

MENTAL HOSPITALS JOIN THE COMMUNITY

PROCEEDINGS OF A ROUND TABLE
AND OF A WORKSHOP
AT THE
THIRTY-NINTH ANNUAL CONFERENCE
OF THE MILBANK MEMORIAL FUND

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FOREWORD

The comprehensive continuous mental health program being developed in relationship to the Dutchess County Unit of the Hudson River State Hospital, which is reported in Part I of this publication, is but one example of a more general movement within the state hospitals of the United States and on the part of local mental services to unite their work in such a way as to provide continuous comprehensive psychiatric care for people with mental disorders which at times can be benefited from periods of hospital care. Some of these developments in the mental hospitals were reviewed at the Thirty-Eighth Annual Conference of the Milbank Memorial Fund, 1961, which was published as "Decentralization of Psychiatric Services and Continuity of Care."

The Milbank Memorial Fund recognized that several hospitals elsewhere in the country were moving along a similar path, and encountering similar challenges to their imagination and ingenuity in undoing the practices of many decades and in finding paths to a more flexible use of their resources, both physical and human. The Fund, therefore, decided that it would serve a useful purpose to bring together a small group of those who had initiated such transformations. A small informal working party was accordingly arranged to provide an opportunity to explore in some detail the way in which these people saw their present work, and the way in which they were identifying and meeting stumbling blocks to progress along the path toward more comprehensive and more continuous psychiatric services.

Dr. Max Pepper of the Department of Psychiatry, Yale University School of Medicine, visited many such locations in the summer of 1962 and acted as the co-ordinator of this small meeting. At the end of the meeting the opinion was expressed unanimously that it had been useful to the participants and that bringing together the accumulated experience of people working toward common objectives had helped each of them. It was suggested that it would help others if the new perspectives that they had gained through this process of interchange were communicated to a broader audience. Dr. Pepper has, therefore, prepared a report of the meeting, which is contained in Part II of this publication.

These reports should be of interest to those who want to understand some of the newer developments in the organization of comprehensive, continuous services, and may be of considerable interest to those concerned with the organization of public and community services. As an example of developments in the field of medical care, the changes reported in this publication may be regarded as an interesting counterpoint in the field of psychiatry to the trend toward "progressive patient care" occurring in the general hospital.

The ongoing pilot plant's comprehensive psychiatric unit for Dutchess County at Hudson River State Hospital, started in 1960, together with the development of evaluation techniques there, fuses the Fund's long-standing interest in the development of local health services and objective techniques for making quantitative appraisal of the effectiveness of health services, and its interest in recent years in the field of mental health.

The current progress report indicates a rapid burgeoning of the rate at which this hospital is being used by the people of Dutchess County, reflected in very high and rapidly rising admission rates, not associated with any increase in the rate of long-term hospitalization for the residents of the area—in fact, it may even be associated with a declining frequency of long-term hospitalization.

The Dutchess County Unit has also successfully participated in the creation of the first general hospital psychiatric service in its region, and is developing ever-closer working relations with it and other psychiatric, public health, medical, and welfare resources. While there is no need to question whether its popularity is deserved,

popularity alone is an inadequate measure of the extent to which this kind of service can make a significant contribution to the limitation and decrease in the amount of human suffering and disability associated with mental disorders. Indices by which this effect can be appraised have not existed in the mental health field. The progress report of the evaluation studies indicates that these indices are feasible and the first findings are reported here.

These findings cannot at this time provide a definitive estimate of the effectiveness of the Dutchess County Unit and program, but they do provide substantial evidence that the program has been instituted without harm. They also indicate the type of information which should make it possible in the future to make the kinds of estimates which planners need in order to know whether their new services are making the kind of difference to the people's health which every health agency seeks.

Part II of this publication, reporting the combined wisdom of the participants in the two-day Workshop, conveys some of the enthusiasm felt by those who are coming closer to comprehensive, continuous local services in their hospitals. In addition it presents, in a general way, their specific ideas regarding the reasons for moving in the directions they have taken and the ways in which they think constructive solutions are to be found to the multiple small difficulties experienced.

The Milbank Memorial Fund is grateful to all the participants at the Round Table for their vigorous and thoughtful contributions. The Fund would also like to thank those who shared their wisdom and experience so freely at the Workshop, which was ably chaired by Dr. Francis J. O'Neill.

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I. PROGRESS REPORT OF THE DUTCHESS COUNTY UNIT

SEPTEMBER 18, 1962

DEVELOPING SERVICES IN THE DUTCHESS COUNTY
UNIT AT HUDSON RIVER STATE HOSPITAL
AND THEIR EXTENSION INTO THE COMMUNITY

Tuesday Morning Session

Chairman: ALEXANDER ROBERTSON, M.D.

DR. ROBERTSON: Ladies and gentlemen, it is a very great pleasure to welcome you to the Thirty-ninth Annual Conference of the Milbank Memorial Fund. I am in the rather curious position of having to introduce you to each other during the day when most of you know each other, and I am afraid I still have the pleasure of knowing only about half of you.

One of the joys of coming to work for the Milbank Fund during the last three months, as I remarked upstairs to our colleagues in the demographic part of the conference, is the atmosphere in which the friends of the Fund gather once a year to discuss problems of common scientific interest. I have been the beneficiary of this atmosphere. I sincerely hope that none of the involved, highly technical matters which will be presented to us by our speakers will make us any less friendly later today than we have been in the early morning.

As you all are aware, many of you for much longer than I, one of the traditional ways in which the Milbank Fund has endeavored to fulfill the conditions of its charter has been to create a demonstration or a pilot project in one particular problem in public health, and

to apply to that a very substantial part of the resources of the Fund, along with the skills of a very substantial number of the leaders in the field to which that problem is related.

Today we shall hear about one such project which has been a major interest of the Fund in recent years. Most of you are sufficiently familiar with the Dutchess County Project at Hudson River State Hospital, and in a moment we shall have an opportunity to have our minds refreshed as to what it is about.

This morning the objective of Dr. Hunt and Dr. Bennett will be to describe the project to you and subsequently to give you an opportunity for questions and discussion about the nature of the project.

In the afternoon, Dr. Gruenberg, Mr. Kasius, and Dr. Sohler will describe to us the method of evaluation and some of the results so far obtained in evaluating the success of their project.

I do not think it my duty to keep you any longer from the purposes of the day, and I have much pleasure in asking Dr. Robert Hunt, Director of the Hudson River State Hospital, to speak to us. Before I do so, I would like to say how very much the Milbank Memorial Fund has valued its association with Dr. Hunt, who has often guided it, I think it is fair to say, and who certainly has enabled us to do things which we have wanted to do. His forthcoming departure from the service of the New York State Department of Mental Hygiene is something that we at the Milbank Fund will be very sorry to see. It is a joy to have him here today just as he comes to the end of his tenure at Hudson River. Dr. Hunt.

DR. ROBERT C. HUNT: Three years ago we reported our plans to create the Dutchess County Unit,¹ and last year² we gave a narrative and impressionistic account of our early experiences in operation. Today we propose to give a progress report, one which is still far from being conclusive but which will be more detailed and critical than anything which has gone before.

To recapitulate, late in 1959 we organized within the Hudson River State Hospital a virtually complete and autonomous sub-hospital specifically for Dutchess County. This was aimed at serving as a base from which a comprehensive and integrated treatment service would be provided for a defined population, under a research

design to evaluate results and in a setting which provides geographical and functional closeness to the population served.

The services provided directly by the Unit include pre-care consultation, day-care treatment, inpatient treatment and rehabilitation, and after-care. Other types of services are provided by referral to an outpatient clinic in the community and to other health and welfare agencies as indicated.

The Unit is housed in two small buildings with a total bed capacity of about 500. Late in 1959 most of the long-stay patients from Dutchess County were transferred into these buildings. In January 1960, the reception function for the county was added by moving in the recently admitted patients being housed in the reception service, the medical staff, the stenographers, the files, and so on, that went with them. Since that time, new admissions from the county have come directly to the Unit.

Professional staff is allocated to the Unit in accordance with the standard New York State staffing pattern.

A grant from the Milbank Memorial Fund made it possible to add some professional staff needed because of the addition of pre-care, a function not normally provided for in state hospital organization.

It was expected that this pattern of organization would provide better services to the mentally ill in a number of ways. In the first place, it was expected that intensive treatment of new patients might be more effective through the ability of the small unit to provide continuity and flexibility which are almost impossible in the traditionally organized large state hospital. It is possible, and it frequently does happen, that a given patient is worked with before admission, during hospitalization, and in after-care by the same physician and the same social worker.

Also, the ease of communication within the Unit makes possible both flexible and immediate decision-making, and release-planning is not hampered by cumbersome machinery.

It was also expected that with the Unit's smallness and closeness to the community, it would be possible to make more fruitful use of other community agencies than is usually the case.

One of the central hypotheses was that out of all this would be

produced a reduction in the number of new admissions who later become chronic patients.

Secondly, it was hoped that the pre-existing group of chronic patients would show improvement through being in a small mixed unit with no back wards, with all patients in an active treatment atmosphere.

There was also confident expectation that pre-care consultations would make a measurable difference in hospital population by diverting significant numbers of patients into more appropriate channels.

In the backs of our minds there was also a dream that somehow the local community would be infected by our enthusiasm and would more or less spontaneously develop a number of additional services for the mentally ill. If there is any one philosophy, any one point of view, which underlies the whole scheme, it is that the mentally ill belong in their own community, that psychosis as such is no reason for hospitalization, that treatment should be provided in the community, with the hospital just one of the resources to be used under certain circumstances.

