Chapter 13

FROM COMBAT TO COMMUNITY PSYCHIATRY

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INTRODUCTION

Experiences from World War I onward have resulted in the identification of a wide range of psychiatric problems among soldiers in combat and in near-combat situations. In this chapter, I will discuss the applicability of principles derived from the treatment of combat-involved psychiatric casualties to psychiatric casualties that arise in peacetime situations.

The first psychiatric problems described[1] were anxiety-depressive, conversion, and dissociative types of psychiatric casualties in combat troops. These disorders, which range from simple fear to severe anxiety and depression, represent continuing problems. In high-intensity combat, another group of ineffective personnel will consist of soldiers exposed to sustained sleep loss, high-volume and high-intensity sound trauma, prolonged autonomic discharge, and other vicissitudes of unremitting combat. The U.S. Army Medical Department must also prepare for comparable casualties from toxic warfare agents and agents used to counter them. Another large group of ineffective soldiers are often found in support roles. These rear-echelon casualties with disorders, including sexual problems, alcohol and drug abuse, and antisocial acts, became the largest percentage of all U.S. casualties in the closing years of the Vietnam conflict.[2]

Study of psychiatric casualties reported in mass casualty incidents and in the Arab-Israeli wars[3] and the nature of modern warfare present the reasonable expectation that in addition to the above casualties, there will be casualties similar to those in disasters ("disaster fatigue"): temporarily dazed, immobilized responses in as many as one-half to two-thirds of unprepared soldiers and some hyperactive, panicky responses.

In wars as different in setting and culture as those of World War I and World War II,[1,4–6] the Korean conflict,[7–9] the Nigerian Civil War,[10] and the Arab-Israeli wars,[11,12] application of the principles of combat psychiatry,[13] usually described as "forward treatment," has minimized numbers and morbidity of psychiatric casualties while failure to treat has been uniformly deleterious.[14]

This chapter will describe how the principles of combat psychiatry developed during World War I and rediscovered during World War II were applied to noncombat settings toward the end of and during the decades following World War II. It will also address the applicability of these principles in treating certain civilian patients, including acute stress-induced conditions. These principles can also be utilized in the treatment of psychological burnout syndrome from inadequate social support as described in chapter 3 of this volume. Interventions utilizing these principles in disasters, terrorism, and hostage situations and refugee situations are also described in chapters 14 through 17 of this volume.

MILITARY VS CIVILIAN PSYCHIATRIC PRACTICES

The military approach to psychiatric casualties is quite different (for good reasons) from that of traditional office-based psychiatric practice; however, it may be quite similar to some community programs that are founded on principles independently discovered in military and civilian settings. The basic understanding of pathology, treatment practices, and theoretical considerations are the same in civilian and military practice. It is in application that the variance may be greatest.

Some of the reasons for the differences are based on the population involved. The military population is a healthy one. Chronic and debilitating diseases have been eliminated to a considerable degree by selection and disposition of those who are severely unhealthy both mentally and physically. The population also is relatively young and still predominantly male. A moderate degree of intelligence is assured, and outside of combat, the military culture supports good health. However, probably the most important reason for differences is that psychiatry in the military setting functions in terms of the needs of the service; that is, military psychiatry is unique because the mission of the military is unique.[15]

The military community devolves from the military mission. Unlike the army before World War II, the new military is largely married with children.[16]

This is to ensure the presence and morale of the soldier, that is, an enhanced recruitment device. The military family community tends to take on many aspects of the military organization. There is usually a formal and / or informal hierarchical structure. Residential communities are represented, sometimes with an elected "mayor," to pursue their complaints or interests. Wives' clubs often organize around issues of interest to them and can be quite influential, obtaining day care services for children, for example.

