbated the problem, reinforcing societal detachment and hindering successful reintegration into community life following treatment.

A key irony identified in the report was the disconnect between medical capability and policy implementation. The existence of highly effective treatments proved that mental illness was manageable, yet these were rarely applied broadly. The Commission concluded that the principal obstacle was not scientific or technical but profoundly social and attitudinal. Mental patients were described as **"singularly lacking in appeal,"** their behavior tending to disturb and offend the general public rather than eliciting sympathy. Consequently, the public--and even many members of the medical profession--viewed the mentally ill not as sick individuals requiring medical intervention, but as **"nuisances to be avoided,"** fostering an environment of indifference and outright rejection that paralyzed progress toward effective treatment.

4. Recommendations for Systemic Reform (Patient Care)

The most revolutionary aspect of "Action for Mental Health" was its detailed plan for the radical revision of the entire patient-care program in the United States, calling for the introduction of

entirely new patterns of treatment centered around the community rather than the institution. The report's primary objective was to minimize the debilitating effects of prolonged institutionalization and facilitate the rapid return of patients to their homes and communities. This required establishing comprehensive and diversified services that covered the entire spectrum of care, from initial crisis intervention to long-term rehabilitation.

The report outlined a phased strategy for implementing this shift, focusing heavily on decentralization and integrating psychiatric services into general medical settings. Firstly, counseling services needed to be made immediately available in the community at the **first signs of disturbance**, ensuring early intervention. Secondly, emergency psychiatric care must be readily provided at the onset of acute episodes. The plan specifically detailed four interlocking components for treating all major mental illnesses: (a) the development of community mental health clinics operating on an **outpatient basis** to reduce the reliance on repeated and prolonged hospitalization; (b) the provision of **short-term hospitalization** within every community general hospital, normalizing treatment; (c) the conversion of suitable, smaller state hospitals (those with 1000 beds or less) into intensive treatment centers, while gradually transforming larger state hospitals into centers dedicated to the long-term care and improvement of those with chronic diseases; and (d) the inclusion of dedicated **after-care and rehabilitation** as essential and non-negotiable components of all mental health service delivery.

5. Recommendations for Research and Training

Recognizing that sustained progress required both new knowledge and a competent workforce, the Commission issued strong recommendations regarding research and training investments. It argued forcefully that a second major need was the immediate development of a **comprehensive and diversified research program**. While applied research was important, the report stressed the necessity of investing a large proportion of funds into **basic, long-term research**, deeming it the only viable pathway to achieving fundamental breakthroughs comparable to those seen in other medical disciplines.

To facilitate this essential research, the report recommended that the Federal Government establish specialized mental health research centers and institutes. These centers would ideally operate independently or in close collaboration with existing educational institutions, ensuring academic rigor and the free exchange of scientific knowledge. Concurrently, the Commission demanded that all mental health professions launch an aggressive national recruitment and training program. This initiative was designed not only to attract and prepare highly professional personnel (psychiatrists, psychologists, social workers) but also to train nonmedical workers, acknowledging the vast scale of personnel required to staff the proposed community care facilities and execute the new treatment patterns effectively.

6. Core Obstacles: Stigma and Indifference

A significant portion of the Commission's analysis focused on the need for a massive, proactive societal intervention to overcome the deeply entrenched negative attitudes that served as the primary obstacle to reform. The report stressed that simply reorganizing care structures would be insufficient if the public and medical community maintained attitudes of indifference and rejection toward the mentally ill. The Commission concluded that the defeatism inherent in these attitudes stood directly in the way of effective treatment and funding.

The required intervention was described as a **"massive campaign of education and enlightenment,"** designed to achieve several critical objectives simultaneously. First, it would disseminate authoritative information about mental illness, reframing it as a treatable condition. Second, it would demonstrate that recovery was possible, showing how to work with the mentally ill and treat them as human beings. The expected outcomes of such a campaign were multifold: fostering more friendly and accepting attitudes within the general public; drawing significantly more workers, volunteers, and eventually necessary funds into this historically neglected field; and, crucially, dismantling the societal defeatism that perpetuated the cycle of institutional neglect and chronic illness.

7. Financial and Legislative Impact

To implement the entire program--encompassing research, training, and the radically revised patient-care system--the Commission asserted that a profound financial investment was non-negotiable. The report boldly called for federal, state, and local expenditures dedicated to mental health to be **doubled within the next five years** and **tripled within the next ten years**. This explicit financial roadmap underscored the urgency and scale of the transformation required.

Furthermore, the Commission proposed a new model for federal financial participation designed to encourage state and local accountability. The Federal Government was urged to develop a subsidiary program that would not only shoulder a share of the immense cost of services but also actively incentivize state and local governments to assume increasing responsibility for the provision of care within their jurisdictions. To ensure fairness and effectiveness in resource allocation, the report recommended that all matching grants awarded to states be based on criteria of **merit and incentive**, criteria that should be formulated by an expert advisory committee appointed by the National Institute of Mental Health (NIMH). The recommendations of the Joint Commission directly paved the way for the passage of the **Community Mental Health Centers Act of 1963**, which fundamentally altered the landscape of mental health service delivery in the United States.

Further Reading

[Joint Commission on Mental Illness and Health \(Wikipedia\)](#)

[Action for Mental Health \(Report Summary\)](#)

[Mental Health Study Act of 1955](#)

[Community Mental Health Centers Act of 1963](#)

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