How have things gone? Most of our clinical experiences and research data will be reported by other speakers, and I shall just touch on some of the more negative aspects, some of the problems as seen by an administrator functioning at some distance from the clinical operation.

I believe that all of us involved in this operation have developed a greater respect than we had previously for the importance of the administrative function. In this Unit we quite deliberately broke away from traditional patterns of administration, placing the emphasis on flexible, individual attention, so that meeting the needs of the individual would not be hampered by the dead hand of habitual procedures and traditional machinery.

Nobody in the Unit is assigned exclusively to administrative functions. The top-ranking psychiatrists, nurses, and social workers are all actively engaged in clinical processes, and enjoy the utmost ease of face-to-face communication with each other and with their subordinates.

This has, on the whole, worked out well and in accordance with

our expectations. It has worked out that way, but we have paid a price for it, also. There have been a number of administrative slip-ups, none of them too serious but all of them rather annoying to a tidy administrator.

It has seemed to us that some of these problems have arisen because of the very nature of the structure we created, with everyone so busy in clinical processes and with face-to-face communication, so busy with individual trees that no one has time to pay attention to the forest. The very ease of communication interferes with over-all administration. Dr. Bennett, who is in charge of this operation, is very good at visualizing problems of the forest, but he often has difficulty finding time for the forest because his staff—aware of his equally great skill with individual trees—swamps him with individual daily problems.

In all probability it is a healthy thing to have a little more chaos than we are used to in our tightly run state hospital organization; but it is being borne in on us that administration and over-all planning are important, and that these functions do not take care of themselves just because you have a lot of clinical zeal and easy communication.

Another problem, again minor but again often annoying, derives from the Unit's being part of a larger organization which in many ways functions quite differently. Some unit functions have to be carried out through channels of the parent hospital, and at times Dr. Bennett's staff runs head-on into rigid routines of the parent hospital. These routines are not necessarily stupid or useless. Probably most of them are necessary and desirable and the most efficient way of keeping things running in the huge parent plant; but they are not necessary or desirable in the Dutchess County Unit, and this sometimes makes a conflict.

I believe Dr. Bennett will agree there has been nothing malicious back of these conflicts. Naturally, there is some jealousy among the staff about the prestige of this special Unit, but the staff of other units have always been most co-operative in coping with mutual problems. It is simply that incompatible systems bump into each other.

One of our disappointments has been the difficulty in recruiting

psychiatrists. This is, of course, a nation-wide problem which is particularly acute in state hospitals. We had hoped, however, that when this program became widely known, as it has, it would be exciting enough to attract some good professionals. We did eventually have the tremendous good fortune of having Dr. Bennett drop in out of the blue but, aside from this, recruitment has been most disappointing. There are constant streams of eminent visitors coming to see the Unit, but no flow whatever of people interested in working in it.

We had originally set up a budget for the grant moneys on the assumption that we would need about four competent, mature psychiatrists to add to our existing state staff. In practice, we have never had more than one person meeting this specification, and that is Dr. Bennett. The additional one or two that we have had from time to time have mostly been young residents in training.

A recent experience with one really good man who was seriously considering working with us led us to suspect that our principal barrier to such recruitment is the dirty word, or stereotype, "state hospital." Even those who know our program quite well, and know that it does not conform to the stereotype, still do not want their names sullied by association with a state hospital.

If I sound bitter about this, it is because I am.

There has also been some disappointment on my part that so little has happened in the community, probably because my expectations were entirely unrealistic. I had allowed myself to dream that something important might be done to provide better services for the elderly psychotic, including geriatric day care, homemaker services, better use of general hospital and nursing home beds. There were dreams that practicing physicians would become much more interested in and skillful at caring for psychiatric patients on an ambulatory basis; that the general hospitals would be stimulated to move more rapidly toward the establishment of psychiatric units for short-term care.

Some changes have taken place in the community. The mental hygiene clinic has shown some shift in emphasis, with more interest in major mental illness, and it has worked quite smoothly in co-operation with our unit. The public health nurses of the County

Health Department have also become interested and are doing much more work than they did before with the mentally ill. There are probably also some rather intangible changes in the practice of an occasional physician here and there. However, the development of major new services simply has not happened, and probably will not happen without more aggressive leadership and hard work than we have been able to provide.

Perhaps our major disappointment stems from the failure of the project thus far to show any spectacular results statistically. Once again, our unrealistic expectations probably led us astray. After the first few months of operation it seemed quite clear to us, in an impressionistic way, that there had been sharp improvement in our clinical results with new patients and in the level of functioning of long-term patients. We confidently awaited verification of this from the research staff. Now that the early research results are beginning to come in, we all feel rather let down. As you will hear this afternoon, there are some indications that improvement has taken place as expected in some directions; but these gains are small, spotty, inconsistent, and certainly not of the magnitude that we allowed ourselves to dream of.

Last night Dr. Gruenberg admonished us that we were taking his research results much too seriously, that the project has had some very obvious success, though most of this success happens not to have been quantified. Nonetheless, it has been rather disappointing, but it may turn out to be a healthy thing. If we are forced to take a hard look at the inadequacy of our present tools, both our clinical tools and our research tools—because one of our great unsolved problems in this business is how do you measure—then we are forced to realize that we must go back to the drawing board and back to the laboratory; that there are no easy, magic formulas for emptying the state hospitals. If nothing else comes out of the entire project, it will still have been worth while if it demonstrates that the millennium has not yet been reached, and that plausible panaceas need hard-headed testing before they can be accepted as solutions to all our problems.

DR. ROBERTSON: Dr. Hunt and Dr. Bennett have suggested that

there be no discussion until after the second paper has been given.

Dr. Bennett, if you do not already know it, is the Director of the Dutchess County Unit, and thereby I suppose both one of the reasons for the success that it has had and also one of these intangibles which makes measurements so difficult, as Dr. Hunt pointed out, because the Bennett factor is one of the things I understand neither Dr. Gruenberg nor Dr. Sohler has been able to identify as a research measurement tool. Dr. Bennett.

DR. C. L. BENNETT: I had prepared a rather formal paper for this meeting. I have had to do some surgery on the paper, largely as a result of yesterday's Workshop. Many things came up in the Workshop that caused us to delete some things from the paper and to add other things. If I seem to be at a loss for words occasionally, and to be groping for ideas, it is, as Dr. Hunt said a few minutes ago, because I am.

How do we know the patients benefit from a decentralized unit? That is a perfectly logical question. It will probably be difficult to organize a statistical answer to that question, but if you work in a small unit every day for a period of two years, you have constant evidence that the relative compactness, the flexibility, and the ease of communication all work very much to the benefit of any patient who is admitted to that installation.

You can move a great deal more rapidly in determining underlying pathology. You can move more rapidly in determining treatment. Of course, you can get that patient out of the hospital sooner than would be possible in a very large and, therefore, necessarily rather slow-moving installation of 5,000 or 10,000 beds.

The other factor that goes along with decentralization is that it enables the staff to have much closer co-ordination with the community than it would otherwise have, and to know what the patient who is discharged or on convalescent care is going back to when he leaves the hospital. I think it is only in such a decentralized unit that it is possible simply to pick up the telephone at the end of an interview, talk to the physician—whom you probably know—to whom the patient is returning, and make recommendations as to continuation of treatment; or to call the welfare department, or the depart-

ment of public health, or any of the organizations which are to be involved in the future of that patient.

Another factor concerns the decentralization of a very large, 10,000-bed hospital. If it is planned to break such an installation into 500-bed units, this means, of course, that you must have, first, 20 clinical directors. Every one of these units, if they are really decentralized, really autonomous, and if they are to have any connection with the community which sends patients to that unit, will have to have a clinical director. There should also be a good supervising psychiatrist to replace the clinical director in times of illness or vacation or any of the things that constantly call him away from his daily work.

So we arrive at an estimate that must number the medical staff at at least 40. For a 500-bed unit you must have at least five physicians on a 1 : 100 basis to keep such units running as they should run.

We finish this way with a staff of 140. I do not know what Dr. O'Neill's actual staff is at Central Islip State Hospital, but I do not think it is 140 right now. This calculation does not take into consideration the various other requirements of the hospital: special projects on geriatric care, special projects on alcoholism, and the enormous administrative load at the top which requires an administrative staff in addition to the clinical staff. I would guess that to properly staff a 10,000-bed hospital divided into 20 units would take at least 160 physicians.

One other matter, to which Dr. Hunt has already referred: that only a little improvement is visible among the chronic, long-stay patients. I am afraid if I had to depend on statistical evidence of improvement in our chronic population, I would not have taken this assignment in the first place, and I would not have any motive to remain in it for the planned five-year period. The professional satisfactions inherent in this work are felt several times a week and are reinforced by the frequent remarks of patients, relatives, and referring physicians. I have no idea whether the approach we are using at the Dutchess County Unit will be economically feasible or whether, from the staffing standpoint, it will turn out to be prohibitively expensive for application elsewhere. But I do know that, in spite of

the headaches involved, in spite of the sometimes frenetic day-and-night activities and the constant pressure of the telephone, the job is more interesting and more deeply satisfying than any of the years that I have spent thus far in military, private, and state hospital work, or in private consultation work. I know of no other position in psychiatry where one can have a close clinical relationship with an individual patient, can establish diagnosis and treatment for that patient, and still have some voice in influencing the legal, social, and medical agencies within the community to which that patient will return.