The Combat Psychiatric Casualty

The combat psychiatric casualty is a soldier whose instincts of self-preservation (or fears of death and being maimed) have temporarily overcome his loyalties to his fellow soldiers and his military mission. At first blush, this conflict between the need to save his life and the need to save his place in his group would seem most unequal. The presence of poor group leadership, the presence of physiological impairment from fatigue, hunger, and thirst, and the presence of personal stress in the soldier (for example, from family concerns) are all known to swing the balance toward becoming a casualty. The forces that bind a soldier to his unit, however, are by no means insignificant. Crane[17] was aware of the sustaining power of unit cohesion:

> There was a consciousness always of the presence of his comrades about him. He felt the subtle battle brotherhood, more potent even than the cause for which they were fighting. It was a mysterious fraternity born of the smoke and danger of death.[17(p31)]

Marshall,[18] after observing the 1956 Arab-Israeli War, put it more bluntly:

> When fire sweeps the field, be it in Sinai, Pork Chop Hill or along the Normandy Coast, nothing keeps a man from running except a sense of honor, of bound obligation to people right around him, of showing fear in their sight which might eternally disgrace him.[18(p304)]

The soldier who has succumbed to the forces to depart the battle will begin to develop severe guilt feelings and loss of self-esteem for having abandoned his buddies. Psychiatric symptoms develop defensively to salvage self-esteem and to assuage guilt. They present an honorable method of escaping combat. Unless interrupted, they will consolidate and increase because at some level the soldier is all too aware of his defection from duty. The further the soldier is from return to his unit, the stronger the symptoms become as he must more strongly justify his defection.

The Civilian Psychiatric Casualty

Obviously, it will be rare that the civilian psychiatric casualty has been exposed to the kind of conflict experienced by a combat soldier. Examples of persons exposed to hazardous occupations do come to mind—police, firefighters, and pilots—but these do not involve legal or psychological stigmas as with soldiers if they quit their jobs.

The better analogy is the marriage partner, teacher, therapist (as in professional burnout syndrome), parent, supervisor, or other person who has responsibilities to a group or another person and who becomes demoralized in discharging those responsibilities. Many such persons will be given labels such as adjustment reaction or depression or anxiety neurosis depending on presenting symptoms and therapeutic school. The principles derived from combat psychiatry are less effective than medications for "organic" mental illnesses such as schizophrenia and biological depressions but are important in treating conditions emanating primarily from psychological antecedents, usually generated by crisis situations. These principles, however, can be usefully applied adjunctively, even in treating organic conditions, particularly in terms of social support.

The similarity between military and civilian psychiatric casualties lies in the acceptance of a medical label as the solution to one's problems of living and one's inability to cope with them. This is not limited to psychiatric patients; in fact, it may be more common in other conditions; low back syndrome, headaches, irritable bowel syndrome, and others come to mind as ailments prone to result from one's efforts to escape from the daily fray of work and family. Such physical conditions do not carry the psychiatric stigma, making them even more desirable as avenues of escape. As will become clear, such persons are not usually malingering or consciously ineffective. Rather, for them the short-term rewards of the invalid or medical label outweigh the long-term rewards of mastery of their life situations.

PRINCIPLES OF PSYCHIATRIC TREATMENT

The basic principles of forward treatment involve treating the combat psychiatric casualty in a safe place as close to the battle scene as possible; as soon as possible; with simple treatment such as rest, food, and, if available, a warm shower; and most important, with an explicit statement that he is not ill and is expected to return to work with his comrades. The fifth principle of centrality was found to be important in the Vietnam conflict.[2] By centrality is meant the provision of sending all out-of-combat zone evacuations through a central screening center so that skilled personnel can prevent inappropriate evacuations. These principles are tailored to optimizing the return to duty of psychiatric combat casualties.

DEVELOPMENT OF COMMUNITY PSYCHIATRIC SERVICES

The development of community psychiatric services grew from a confluence of approaches in civilian settings with periodic injections of military experience. The late 19th century psychoanalytic writings of Freud,[19,20] emphasizing infantile sexuality, aggression, and trauma, logically called for evaluation of early childhood experiences in the genesis of adult psychopathology. Freud's disaffected follower, Adler, rejected the emphasis on childhood sexuality and emphasized family interactions in personality development. In Vienna in 1919, Adler founded the first child guidance clinic.[21]

A Viennese school teacher, Aichorn, worked with delinquent children and established two reformatories, the first in 1918 and the second in 1920. Aware of his work, Anna Freud persuaded him to undergo psychoanalysis to assist his understanding of why his highly successful programs worked. After completing psychoanalysis, Aichorn published *Wayward Youth* in 1925 in Europe and in 1935 in the United States.[22] Basically, he described a therapeutic community led by a warm, loving, father figure with whom the adolescents could identify.[21] Residential treatment facilities such as Boy's Town and Boy's Ranch have incorporated this model of firm discipline combined with warm acceptance of youth in a setting maximizing individual responsibility and autonomy.[23]

In the United States, Meyer[24] was teaching a holistic approach to the psychiatric patient that he termed psychobiology. In 1902, Meyer married Mary Potter Brooks, who became highly interested in his work. In 1904, she began visiting the families of his patients to learn about their backgrounds, thus becoming the first American social worker.[21] Commenting on his wife's work, Meyer stated, "We thus obtained help in a broader social understanding of our problem and a reaching out to the sources of sickness, the family and the community."[24(p22)] In 1927, Meyer was elected president of the American Psychiatric Association, and during the first third of the 20th century, he was considered the dean of American psychiatrists. He taught that people fell ill because of faulty reaction patterns that could be treated by reeducation and social therapies.[21] His students were the chiefs of most of the important American psychiatric training programs and state hospitals from the 1920s to the 1940s.

In 1907, Meyer met Beers, a graduate of Yale University who had suffered several severe psychotic episodes and received treatment that could only be called atrocious although life-saving. Beers later described his experiences in *The Mind That Found Itself* (1908)[25] which was highly influential in stimulating reform of mental institutions. Beers established the National Committee for Mental Hygiene in Connecticut in 1908. Among the 12 founding members were Meyer and William James. In 1912, Salmon was appointed director. By 1919, the International Committee for Mental Hygiene had been formed.[21]

When World War I broke out in Europe, Salmon was commissioned to go to France and Britain to learn what they were doing to treat psychiatric casualties of combat. Salmon's report, which became the primer for American psychiatrists when the United States entered the war, was published by the National Committee for Mental Hygiene.[4] Salmon was appointed chief psychiatrist for the American Expeditionary Forces.[1] Psychiatrists returning from World War I brought with them an understanding of Salmon's principles for treatment of acute, stress-induced malfunction; however, the psychoanalytic approach involving lengthy analysis was gaining prominence, and these insights were lost.[26] As in psychoanalytic theory, Salmon conceived a combat stress casualty as suffering from a mental conflict between the instinct for self-preservation (Freud's id) and the demands of military conformity (Freud's superego); however, rather than

analysis of childhood antecedents, Salmon proposed simple, direct interventions.

In 1909, Healy was commissioned by a Chicago philanthropist, Dummer, to study the work on the causes and prevention of delinquency. Healy found only two clinics that were even giving children psychological testing, much less organized programs. Dummer then underwrote a research clinic, the Juvenile Psychopathic Institute, founded in 1909, under Healy's direction. After a 6-year study, in 1915, Healy[27] published *The Individual Delinquent: A Textbook of Diagnosis and Prognosis*, an exposé of the social and economic roots of delinquency that discounted the prevalent theories of defective mentality or genes, that is, degeneracy.

In 1912, the Boston Psychopathic Hospital was organized under Southard, who with Janett, introduced the psychiatric social worker into the child guidance team. In 1922, the National Committee for Mental Hygiene inaugurated a 5–year program for fellowships at child guidance centers, and in 1924, the American Orthopsychiatric Association was established to bring together disciplines in child guidance programs.[21] Child guidance centers were the forerunners of community mental health centers. By 1946, there were 285 psychiatric clinics exclusively for children in the United States, and another 350 served children and adults.[28]

While progress was being made in establishing child guidance clinics in the community, military psychiatry after World War I languished with minimal resources and no organized community programs. After World War II broke out in Europe and as the possibility of U.S. involvement increased, psychiatrists were recruited to screen out soldiers who might break down in combat, a program that was a dismal failure.[29] The community mental health approach in the military did not begin until the United States became involved in the war.