The last of the items I would like to discuss is the matter of pre-care. Since pre-care seems to mean all things to all people, depending on the state or province or county in which the term is being used, I would like to say just a few things about it.

First of all, it is not a device to keep the patient out of the hospital. It is a device to determine ahead of time whether the patient will be best served by in-hospital treatment, day-care center, community clinic, or return to private care by his own general practitioner or private psychiatrist.

The pre-care cases we have seen have been referred to us from every conceivable source, including welfare, police, courts, neighbors, families of the patients, physicians of the patients, and the patients themselves.

A pre-care consultation means that that patient is seen for a period of time, usually at least 40 minutes, by one of the Unit's psychiatrists. It is not a matter of turning the patient over to social service, although we like to bring social service into the pre-care consultation. If it is determined that the patient will be referred to the clinic or to another agency in the community, then social service is very helpful in following up the patient and determining what happens.

A total of 450 residents of the county were referred to us for consultation and disposition during the first two years. Owing to Dr. Hunt's early insistence and our own sustained reminders to the referring physicians and agencies that referrals be limited to those seriously ill, the overwhelming majority of this group represents persons for whom hospitalization, either full-time or day care, was

seriously considered. Because of repeated consultations on some of these patients, the total number of interviews has been 565.

In addition to these 450 pre-care cases, 508 patients presented themselves for voluntary admission to the hospital and were admitted to the Unit directly. While they also required psychiatric evaluation and decision as to disposition, just as our separately listed pre-care patients did, we felt that, since such self-referrals for voluntary hospitalization had been an increasingly frequent phenomenon at Hudson River State Hospital prior to the creation of the Dutchess County Unit, such patients do not reflect the results of pre-care activity.

Thus in this two-year period, 450 people were referred to us for pre-care and an additional 508 patients presented themselves for voluntary admission and were admitted following examination.

There were 60 other self-referred patients who were turned back to the community with recommendations to seek help through private practice, community clinics, Alcoholics Anonymous, or the welfare department. Perhaps this group of 60 could be considered a variety of pre-care because in the years prior to the opening of the Dutchess County Unit patients rejected for full hospitalization and referred to other facilities were few. Nearly everyone who appeared at the hospital prior to the Dutchess County Unit's inception was automatically taken in. It was felt that that was the safe thing to do.

The pre-care figure of 450 restricted to cases referred to the Unit for examination thus represents less than half of the cases actually examined prior to hospital care. The number is unfortunately also subject to human error, in that the seven physicians who have been irregularly involved over a two-year period have not always made out the data cards promptly, leaving an undetermined number of pre-care cases unreported.

Effective follow-up of every pre-care patient presents a virtually insurmountable problem in the way of man-hours for our scant personnel. It is no problem to determine the percentages admitted to our own hospital and to the day-care center. Similarly, there is little difficulty in determining whether patients referred to the community clinic actually show up there, because we have weekly telephone cross-checking of admissions between these three installations—the

Dutchess County Unit, the day-care center, and the community clinic. Patients referred directly to the small number of private psychiatric hospitals within a 50-mile radius are also easily followed because we ask for and receive progress reports on these patients. But when it comes to those referred back to the private psychiatrist or to the general practitioner, we have no dependable follow-up.

The 450 prospective patients were examined at their homes, at county and city infirmaries, in general hospitals, jails, hotels, or, in some cases, in private cars outside the Unit (when the patient got as far as the hospital but wouldn't get out of the car), and in the offices of the Unit itself. Only 70 of these 450 pre-care patients were directly admitted to the inpatient service. The remaining 380 were initially referred as follows: to the day-care center, 187; to the community clinic, only 26 (we were amazed when we went over the cards and found this number so small); returned to private care with appropriate recommendations, 76; presenting minor problems not requiring any definite disposition beyond the therapeutic discussion we had with them, 91.

It should be pointed out that this was not necessarily the permanent disposition of these patients. There is considerable shuffling between inpatient service, day-care center, and community clinic, depending on clinical progress or lack of it after appropriate observation, which determines the patient's ultimate location. During the six or eight weeks following the pre-care consultation, some patients initially referred elsewhere become admissions to the Unit. So, instead of 185 actually getting their treatment in the day-care center, it is more nearly 160; and the group of 70 who were originally admitted to the hospital is usually increased to almost 100 at the end of six or eight weeks. This is the result of partial failure in the day-care center; partial failure on the part of the physicians to whom the patient is referred back in the community; or simply the course of the illness itself which is not always easy to predict.

One of the most professionally satisfying aspects of our Dutchess County work is the opportunity to be called into consultation relatively early and have an active part in influencing the treatment and disposition of a patient toward the appropriate facility rather than to

be confronted by the automatic hospitalizations resulting from policies that obtained before pre-care was established. Unfortunately, we are not in a position to push pre-care to the point that it becomes a requisite for admission. For one thing, New York State policy is against the establishment of any waiting list based on alleged lack of bed capacity. For another thing, when pre-care requests start coming in rapidly, it takes a good-sized staff to keep up with them. Unfortunately, pre-care requests have a habit of coming in groups, so that we will get several in one week and then perhaps two weeks will pass without any requests. It is not possible to use all the physicians on the staff for pre-care work—the physician must be one who can be sent down into the community to represent psychiatry in the general hospitals and to the public and the general practitioners. At no time have we had more than three people available for this rather touchy job which requires a lot of experience.

In addition to some 500 patients, our medical and social services are also solely responsible for 225 patients on convalescent care and 75 on family care; pre-care work is an additional load on the same staff.

So much for the pre-care program. I would like to give you three or four short case histories which show the involvement of our Unit with the community. Not long after the Unit opened for business we had a call from Deputy Welfare Commissioner Egan. His social service personnel were having a great deal of difficulty with an unmarried couple living together in a deteriorated and ramshackle barn on the outskirts of the city. His workers had reported to him that the couple were mentally unbalanced, and he therefore hesitated to commit the Welfare Department further without benefit of consultation.

One of our pre-care physicians, accompanied by Deputy Commissioner Egan, visited the area to investigate. He found the couple living alone in the barn, without beds, without plumbing, without heat, and with only a small Sterno burner over which stood an old charred pot for the preparation of food. The man was an Indian, and their chief source of nourishment was squirrels and woodchucks that he shot in the neighborhood with his .22 rifle. The woman was

a simple schizophrenic who was apparently quite content with her existence. At odd times she collected old rags and newspapers which were scattered around the barn awaiting the junk dealer to whom they would be sold for a few pennies.

The living conditions were, of course, indescribable. Through pressure from the Department of Health, the couple was prevailed upon to accept housing from the Welfare Department, plus temporary financial support until a job could be found for the Indian. We could find no signs suggestive of psychiatric illness in the man that could not be accounted for by his ancestry and culture. The woman had never been hospitalized, and there appeared to be no reason to spoil her record at this late date, unless in the move back to civilization new problems were created with the neighbors.

Actually, in the subsequent 18 months since we saw them, the couple has made a satisfactory marginal adjustment, and further psychiatric attention has been unnecessary.

On another occasion we received a frantic telephone call directly from the manager of a very old and conservative hotel in the center of Poughkeepsie; he said that one of his guests "had just paraded through the bar and the dining room without a stitch of clothing on." After he had described this situation to his own physician and two or three others who were suggested to him, it became evident he was not going to elicit any offers of help. He called us in the hope that he would not have to call the police and "have the whole thing get in the papers."

One of the more persuasive members of our pre-care staff promptly drove to the hotel, corralled the patient, still nude, in one of the upstairs hallways, persuaded her to get into his car, and brought her back as a voluntary patient.

DR. HYMAN PLEASURE: Still nude?

DR. BENNETT: No, not still nude. Besides, he took one of our social workers with him to preserve the amenities.

This patient was 58 years old. Her aberrant behavior proved to be the result of organic damage from a cerebral hemorrhage, and she died three or four weeks after admission.

More recently, we were asked to confer with the Health Depart-

ment about a multi-problem family. The husband and provider was currently hospitalized at Castle Point Veterans Hospital for active tuberculosis. His wife, in spite of repeated entreaties and warnings from their own family physician as well as the Health Department, was putting pressure on the patient to leave Castle Point, to return home, and again take up his job. Of course, she did not think far enough ahead to realize that if he came back as an active case of tuberculosis he could not take up his job anyway. The main thing she was interested in was to get a monthly or weekly pay check.

Apparently as a result of the wife's activities, the patient was about to disregard medical advice at the tuberculosis hospital and come back as an open case of tuberculosis, which, I understand, he can now legally do. In addition, the wife was refusing to bring a 15-year-old daughter into the tuberculosis clinic for a routine checkup following exposure to the father. She was also successfully influencing the two older boys, who were over 18, not to go to the clinic because "you never know what kind of a disease you will pick up in a place like that." The two boys were already known to our Unit as they had attended the adolescent clinic where they had been examined repeatedly by one of our own staff members. This physician described them as a couple of "embryo gangsters who swagger around in black leather coats and are constantly in minor trouble with the police."

After a long conference with the public health officers, it was decided that the Children's Court judge might provide a valuable authority figure in dealing with this situation. On the same day, we went to his chambers and explained to him that, in our opinion, this situation would respond better to authoritarian pressure than to psychiatric treatment. We obtained his consent to see the family individually or collectively in his chambers, since there was no valid reason to charge them or bring them into court.

Subsequently, the Health Commissioner for the county, who is here today, informed the mother that she had a tentative date to explain her behavior to the judge. I understand that there is now no question of her husband's leaving the tuberculosis hospital prematurely, and the offspring have all come in for their X-rays.