Community Mental Health in the U.S. Army

Halloran and Farrell[30] and Cohen[31] established mental hygiene consultation programs at replacement and training centers within the first years of U.S. entry into World War II. Initially, these programs furnished a kind of orientation and "pep talk" for soldiers being sent overseas. Later as the success in decreasing psychiatric casualties through such strengthening of morale became recognized, they spread to other settings and, by the end of the war, were an integral part of the mental health program of the U.S. Army. During the war, 35 mental hygiene consultation services (MHCSs) were established and, by the end of the war, many were practicing preventive psychiatry based on military experiences.[32]

With the end of World War II, the pioneer MHCS efforts were rapidly reduced, and by 1949, there were only two MHCS units left on army posts. After the outbreak of the Korean conflict in 1950, the MHCS concept was rapidly revived and implemented, with these services being established at all major posts.[33] The MHCS was described in Army Regulation 40–216, *Neuropsychiatry and Mental Health*, in 1958. By the mid-1960s, the army had 40 MHCS units.[34] Today, these facilities are called community mental health services (CMHS) or activities (CMHA), and almost every significant army post has one.

Bushard[15] chronicled the empirical development of army community psychiatric services during the decade following the Korean conflict. Cold War tensions had resulted in the continued need for drafted soldiers, many of whom preferred to be civilians. The early psychiatric services were little other than struggling outpatient clinics that were totally overwhelmed by the problems presented to them of large numbers of disaffected troops. Applying the usual psychiatric treatment techniques growing out of psychoanalytic theory in this situation produced results that were frequently discouraging. The usual conclusion was that in view of the disparity between large referral load and limited psychotherapeutic talent available, little could be offered. Considering the large caseload and the brief period of the patient's stay on post, traditional psychotherapy was not feasible. Dire predictions about the future of individuals examined were frequently offered.

After several years, a review of the situation by Bushard[15] led to several consistent observations:

- Extensive and intensive work-ups did not really contribute a great deal of helpful information. As far as the therapeutic result was concerned, frequently, a brief interview would have been as valuable as the thorough study conducted.
- Psychiatric and psychological data did not reliably predict future performance. Although indepth examinations frequently revealed highly disturbed and distressed individuals, prognostications based on these findings were not a reliable basis for predicting either actual job performance or

the future of the symptomatology. Information derived from actual observation of the patient at work and study of the actual nature of, rather than his verbalizations about, his relations with others were a far more valid basis for predicting the outcome of his problem. Army mental health professionals tended to over emphasize pathology and over predict failure.[35] It was observed that persons with more serious psychiatric disease, such as schizophrenia, frequently continued to function in the field without coming to psychiatric attention.

- The immediate determinants of the psychological reaction were usually clearly evident. For example, a soldier got a "Dear John" letter from his girlfriend and cut his wrist.
- The disability would be described by the soldier as of a more global nature than one ordinarily encounters. The number of things the patient "could not do" seemed to pervade a wider segment of his function than one was accustomed to find in other practice. Anxiety, anger, and other affective responses appeared to be related more clearly to the problems involved in mastery of the immediate situation than to infantile and oedipal experiences. There was an almost universal and nearly magical conviction that escape from the reality of the situation was the answer. Rarely did one encounter the attitude that success or mastery was the desired endpoint, as it might be, for example, in marriage, career, and parenthood. It was not seen as an important aspect of growing up.
- There was a predominant use of the mechanism of rationalization. A patient might explain his discomfort on the basis of intolerance of military profanity, on rejection of the use of force in human relations, or on the basis of concern for sick parents. These were usually recognized as transparent devices. In the absence of such rationalization, there was frequently a willingness to admit to weakness and unpatriotism and being simply no good as an explanation for giving up. Such persons were influenced very little by competitiveness and group spirit.
- Even when it was available, traditional psychotherapy had little impact. The psychotherapeutic interpretation, however clever, was lost; the urge of the patient toward health, if that involved staying in the military, was minimal. To address one's efforts to the classical psychiatric syndromes was simply not feasible and had little value. If this were done, the mass of the referral load went untreated and the patient would often be abandoned either to punitive measures or, conversely, to environmental manipulation that would tend to produce continuation of the symptom.