As a final vignette, to illustrate the wide ramifications into which a

unit such as ours can be drawn, I will mention a case that was brought to our attention through the county public health nurses in the course of the routine conferences we have with them. These conferences are concerned with our own patients who have been discharged into the community, and with other residents who, the nurses feel, can benefit from some form of psychiatric help.

A schizophrenic patient of ours, discharged from the hospital about a year ago, had subsequently had a baby, and this baby's care had become a source of great concern to the neighbors and to the family physician, who reported the situation to Public Health. Since the patient was fully discharged, and since no request had come from the family for intervention on our part, we had no legal standing whatever in the case, no right to re-enter the situation; but one of our pre-care physicians gained entrance, more or less by hiding behind the skirts of the visiting public health nurse. After about an hour's cautious work, he reported that of the three adults living in the home the schizophrenic mother probably showed the best overall judgment. She had attempted several times to take the child to a local pediatrician because of its advanced state of malnutrition. She had been persistently blocked in this attempt by both her husband and the husband's mother. They felt the child's nutrition was perfectly satisfactory. The resented any intrusion in their home, and the husband's threatening behavior toward the neighbors for their "nosiness" had become a source of local tension.

On the strength of this visit, it was not feasible to return the patient to the hospital on any legal commitment. In any event, it appeared that removal of the mother from the environment would guarantee a continuation of the baby's malnutrition, which was the crux of the problem.

Subsequent conferences with the Welfare Department indicated that they too were powerless in such a situation, unless one of the neighbors were to bring a formal complaint that the child was being neglected. After such a complaint, Welfare would be permitted by law to investigate the problem, but would probably have to drop it thereafter unless they could prove neglect in the Family or Children's Court. This door was closed because the neighbors were not of a

mind to antagonize the medically ignorant and aggressive father by lodging formal complaints.

Finally, through constant liaison with the Health Department, we found that they had succeeded in persuading the family to visit a local pediatrician. Since the doctor in question was well known to us, we were able to brief him ahead of time about the total situation. When the baby appeared in his office, he threw a tantrum about the child's condition, predicted its early death, and had the whole family taken immediately to the pediatric service of one of the general hospitals. The baby has already improved markedly; the father and grandmother have a chastened attitude, and the mother, at least temporarily relieved of the responsibility of the baby, is making plans to return to Hudson River for a brief period on a voluntary basis, "to get my nerves back."

To judge by our own experiences, the directors of new decentralized units and local mental health centers are going to face one of the most variable, interesting, and demanding jobs that psychiatry has to offer. In addition to providing consultation service freely to their colleagues both in and out of psychiatry, and helping to decide whether and by what means private patients are to be admitted to which hospital, the prospective director will face a bewildering array of community duties. He will be asked to sit in with the sheriff of the town, the justices of the peace, and the chief of police to help set up a sensible program for the handling of drug addicts, exhibitionists, alcoholics, and residents of the city and county jails who are suspected of psychiatric illness. He will also be asked to give lectures to the city and town police in those areas where police work and psychiatry overlap.

Along the same line, new roles and functions will arise unexpectedly. I have been asked by the city judge, who is the newly appointed chairman of the county committee for alcoholism, to come to his home repeatedly at night to help solve what in Dutchess County is a major problem, namely, alcoholism. The recently appointed Family and Children's Court judge will also arrange evening meetings of small groups of representative persons in the community. The Unit Director and the Director of County Mental Health

Services will be included, in order to help the judge meet intelligently the huge task to which he has been appointed.

If he happens to be in an area where hospitals like Matteawan or Dannemora (mental hospitals for criminal cases) are located, the county judge and the State Supreme Court justice will expect him to visit and examine certain patients when they receive conflicting medical testimony in court, and need the opinion of a sort of medical referee to determine whether the patient should be released to stand trial for his original offense.

He probably will be a member of the county mental health board, and, as a psychiatrist, he will find himself attempting to recruit a director for the local community clinic. Then he will have to go before the county board of supervisors and explain why more pay will have to be offered to a really good director than the supervisors are paying the mayor of the city, the county judge, or, for that matter, anybody else in the county.

As psychiatric consultant to the planning committee for the new psychiatric unit in the local general hospital, he may find himself enmeshed in matters of construction, bed spacing, proper staffing of the psychiatric unit about to be opened, and proper means of obtaining money for the general hospital under the 1954 Mental Health Services Act. Finally, he will have to exert personal pressure on friends in the community who are in the private practice of psychiatry to give enough time to the new unit so that that section of the general hospital will be a credit to the community.

Such a psychiatrist can expect to be either a member or the chairman of several committees appointed by the county medical society, such as the Forensic Committee or the Committee on Mental Health. He will be expected to take an active part in various rehabilitation projects within the county and the schools and homes for mental defectives and cerebral palsy patients. Also, he will probably be a member of the Community Chest panel, which governs the financing and staffing of these organizations, as well as the county mental health society and the visiting nurses association.

All of these things he must do, in addition to carrying the responsibilities mentioned above. How is it possible to do all these things?

It is possible only because much of the community activity is night work. A great deal is done on a purely personal basis in the homes of other persons involved in the same problems, and thus, except for pre-care, the community duties do not usually use the same part of the day as do the problems of clinical administration, except by way of the telephone.

Unfortunately, no way has yet been found to measure the results of such activities as those outlined above. Personally, I am convinced that this kind of integration between state hospital and community is highly important to both installations and to the citizenry at large, whether it can be objectively calculated or not.

This policy of prompt evaluation, prompt treatment, and early discharge is sometimes referred to as the "churning" process. Much is made of the fact that a relatively high readmission rate, in comparison with that of a more rigid and slower processing of patients, proves that such efforts are pointless. I do not believe that for a minute. I think this so-called "churning" process has very definite benefits for individuals who come in as acute patients, and I think it is highly important to them to get out as soon as they can, provided they have received the proper evaluation and proper treatment.

I am aware of the advantages of detailed investigation and almost excessive caution, of requiring long summaries, extensive social service investigations, and appearances before committees when a patient is discharged or placed on convalescent care. But I am afraid most of these advantages accrue to the physicians and to the hospitals rather than to the patients.

It is my understanding, from what little I know of the statistical results so far, that the formation of the Unit, the addition of pre-care and the policy of maintaining both acute and chronic patients together, the rapid turnover, and many other factors, have not entirely eliminated chronicity, loss of function, or deterioration among our chronic patients. This, I am afraid, is no great surprise, because we still have no satisfactory treatment for either schizophrenia or arteriosclerosis. These are diseases, and although environmental change can modify the outward expression of their symptomatology and perhaps even slow it down, the diseases are still running their courses.

Finally, I would like to say something in general about what seems to be happening from a progressive standpoint. It seems to me that by providing a series of services to the community, we have created a demand for more and better services. At the present time about half of our staff are in community pre-care. All of our little medical staff of seven—eight altogether including myself—are involved in the day-care center. Furthermore, when St. Francis, the local general hospital, opens its psychiatric ward on October first, we plan to funnel our own staff through that also, in order further to promote our association with the community. St. Francis will be happy to co-operate, because it needs all the help it can get.

From the standpoint of daily contact with this problem as a clinician, there is simply no question in my mind that we are accomplishing a great deal for the benefit of the community. I do not know if these things can be shown in statistical tables, but, frankly, after looking at them every day for two years, I do not feel that I need to see statistics in order to see what is going on in this situation. The only thing that worries me is the fact that it has a tendency to snowball. It is getting quite frenetic. Somebody said yesterday, "We could do anything if we only had one more doctor." Of course, this is true everywhere.

In 1960 we had 518 admissions. In 1961 we had 583. Judging by the figures for the first six months of 1962, we will have had about 640 when this year is over. This is a 20 per cent increase in this short period of time, tacked on to an admission rate which is already the highest in the country on a county basis. It is going up faster than it is going up elsewhere in Hudson River State Hospital's district. This is going to make continuously heavy demands but, regardless of the way the statistics turn out on this thing, I very definitely feel that it needs to be done.

DR. ROBERTSON: Thank you very much indeed, Dr. Bennett.

We propose to have a coffee break in a few minutes and to postpone discussion of these two interesting papers.

I was thinking that Dr. Hunt and Dr. Bennett are really guinea pigs, and one of the complications in evaluating the activities of human beings is that those who in one sense are being evaluated

can talk back to you. The evaluators, who are yet to come before us this afternoon, have the advantage or disadvantage of getting their guinea pigs out of the way this morning. I am sure that before the statisticians and social scientists get their say this afternoon, you will want to ask some questions.

Before that, I would like to add two additional words to my opening remarks.

First, I wish to express to you the personal regret of Mr. Milbank, who is Chairman of the Board of the Fund, as you all know, and who also has succeeded Dr. Boudreau as President of the Fund, that he is not able to be here today. He is very much interested in the work of this section, and he will see many of you tonight.

I know he would like me to extend a special welcome at this point to those of our guests who come from other countries. It is perhaps a little embarrassing for the Chairman this morning since the two countries which most of them come from are the countries from which he also comes, but I would be very happy if they would care to stand and be recognized. One of the reasons we are happy to see them here is that all of us will have the opportunity of getting to know them and sharing ideas with them.

I would like, first of all, to welcome Dr. Kirsten Aukén, of the Department of Psychiatry, University of Copenhagen, Denmark.

From the United Kingdom, I would like first of all to welcome Dr. Jacqueline C. Grad, who is currently on a Milbank Fellowship.

Dr. Abel-Smith, who will be more fully identified to you this evening. He is, as most of you know, Reader in Social Administration at the University of London, and a member of that regional board which operates the Worthing Experiment.

Finally, from the United Kingdom, Dr. Walter Maclay who, I understand, is in the category of hospital "buster" in that he busted the board that he belonged to in the most successful and delightful manner possible.

From Canada (which I am told is a foreign country, contrary to appearances), I would like to welcome Dr. D. Ewen Cameron, from McGill University.

Dr. D. G. McKerracher, from the University of Saskatchewan,

who at the moment is also engaged in a particularly fascinating task, that of Chairman of the Mental Health Services Project of Canada's Royal Commission on Health Needs. This may or may not make him rather more up-to-date than almost any of us because he is spending this year traveling around in most of the countries looking at what everybody is doing.

Also from Canada, Dr. Roberts, from the Verdun Protestant Hospital, whom most of you know, and who is one of the courageous leaders of mental health services in Canada.

Finally from Canada, Dr. Robin F. Badgley, who is a medical sociologist and who is acting head of an institution known as the Department of Social and Preventive Medicine at the University of Saskatchewan.

Dr. Gruenberg would like to say a few words before we take our 15-minute coffee break.

DR. ERNEST M. GRUENBERG: I would like to say that the references to statistics showing the accomplishments of the Unit have been displayed from the service point of view. There is a series of small graphs which reflect to some extent the frenetic pace that Dr. Bennett referred to. We have not made big charts. There are lots of ways of counting these movements. Those of you who are particularly interested in the quantitative aspects can see them there. There will not be too many references to the exact figures in these graphs.

DR. ROBERTSON: There are undoubtedly at least two ways of arriving at new knowledge: the clinical and the statistical. I would like to issue just a gentle warning that we are raising questions about, and discussing, two papers that have been given to us this morning which are essentially from the clinical administrative viewpoint rather than the statistical. I hope there will not be too much overlap between things that can be answered only after we have heard whatever we are to be told this afternoon.

The four people at this table are in constant communication with each other. Please feel free either to address questions to anybody or to raise topics for discussion. The meeting is open to the floor.

DR. MAXWELL JONES: I would like to say how much I enjoyed the two papers and how enormously stimulating this whole approach

seems to be. It seems to me the state hospitals are showing vitality, and this kind of program of decentralization is the symptom of that vitality, rather in contrast to the sort of gloomy note, perhaps, that one might find in the final report of the Joint Commission. We are deeply interested in this program at Salem State Hospital, where we have our own decentralized units now for the two counties in our area serving a population of 100,000. I would like a little more information on one or two points.

Why 500 beds? I have heard nothing, in going around to various decentralized units, that makes any sense about the exact size of a treatment unit. No one seems to know. Perhaps Dr. Heninger at Utah has some idea of this. I do not know. I have not yet met anyone who satisfied me that he had discovered the optimal treatment size for making maximum use of the treatment potential within the patient's environment. This question of size is vital, it seems to me. With 500 beds you cannot treat 500 people together. You must subdivide into some kind of units—wards, occupations, activities, clinical classification, age groups.

This, it seems to me, is one of the most neglected areas in the whole field of psychiatry. We generally just accept the size of the ward and go on with this. The World Health Organization has a report on the social organization of psychiatric hospitals, including their size and architecture, but I think it is again merely expressing personal opinions. We all think we know, but no one really has tested the ideal size of a ward or unit from the point of view of actual function. Obviously, much depends on your goal. For my part, I would certainly want subunits of 80 patients at the most, because personally I believe 80 patients should have a say in ward management and treatment and meet daily with the staff. The whole question of roles and relationships, the actual function of the patient and the role of the patient, is central to our theme.

This is the first question I wanted to ask.

The second point I have already touched on. Is it advisable to mix all the patients who come in? It certainly is good for the chronic schizophrenic to be mixed with more active, more interested people who can relate to him; but is it equally good for the new admission

and for the geriatric patient? I would like to know what are the thinking and practice of this group in relation to selection on the basis of clinical criteria.

The next point is the degree of autonomy. Dr. Hunt told us about the considerable freedom the Dutchess County Unit enjoys, but I would like more details. Does the autonomous unit hire and fire its own staff? This seems to me to be elementary. You should have a say in choosing the individuals with whom you are to work. This implies the possibility of a cultural development in a specific unit which is central to the whole purpose of decentralization. If you ask, "decentralization for what?" I would say in order to allow patients and staff to get away from many of the sterile traditions of medicine and to develop a treatment situation which meets the treatment needs of the patient, and uses the skills of the staff and patients optimally.

So I would like to know how far this freedom of direction is allowed, and to what extent there are restrictions.

Finally, the decentralized unit's relationship to the central authority is clearly an area of great importance. I had one experience in London where, as a result of our early attempt at decentralization from the main hospital, we ended by sloughing off and becoming a separate hospital. This may have been due to my personality or it may have been due to the stupidity of the rest of the hospital; I do not know. I think it is one possible and probably undesirable outcome of these decentralized programs. I think that we need a great deal more study of how the central authority perceives its relationship to the "child" and how far it trusts the "child" to grow up. Is it a good parent in the ordinary sense of the term?

On the question of how much treatment we hand over to the outside community by the current tendency to early discharge, I would be particularly interested in hearing any findings that have come up in relation to the harm that one may do to the community. I am so glad to see Dr. Grad here. I feel that the studies they are carrying out in England are the first really careful studies of what Barbara Wooten would call the role of the psychiatrist as a moralist in society. She says that we are tending to tell society what is good

for it. That it should look after its own aged, and so on. Is this trend to the benefit of society as a whole?

DR. HUNT: The first question was: "Why 500 beds?" The answer is because this is what we had that came closest to fitting what we needed. Had we had unlimited funds and a completely free hand to plan a totally new facility as a separate small community-based hospital, to plan it, to construct it, to staff it, to operate it, things might have been radically different.

One of the perhaps unstated but necessarily important considerations in this whole project is that it is a relatively inexpensive way of testing one of the current shibboleths, a way of testing it with our existing capital investment, with our existing staff structure, without committing ourselves and the taxpayers to some radical departure.

So the planning as to how large a facility starts with asking how many patients do we have? We had, at the time we made our first survey, something in the neighborhood of 700 Dutchess County residents in the hospital already, and we were admitting patients from Dutchess County at the rate of about 500 each year. Therefore, we began thinking in terms of how large a structure was needed to handle this group. We looked over the structures we had, their physical condition, their location on the grounds with relationship to such things as the X-ray machine and the dental clinic. The best we could arrange was two small buildings which happened to have a little less bed capacity than we needed for the total existing patient population, but they were the nearest facilities we could find in a suitable location on the grounds. So it was a *faute de mieux* compromise, using what we had, which was rather unsatisfactory, but doing the best we could with what we had.

I am sure many in the audience are sophisticated enough to know how large hospitals operate so they will not be deluded with the false model of 500 all in one mass. There is internal subdivision into units in which there is interpatient, interstaff function in much smaller groupings than the 500. The 500 is the totality, but it is made up of 12 different ward units, each of which has some internal autonomy, and there are much smaller groupings for the living experience of the people involved.

The second question was on the advisability of mixing all patients in together. I will let Dr. Bennett tell you how this has worked in practice. I will first, however, mention the basis on which we made the decision to try it this way.

There was certain theoretical considerations stemming from convictions that one of the causes of regression is residence in a regressed ward; that being completely surrounded by regressed patients is a regressing factor; that it is better for the chronic patients to be mixed. This was one of the elements entering into it, but the decision was really made on the basis of just counting the number of wards we had and realizing how inadequate the number would be if we tried to reproduce in miniature the usual classification system in a large state hospital. By the time we had reception wards, male and female, for the varieties of new patients of all ages and all behavior, plus special nursing areas for the aged infirm, plus special areas for all the other special groupings, there just were not enough units. We made the decision largely on the basis of the amount of space we had; that it would make more sense in operation to try it this way.

We had plenty of reservations in our own minds as to whether it might be unduly damaging to newly admitted patients to be mixed in with old chronic schizophrenics, and so on, but we have watched it in operation. Dr. Bennett can tell much better than I can the clinical impression of how it has worked in practice.

DR. BENNETT: From our own standpoint in seeing it working out over a two-year period, we have been repeatedly impressed by how few voluntary patients we have lost as a result of throwing them unceremoniously into a ward that was inhabited by individuals who were obviously delusional, obviously more ill than the new voluntary compulsive obsessive was. Over the two-year period I do not believe five patients have come in on the morning following admission to complain and insist that they must leave the hospital because of this; and in the two-year period this less than five would be of at least 510 voluntary admissions in that period.

On the question, "Is it advisable?" In Montreal a year ago in June at the World Congress, one entire afternoon was given to trying to answer this question. People from Australia, China, and else-

where all put in their opinions on this matter, and it was finally settled toward the end of the afternoon by a Canadian who got up and said: "I have been doing this for 16 years on my ward, and I am not going to change." This was the general attitude.

It reminds me of a long time ago when I was in college; there was a local dog wagon where you went to get hamburgers early in the morning after coming back from a neighboring town. You would carefully tell the man behind the counter, "I would like it to be rare. I would like to have onion on it. I would like this, that, and the other." But when you got the hamburger it was always absolutely charred and there was no onion on it. You would complain, and he would look at you with all the blandness in the world and say, "That's the way I like it."

This just about gets down to the same thing. "You pays your money and you takes your choice."

However, to get back to our own experiences, we are divided on this within our own unit. There is no unanimity of opinion, even after two years, as to whether we are doing the right thing in mixing the patients.