Concurrence and Commitment

Eventually a view of the soldier emerged in which he is seen as part of an interactional set with his environment. The dynamics involved relate not so much to oedipal traumas and disturbed biochemistry as to disturbed homeostasis in the soldier's social ecology. Figure 13–1 shows the stresses that tend to precipitate psychiatric casualties and the supports that tend to prevent or terminate illness. Depending on the balance achieved, one may see increased or decreased rates of ineffectiveness as measured by absent without leave, venereal disease, sick call, and disciplinary action rates.

Bushard used the concepts of concurrence and commitment to explain both the soldier's problems in adapting and their solution:

> By concurrence we mean that aspect of internal psychological operations which looks to the incoming sense data for evidence that one's behavioral negotiations with the environment are leading to goal achievement, instinctual gratification and successful social interaction.[15(p436)]

It is easy to translate this concept into behavioral terms involving positive social reinforcement; in fact, research projects for treating delinquent soldiers used such translation.[35–37]

The soldier would seek concurrence as he looked for the support of his chaplain, his inspector general, his family, his legislators, or anyone else who might agree that the proper solution of his discomfort was a specific change such as return to his home. Seeking support from more official sources, he had usually either abandoned his immediate colleagues or failed to obtain a comfort-giving concurrence from them.

If the soldier did allow himself to see his sameness with those about him as opposed to his difference, he would begin to sense a diminution in anxiety

level, an increased capacity to function, and a waning of his conception that he could not succeed and that escape was essential. He might continue to have his problems, but functionally, he was approaching a level of mastery.

In the concept of commitment, Bushard attempted to describe

> that emotional and behavioral set by which the individual addresses himself to the mastery of the problem at hand. It involves his maintaining his attention to it at an intensity that results in the mobilization of his physical and psychological resources in the direction of achieving this goal as opposed to or differentiated from others.[15(p437)]

The inductee who had failed to make provision for the needs of his dependents and who did not find some source of pleasure and relaxation within the military had little likelihood to succeed. Failing to commit himself through a realistic appraisal of the situation, he became distracted, worried, and preoccupied or found life so dull that in no way could he conceive of success in any undertaking.

Life is full of examples of lack of commitment. It is absent in the student who watches television rather than doing homework, in the worker who does not get enough sleep, and in the adolescent who quits school altogether. Failure of commitment in other situations such as work, schools, and family responsibilities is a frequent finding in people who fail to commit themselves to military service as an accepted responsibility.

Commitment and Concurrence Example: Burnout Syndrome

Psychological burnout syndrome frequently afflicts persons who are exposed to repeated or continuous psychological stress. This includes occupations such as teachers, police, fire fighters, air traffic controllers, nurses, and mental health workers among others.[38–42] While time away from the job (reminiscent of the rest from combat utilized in the Vietnam conflict)[2] may be helpful, real prevention requires intervention at the small group level. The potentially afflicted person must feel the concur-