In addition to the lack of anxiety and disturbance on the part of our voluntary patients, it is also very noticeable that one of the first indications of improvement in the anxiety neurotics and phobics is that they become increasingly interested in what they can do for these seriously sick people. One of the first indications of real improvement in such a voluntary case is the fact that he or she—usually she—begins to telephone the relatives of one of these patients, suggesting specific things that the relatives should bring the next time they come to visit. She begins to have a feeling of responsibility for this chronically ill patient she has taken under her wing. This ability to externalize one's own concerns and begin to take an interest in what is around one is always a good sign, as far as we are concerned.

Further to illustrate the lack of unanimity, Dr. Duncan MacMillan said that he is definitely opposed to the idea of mixing these patients. He feels that it will represent a self-imposed hurdle on our part from the standpoint of treating the acute patients, to have them mixed in with the chronic patients.

My own feeling about it, and I think Dr. Hunt's also, is that this may be overridden by the fact that if you have your chronic patients mixed in with the acute, you will not lose track of those chronic patients. I think from the practical standpoint that is the most important of all.

DR. HUNT: A couple of other considerations might be mentioned. A confession is in order: I am emotionally much more committed to the chronic patients than to the acute patients. Any damned fool can cure the acute patients. These are no problem. We invest a tremendous amount of our money and efforts in the transitory, acute problems, which are pretty much self-limited. The great unsolved problems in our business are with chronic pathology. So, personally, I have much more sympathy with the chronic patient, and if somebody is to be sacrificed, I would rather sacrifice the acute patient who cannot be hurt much anyway.

More seriously, I think this kind of question may in some people's minds reflect a false model of what the chronic ward is like in 1962. If you have the model of the old locked insane asylum, this is a totally false picture. These wards are all wide open, and the acute patients actually spend very little time on the ward with the chronic patients. They are off the ward in therapeutic activities and recreational activities, or something or other, a great deal of the time. When I take visitors through there, I just can't find a recent admission to show them. All we see is some chronic sitter sitting around the ward. There are scads of recent admissions in the Unit, but you can't find them when you take visitors through there in the daytime. So, actually, they are not cooped in with these patients as one might think.

DR. C. A. ROBERTS: I would like to address myself for a moment to what I took to be Dr. Hunt's disappointment with the response of the community in terms of services for the Dutchess County experiment.

First, may I say I think it has been extremely interesting to have had the opportunity to hear about the planning of this Unit, to visit it, and each year to be able to hear the report of developments there.

It does seem possible that one should have some reservations as to

whether this experiment of itself is capable of demonstrating certain things about the transferral of responsibility for the care of the mentally ill to a community. There are a number of questions I would like to hear discussed, as I am not sure what the situation actually is at the Dutchess County Unit.

For example, it is traditional for a service responsibly operated locally to be operated by a local board. I do not believe there is a local board or a local visiting committee related to either the main hospital or the Dutchess County Unit, and one wonders what part community representation on a board would play in seeing that the community was aware of the needs for supportive services.

I have not heard any mention of an organized auxiliary, such as we have in the general hospitals and some mental hospitals. One of our best media of communication with, and education of, the public in terms of developing services is to have this large body of women organized with a priority job of giving identification to a mental health service. How many volunteers are involved in a 500-bed unit of this type? Is there a full-time director of volunteers for this particular service?

Then there are other questions about the involvement of the hospital in the local welfare council or health planning council, the local and state hospital associations. Also, while perhaps professionally one hesitates to raise the question, to what extent is a public relations officer involved in this program?

I have heard Dr. Bennett mention his involvement in the welfare planning of the area, and it seems to me one can already see a great deal of involvement at the professional level. But I still wonder if local service is not being imposed on the community, rather than being operated by a community board which would feel that this was a community facility owned by, operated by, and responsible to the community.

DR. GEORGE S. STEVENSON: My comment turns out to be in support of further emphasis on the point Dr. Roberts just made.

The title of the program this morning includes the words "state hospital" and "extension of . . . services into the community." This may be all right as a working process, but as an objective, to me

it presents a one-sided approach. A two-sided approach would recognize that this division of hospital and community is a man-made division. The patient is not so divided. He needs whatever the community can develop to serve him. It seems to me that if this program is to succeed it should deal not only with the extension of the hospital, but also with the promotion in every way possible of the complementary processes which only the community can offer.

I realize that New York has certain problems in this respect as contrasted with some other states, because it has tended less than many others to preserve community responsibility up to 1954. Partnership with the local community even since then has been less than in states that have never abandoned the local financial or other responsibility for the patient when he goes into or leaves the hospital. This separation makes the job harder. But I think it is simply a further challenge to the program to work this out so it will be ready for use in other places when it has progressed to the point of wider application where it can be taken over to a certain extent.

DR. NATHAN BECKENSTEIN: The first comment I wish to make is on the question of mixing the chronic and the acute patients. I believe that whether you mix them or separate them is not important, provided there is a good program of therapy such as that represented by open wards. Dr. Redlich and his co-workers, Dr. Caudill and others, have demonstrated that regression breeds regression and that regression is the patient's solution of the institutional problem. This occurred in the days of the custodial attitude. With our present program of the open-door policy with all its modern ramifications, the patient no longer needs to regress. Instead, he is directed toward a program of rehabilitation. The important thing, therefore, is, what are you doing with the patient to help him?

The other question which arose in my mind is this: Is it not too early, really, to evaluate the results of a project like this? Things have been started. There must be further implementation of programs. In time these will develop. Then we will be able to test whether we have continuity of program and how effective this is. Right now, I am sure that even in this project there is a great deal of difficulty in effecting continuity of treatment of the patient from the hospital into the community.

Hence, I think we must reserve judgment on results until we have had adequate experience in the development of the programs in our communities and in our hospitals.

DR. ROBERTSON: I would say that what Dr. Beckenstein was referring to demonstrates, to me at any rate, all the more clearly the courage of this group in coming before us to present what they are doing at this precise partial stage in their development. Part of the fun and excitement for us is seeing it evolve year by year.

DR. HUNT: I wonder if Dr. Gruenberg would care to tackle the questions raised by Dr. Roberts, which bothered us all the way along. Do you want to try that?

DR. GRUENBERG: I will give you my viewpoint on it. I do not think there is very much difference in viewpoint between the concepts that Dr. Roberts expressed and the general ideas that Bob Hunt has had and that I think the Fund has had.

I shall not say anything about a local board. From my own frame of reference, I think it would be a fine thing to have something like an advisory board of some type in connection with such a unit. I think it is almost impossible—I do not say it is absolutely impossible, but I think it is almost impossible—to set up such a board in relationship to a part of a New York state hospital under the present administrative structure and conditions. But if it is quite clear the board has no administrative authority and does not have the power to call itself together, and if you can still get people to participate in it, then something good might come of such an arrangement. I am not quite sure how it could be handled. I think that is very difficult.

As to volunteer problems, we have had discussions on this from the beginning. I cannot give you any statement. I would like Dr. Hunt to say something about the question of volunteers. In discussions at which I have been present, he has expressed himself quite strongly on the problem. I will give him a head start and say for him that you must realize this is a 5,000-bed hospital. Practically all the volunteers who give any service at all in this 5,000-bed hospital are residents of Dutchess County and always have been, because the hospital is located there. This adds a particularly difficult problem in setting up a special corps of volunteers for the Dutchess County Unit, because it would create problems for the rest of the hospital.

I want to add two things to what has been said. I do not know why it has not been mentioned, but I think some of you are getting false impressions about the degree of local involvement. Dr. Bennett was a founding member of the Dutchess County Mental Health Board when it was first organized, appointed by the local government for the development of its local services, and has been a key person in that board's activities. He made some passing reference to it. He is also their part-time executive in a sort of joint-user arrangement or double-appointment thing. So there is an opportunity now for close integration.

In my observation, there has been no conflict between the community Mental Health Board's program and their local clinic and the hospital. They throw things back and forth to each other very well. I do not think the local Board of Supervisors has shown any great excitement about the idea of increasing its stake in mental health services very rapidly. The volume of services provided by the local community is mediocre when compared to that of other communities in New York.

I think people have got the impression that perhaps the existence of a county unit in a state hospital inhibits the community's investment in mental health services. I think it is because of Dr. Bennett's modesty that he doesn't make more reference to his role and to the role of the State Hospital in helping the St. Francis General Hospital develop their psychiatric unit, which is to open next month.

These are all actual manifestations of progress.

As far as public relations are concerned, I do not know what I should say about them. I have no strong views one way or the other. It would be good to have somebody representing the Unit outside.

DR. HUNT: Further to set the record straight, our thinking was exactly along Charley Roberts' lines in our earliest planning phases. We were both convinced on theoretical grounds that it would be much healthier if the grant moneys went to the county, so the county would have an official stake in this entire operation. On theoretical and administrative grounds, we saw nothing wrong with this. It would not cost the county any additional tax moneys at the time,

but they would be, to some extent, the users of the money and the administrators.

But before actually embarking on such a scheme, we had a conference with Dr. Bennett, who at that time had no official connection with the State Hospital, and with the then Chairman of the community Mental Health Board, who was also a member of the Board of Supervisors; we laid the whole thing before them for advice. We were advised very strongly that the surest way to kill the thing was to propose that local government be involved at this time; that this particular local government was highly sensitized to gift horses because they had had some sad experiences with them in the past. Our advisers were quite sure that the whole thing would come a cropper if we ever even raised the issue. They recommended most strongly that this had better be a state operation for the demonstration period; that, hopefully, it would then prove its worth to the local citizenry and the Board of Supervisors; and that, again hopefully, its continuation or extension would involve the local county.