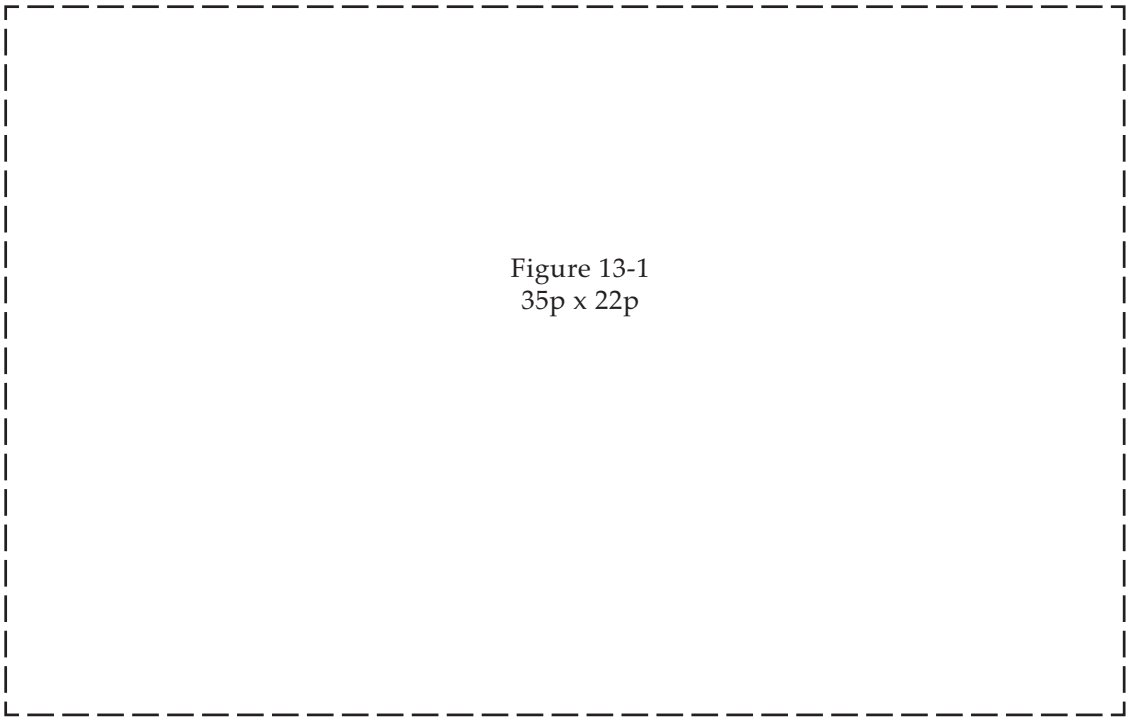

Fig. 13–1. Factors in mental disorders in the military. This figure demonstrates the stresses that tend to precipitate psychiatric casualties in the military and the supports that tend to prevent or terminate illness. Depending on the balance achieved, one may see increased or decreased rates of ineffectiveness as measured by absent without leave (AWOL), venereal disease, sick call, and disciplinary action rates.

rence of his support group. This social reinforcement toward mastery of efforts will then strengthen his commitment to the job and create further social reinforcement. When effective, this interaction should increase productivity and group morale. Group discussions and exercise, recreation, and eating meals together can be effective tools in producing a sense of group belonging and cohesion.

The Japanese management system employing group decisions even involving the lowest manual worker has elements of concurrence and commitment. It is, thus, not surprising that psychological burnout, even among those engaged in repetitive, boring tasks, is relatively rare.[43–45]

Applicability of Principles to Noncombat Settings

The practice of military psychiatry in combat and garrison settings can be shown to have a number of similarities, particularly when one is handling acute adjustment disorders. These practices can be seen to include various elements of the centrality, proximity and immediacy, simplicity, and expectancy elements of treating combat psychiatric casualties. These elements will be discussed separately.

Centrality

Centrality is an important aspect not only of battlefield psychiatry but also of preventive psychiatry. In the combat setting, it refers to having a casualty evaluated before departure from the combat zone, but in a noncombat setting, it is better seen as an aspect of what Glass[46] has referred to as related echelon psychiatry. Related echelon psychiatry is traced back to Salmon's[4] provision of a first echelon division psychiatrist supported by a second echelon small (150 bed) neurological hospital and third echelon special base hospital. The comparability with a community mental health center and the hospital to which it refers patients should be obvious. The two must closely coordinate their efforts to ensure that the patient is not lost to follow-up care. A further refinement increasingly found in mental health settings is the provision of partial hospitalization or interposition of an echelon between outpatient and inpatient status.

Proximity and Immediacy

In initially treating the disaffected soldier, it is as important to know what his unit is, who is his commander, and how long he has been in the service as to know who he is, where he came from, and what his specific symptoms are. This kind of information can only be obtained by an intense familiarity with the supported community. Hospitalization is avoided if at all possible, and attempts are made to prevent the patient from being taken for any significant period from actual, if impaired, participation in his work. He is seen immediately on the day of referral; delay tends to consolidate the problem. Physical separation of the patient from the scene of his difficulties will cause him to indulge in the hope of not having to return, which usually increases his symptom in a manner making return to work less possible with the increasing distance in time or space between him and his group (loss of immediacy and proximity).

Simplicity

This crisis-generated patient seldom requires more than simple supportive psychotherapy. This psychotherapy usually involves some degree of catharsis and a great deal of clarification. Other significant members may be brought in for consultation if they are supervisors or for additional support if they are peers or relatives.

Expectancy

These maneuvers alone will begin to create the expectancy that the patient will continue performing; however, other procedures will enhance this expectancy. The soldier is kept in uniform, a part of his healthy identity. Interviewing is restricted to the situation. Lengthy inquiries into childhood vicissitudes moves the emphasis from the present that can be overcome or influenced, to the distant past that cannot. Most efforts are directed at keeping the patient in the fray where his own innate adaptive talent may come to his aid. This talent is indicated more nonverbally by returning him rapidly to work than in any verbal manner. Psychiatric labels are avoided if possible. If a diagnosis must be made, it is kept bland (adjustment disorder, for example) to keep the patient from being treated as, and learning to respond as, a patient rather than a person. Follow-up is of extreme importance and should be at the working level rather than at the clinic. Here it is possible to assess the manner of the patient's effort, the degree of his success, and the limitations that are insuperable. By one's working with the supervisor, work restrictions or other

changes may be recommended and job limitations implemented. Medication is usually not indicated and gives the wrong message if given electively.

When adaptation to the work or social unit is impossible, the therapist may recommend changes. This recommendation is seen as a therapeutic environmental manipulation and should be under circumstances and by means that encourage the least possible persistence of chronic symptomatology, yet does not encourage others to follow suit. All of this approach is directed at resolving anxiety through implementing the patient's use of his own skills, the treating of anxiety as a normal phenomenon rather than as a pathological one, and the dealing with it in such a way as to imply that success is possible.

This approach appears to meet Caplan and Caplan's definition of community psychiatry:

> Community psychiatry denotes the body of knowledge, theories, methods, and skills in research and service required by psychiatrists who participate in organized community programs for the promotion of mental health and the prevention, treatment and rehabilitation of the mental disorders in a population. It *supplements* the clinical knowledge and skills which equip the psychiatrist to diagnose and treat his individual patients.[47(p1499)]

Current Situation

The military currently has a CMHS at most significant military posts and division psychiatrists assigned to almost all combat-ready divisions. A regimental system assigns physicians, including psychiatrists, to specific field units in the event of deployment. Unfortunately, there may be little contact with the field unit until deployment.[48,49]

The mental hygiene consultation model has proved quite successful. In 1951, just before the wide-scale use of these methods, the rate of admissions for all psychiatric disease was 24 per 1,000 troops per year. By 1965 and roughly since, the rate dropped to 5 per 1,000 troops per year. The number of outpatient visits in 1951 was 107 per 1,000 per year and, in 1965, 305 per 1,000 per year.[33,50]

In civilian settings, crisis intervention walk-in centers are prevalent in decentralized, community settings (immediacy and proximity). There is an emphasis on current environmental factors to assist the patient in coping with work and home (expectancy), and remote childhood dynamics are usually deemphasized (simplicity).[47] Many state hospital programs require entrance via community mental health clinics and maintain close liaison with them (centrality).[34] Many businesses have employee assistance programs. The Department of Veterans Affairs eventually established store-front Vietnam Vet Centers to provide a community-based, nonhospital setting for helping veterans with posttraumatic stress disorders and other problems of adjustment. Recently, "Vietnam" was removed from the title because the centers were authorized to assist veterans of Operations Urgent Fury (Grenada), Just Cause (Panama), and Desert Storm (Persian Gulf).

SUMMARY AND CONCLUSION

The concept of community psychiatry has undergone a slow evolution during the past 100 years. Major contributions to the movement came from the child guidance programs and psychiatric experiences in the two world wars. The major drawback to this approach has been the failure to allocate adequate financial resources despite the general recognition that keeping the individual as a productive community member is far less expensive than maintaining him in a state hospital. The military has continued to exert leadership in this area, probably because the soldier is guaranteed free access to medical care. Even in the military, however, the community mental health team has been somewhat fragmented by professional jurisdictional issues (independent social work, psychology, and psychiatry services), resulting in duplication of services and failures to refer appropriately. This issue is awaiting the efforts of an enlightened command to reinstate the integrated community mental hygiene services of the decades after World War II.

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