Perhaps we were wrong; but this was the advice we got and we took it, not because we thought it was the best way, but because we were advised this was the only way at that time in this county.

DR. ROBERTSON: Dr. Bennett, do you wish to add anything on these points?

DR. BENNETT: With regard to Dr. Stevenson's question, I am sorry to say there is a tendency to divorce the patient from the community as soon as he is admitted. We have tried to combat that as much as we could, but we can make a difference only on the professional level in connection with the medical profession. We try to keep the general practitioner who is the family physician informed as to the patient's progress. We try to get him to come to the hospital and see the patient, and to sit down with us and go over the problems involved. When the patient is sent out on convalescent care or discharged, again we call or write to the physician, giving him a summary of what has happened and making suggestions as to continued care.

I am sorry to say that Dutchess County does not provide anything

in the way of halfway houses, anything in the way of clubs or follow-up services within the county itself to take care of discharged or convalescent-care patients. There seems to be very little tendency on the part of the county, in spite of many efforts on our part and on the part of others, even before the Dutchess County Unit started, to become economically involved in setting up any such thing. This is true throughout the county. For example, Poughkeepsie's population is about 45,000, I think, and the last time I inquired there were only 80 beds provided in the city infirmary, for those who were unable to afford nursing homes and who were sufficiently disabled to require further medical care.

This has been quite characteristic of Dutchess County. It is extremely conservative. The people are intensely interested in what the money is to be put out for.

DR. HUNT: I think it is only fair to mention that some progress has been made. It is much slower than we would like. The outpatient psychiatric clinic did not exist 10 years ago. It was about eight years ago that it was first started. The initiative came from staff members of the state hospitals in this community, who got together with some interested citizens and thought we ought to have something like this. In the early days it was staffed entirely by volunteers from professional staffs of the state hospitals. Little by little the clinic gained community acceptance, and the time came when local government was willing to put up local tax moneys to support this matching state money, and this has become an established facility in the community.

The same thing is happening to a small inpatient unit in a general hospital. The state hospital people again have been among the main instigators and promoters and advisers of this development.

But to us, this is very slow. We want to see overnight a pattern such as the one Dr. MacMillan took many years to develop in Nottingham. So we get impatient.

DR. ROBERTSON: Dr. Roberts, do you wish to say another word, perhaps, on the same topic? Then I will call on Dr. Esselstyn and Dr. McKerracher, and we will hold our two answerers back for a few moments.

DR. ROBERTS: Mr. Chairman, I do not wish to ride a hobby-

horse, but in trying to get people to support different types of programs in Canada, where my experience has been, the story Dr. Hunt has given is typical. It would not be safe at this time, by the very nature of political circumstances, to allow a local government to become involved. The community is not ready to accept responsibility, and if we in our wisdom do not go in and do this, the community will not do it.

I would like to say that in a matter of four years, I think, because of a hospital board and because of an auxiliary, we have seen the construction of a fine halfway house, the finest that I know of, and we have seen the development of a social club, paid for by the community, which is doing an excellent job of supporting patients in the community. I do not think these things would have happened, even in Montreal, if the prime advocates had been we professionals.

The fundamental point I am trying to make is that understanding by the community, learning through their own mistakes, learning what is needed to provide service to their friends and relatives, are of the essence. We cannot go on accepting the idea that the civil service of the state government has all the wisdom in the development of local services. I am saying this not to criticize the present project, but only because we must somehow get other experiments going.

The second thing I would like to comment on is that I do not see how any psychiatrist could say we want to have the local board assume the responsibility, provided it has no power whatever, and is directed by us. I think the essence of our relation to a local board is that we are professional advisers to it, and that we do allow the board to make decisions and become involved. I cannot imagine saying to any board I would be working with, "You will not be able to have a meeting on your own and won't be able to make decisions. You are purely advisory." I think this is a sure way to have them not fully involved.

I therefore make a plea—not by any means criticizing what I think is a very worthy experiment—in the hope that somewhere along the way we shall be able to try the other type of community support program.

DR. ROBERTSON: We are getting to the delightful stage, which

is most pleasurable for any chairman, of having more names than he can put on a piece of paper. We shall put our two answerers in cold storage for a moment and hear further words from the floor.

DR. CALDWELL B. ESSELSTYN: I should like to ask four questions from the poor sister county to the north of Dutchess County. We come from a county which is noted as being willing to share with you anything that you have.

I just wonder, being mundane about this thing, what percentage of patients, if any, pay in the pre-care treatment, and what kind of a fee schedule you have.

The second question I would like to ask is how you would clarify the role of the social worker in the pre-care clinic.

The third question is: Do you find that it is easier to use group therapy with people who come from a relatively small community and who are interwoven in their lives outside, than you do in a large institution where people perhaps do not have any relationship to each other or their families or friends on the outside?

Lastly, I wonder how intensive the medical care of the inpatients is. Do you have any screening of the patients in the hospital? If so, how much?

DR. D. G. McKERRACHER: Following the lead taken by Dr. Roberts and Dr. Stevenson, I am still concerned about the involvement of the community in this project. I am particularly concerned about the lack of involvement of the family physician. Dr. Bennett has mentioned this. My question to Dr. Bennett would be: What step does he see that the psychiatrist could take in a direct effort to involve the family physician, and might he not be more easily involved if the Dutchess County patients were taken care of in a building very close to the general hospital (actually as a part of it), rather than continued as a part of the state system?

DR. ROBERTSON: Mr. Forstenzer has been trying to get a word in from the State Community Mental Health Services, and this may be a point on which he would like to comment.

MR. HYMAN M. FORSTENZER: My comment relates to the question Dr. Roberts raised. I think it should be recognized that Dutchess County still has the reputation of being the last feudal stronghold in

New York State. Things change very slowly in Dutchess County. I think, too, we ought to recall the statement made by Dr. Hunt that the admission rate to Hudson River State Hospital from Dutchess County exceeds that of all other counties in the state to state hospitals. This relationship between the county and the state hospital is explained by one of the early studies of the New York State Mental Health Commission's Epidemiological Research Unit, when Dr. Gruenberg was the Commission's Director. The proximity of the state hospital to this particular county resulted in misuse of the state hospital rather than in its development as a community resource in a program of continuous patient care.

Perhaps the best way of illustrating this is to point out how alcoholics were treated until very recently in the city of Poughkeepsie. No other services for alcoholics were developed by the city or county. The police brought alcoholics directly to the state hospital even for simple detoxification—for drying out. The community simply unloaded another problem group on the hospital.

I think if we had chosen any other county in the state the rate of progress in terms of the development of the community services would have been much different from what it is here.

The last point I would like to make is that Dr. Bennett has recently become the part-time Director of the Community Mental Health Board. This board for four and a half or five years functioned without a professional director. The clinic which it supports is a contract clinic. The staff of the clinic devote themselves to clinical responsibilities, assuming no responsibility for planning or for doing the kinds of things that Dr. Stevenson feels a board should do. I do not think the Mental Health Board ever concerned itself with anything but passing the budget for the clinic. It took no leadership in assessing the needs of the county or of developing services to meet the needs.

It is important in developing any decentralization plan, it seems to me, that the plan be viewed in its totality. Decentralization produces some obvious improvement in patient care within the hospital, but for the full development and the full reaching of the end purposes of decentralization there must be careful thinking through of the role that the community is expected to play.

This goes beyond the simple factor of hospital-community relations. It relates to the whole issue of who pays for what and what the practice has been in the past in terms of the state taking on the full responsibility for the hospital care of the mentally ill.

MR. PHILIP E. RYAN: I would like to make one brief comment and then ask a question.

I think this last discussion—and most of the discussion so far—has indicated a most significant role for the Mental Health Association, and has given me a lot of ideas.

The question relates to my understanding that the original hope was that such a unit could handle all of the hospitalized patients for the particular geographic area. I am wondering whether experience has indicated that there are certain categories of patients who are not best handled through the Dutchess County Unit—for example, children or tuberculous patients or other categories. Are there certain patients who just do not fit into this particular setting, who must be handled on a broader base—on the basis of the services of the entire hospital?

DR. D. EWEN CAMERON: In relation to this discussion, I must confess that it seems we are dealing with the whole treatment of the mentally ill as though it were an administrative problem. I do hear nothing, or practically nothing, about the actual medical treatment of these people. I think nearly all of us are persuaded that in order to make a break with the past we have to break with the old ways of the state hospital. I shall not make an apology for the state hospital. It did the best it could at the time, but it undoubtedly was a bad kind of organization. However, I think we are finding difficulty in making this break. This is why we go on talking administratively.

I would like to know much more about what is being done to ensure first-class treatment for these people. When I say first-class, I really mean first-class. What are we doing to see that the treatment available for the mentally sick is equal to the kind of treatment that you get in the really outstanding departments of surgery and medicine throughout the country? Frankly, I do not think very much is being done. It is difficult, and I think we are still dealing with this thing from the administrative point of view.

I would like to know what is being done, for instance, to ensure that every patient is worked with every day.

Fifteen years ago Dr. Myerson, of Boston, advocated as a new treatment the technique of total push. It seemed a most original advance, but actually total push was simply active treatment such as internists and surgeons had been carrying out for many years. It only seemed new to us because we had been so long accustomed to undertreatment and inadequate treatment as carried out at that time in the mental hospitals.

I think one ought to be absolutely certain that excellence is being pursued in every possible way. Excellence is a very difficult thing to attain and is never really attained. We are always in pursuit of it.

I would like to ask whether, for instance, this Unit is set up in terms of small services. Is there a chief of staff? Does somebody go around with a medical team every day to see the patient, to plan for his treatment, to watch for day-to-day changes, to push the patient and the community forward as rapidly as possible?

To indicate to you how seriously I think one might take this, some of you know that the surgeons have a very interesting device called a tissue committee. This tissue committee goes over all tissues extracted at operations to see whether the operations were necessary. Would it not be advantageous for us if we had a commitment committee to see if all commitments were really necessary?

This gives you some idea of the intensity with which I think this thing should be pursued. If we are to make real progress in the treatment of the mentally ill, we must deal with this as a medical problem and not an administrative problem. The administration has to come afterward. Have we a medical board here comparable to what is found in general hospitals, or have we simply translated into this Unit the old medical social organization that we find in mental hospitals, whereby the medical superintendent has the final authority on all matters, both administrative and medical?

DR. WALTER S. MACLAY: I would like to say a word about two things.

I was glad to hear the family physician brought into the discussion, because I do not think enough is being done in England or in this

country, probably, to drive home to the family physician the important part he must play. It is my view that all the services given in the community or in the hospital should be given to help the family physician, if continuity of care for patients is to mean anything at all. That is one point.

The other point is about a visit to the Manchester region 10 days ago, and what I saw there. I know some of you already know about what is going on, so I would like to preface my remarks by saying I do not want them to be interpreted as meaning that I personally think that mental hospitals are no longer needed.

There are several psychiatrists in the Manchester region who are running units in general hospitals which vary in size from 40 to something like 200 beds. All of them are admitting from their catchment areas every kind of psychiatric case, with no special selection, and all of them say they do not need a mental hospital to help them, provided they have a good geriatric service working closely with them, good community services working closely with them, and some national "special" hospitals for dangerous, violent, and unusually difficult patients.

In the Manchester region they have those things. They have a very good local authority service and a very good geriatric service. When we visited we talked with geriatricians and medical officers of health, and they backed up everything the psychiatrists said, and confirmed that it was all working smoothly.

Those units do have parent mental hospitals, but they are sending to them only something like four or six patients a year, and mostly for social rather than clinical reasons. At the end of each year they have only five or six patients remaining from the year's admission to join the chronic population. This to me is very fascinating.

Curiously enough, in the same region there is a big mental hospital which does not have good geriatric services, which does not have good relationships with local authority and community services; nonetheless it has been transforming itself from about as unpromising a hospital as you could pick into a first-class comprehensive hospital. They have been able to reduce their patients to such an extent that there are a lot of empty wards in what were previously the chronic

wards of the hospital. They then tried to form a comprehensive hospital along Professor McKeown's lines. They have now a thoracic unit, an orthopedic unit, a unit for delinquent adolescents, a geriatric unit—not psychogeriatric but geriatric—and a unit for bedfast, low-grade mental defectives. The result is that it is a hospital with no stigma attached to it. Patients enter it just as they do any other hospital. That this is going on in the same region with the units in the general hospital seems to me very interesting.

The other thing I want to say is that the physicians in the units in the general hospitals estimate that they need less than half a bed per thousand of population, and that is a great deal less than the Ministry estimate, which is 1.8 beds per thousand of population, and this is a great deal less than the World Health Organization estimate, which is four beds per thousand of population.

Coming back to the region I work in myself, which is Wessex, we are not finding things the same as in Manchester. This is probably because of the different culture. I do not know. They have closely knit communities in the Midlands. They look after their old people, children, and families very well. In Wessex we reckon that we shall in time get down to the Ministry's estimate of 1.8 beds per thousand of population; having done that, we shall still have our mental hospitals, but instead of being grossly overcrowded they will be just nicely filled and able to do a lot better work.

So there isn't just one answer. I think the circumstances in which people work and the geographical layout and all the other factors that come in will make each area a different problem with different answers to the problem.

DR. BERTRAM S. BROWN: Dr. Robertson said he put the speakers in cold storage. I am afraid they are going to be frozen by the sheer weight of questions by the time they get to speak.

I just have some brief questions in terms of staff and staff roles, from two points of view: recruitment and what they do.

On the recruitment issue, I was very much impressed, Dr. Bennett, by some of your estimates of what would be needed to do the work load. Extrapolating it to the half million public mental hospital population, you get the inordinate figure of 10,000 psychiatrists

needed, who will not be available. Is not the more fundamental issue that you are demonstrating something that cannot be staffed over the next decade?

A secondary question would be whether in this sort of active treatment service, the roles of the psychologists and social workers tend to merge. You have groups of three or four people coming in. Only one person may be free, perhaps the psychologist, but the social worker is out. Do you have a sort of mixing or smoothing out or generalist role emerging?

DR. JACQUELINE GRAD: I can sympathize with Dr. Hunt's disappointment with the statistical evaluation of outcome, because we have this kind of problem, too, in England where, as we have just heard from Dr. Maclay, the large mental hospital is out of fashion. The problem of evaluation surely is not to show that you do better with community care than with mental hospital care, but that you do as well. If, as Dr. Hunt says, this chronic population of schizophrenics and arteriosclerotics cannot be cured, why take them to the mental hospital? The reason for taking them to the mental hospital in that case is purely custodial and for the protection of the community. The question then arises, does the community want this? There are several studies showing that the community often prefers the patients to stay at home.

There is just one other thing I want to say. Dr. Hunt said they have not found any magic way of keeping patients out of the hospital. We seem to start at an earlier point in Chichester and keep patients out of the hospital by not admitting them when they are first referred. This is not done by any large-scale provision of community services, halfway houses, and social work in the community, but by much more extensive provision for taking care of patients in outpatient community clinics and close co-operation with the general practitioner.

DR. PLEASURE: Last year when the results were even more preliminary and tentative than they are now, I was very much impressed by the figures which were given for discharge rates from this Dutchess County program. I went home and decided to check my figures at Middletown State Hospital and see what they were like in compari-

son with this program. I thought our release rate would be very much lower, although the county of Orange, where I work, is the county next to Dutchess County and has a similar population. When I came to check my figures, I found that the discharge rate was almost a perfect copy of the ones I had heard at that meeting.

To check it I took an unselected group of patients who had been admitted in a randomly selected period, which turned out to be February 1 to March 31, 1961, and I followed them up monthly for about a year. I found that during this period we had 152 admissions, of whom 100, as it happened, were younger than 65 and 52 were older. I found at the end of about six and a half months, that 91 per cent of the patients who were under 65 were out of the hospital, which is almost a perfect copy of the figures you had.

For the people over 65, who, to coin a phrase, constitute one of the "core problems" of our hospital, we had figures also very similar to the ones you had. Within two months, 33 per cent of these patients were dead. During the next few months, very few more died. Within six months, in spite of the unlikely appearance of the patients over 65, 20 per cent were out of the hospital, improved. At the end of a year most of those who were not out within six months and were not dead, were still in the hospital; and there was no possibility of getting them out, as I know because I saw every one of them myself.

Dr. Hunt, I think, has slandered himself when he said that any fool can get these patients out of the hospital if they are acute. Such fine results are pretty general today, but did not exist a few years ago because the program we now have in the admission services of New York state hospitals is very different from the one we had only three or four years earlier. Dr. Hoch has managed to procure for us increased appropriations to make the treatment in admission services in all the state hospitals intensive. In my hospital, for example, we now have a ward attendant-patient ratio of 1:2.6, which I think is quite good. We have 8 or 10 doctors for about 220 patients in the admission service, which means the patients do receive quite intensive treatment. I think this accounts for the results.

To answer Dr. Cameron in just a word, the patients have a very active program. They are busy all day. As Dr. Hunt said, you cannot

find the patients on the wards when you come in. There is something going on all day. Exactly what is done is just intensification of the program as we know it.

I am glad to hear today that the program of Dutchess County has by natural evolution gone from the state hospital out to the community, because I think the future of our state hospital program will be to spread more into the community, along the lines of the Worthing program in England.

To give you an example of how not to involve the community's general practitioners, I will tell you about an experience I had a couple of months ago. I got an emergency certification paper from Newburgh in which a patient who was being sent to us was described as "95 years old, lies quietly in bed out of contact, recent fractured hip, blind, hard of hearing, incontinent, and confused." I called up the health officer who had certified this patient and I said, "Doctor, why are you sending this patient to us? There is no use giving her tranquilizers or any form of special psychiatric treatment, and certainly we cannot do any psychotherapy. Don't you think she belongs in the chronic ward of a general hospital or a nursing home or a home for the aged? You have a county infirmary in your city."

He laughed and said, "Why, we have been sending these patients to you for 20 years, and this is the first time I ever heard you complain."

I said, "Well, this one really raises my hair, and I thought perhaps you could do something else."

He said he would look into it and he would try to get another disposition.

About five days later, after the paper lapsed—it is good for only 10 days—I got a call from the family doctor; he was in a rage. He said, "Do you know it is costing this family \$30 a day to keep this patient in St. Luke's Hospital in Newburgh? She should be in your hospital free. Why are you delaying the admission?"

I repeated what I had said to the health officer. I told him the patient did not seem to belong to us. She wasn't disturbed. There was nothing special we could do.

The next day I got a new certification paper on the same patient.

This time it said: "Ninety-five years of age, blind, recent fractured hip, hard of hearing, incontinent, confused, and throws bedpans at the nurses."

I had to take the patient.

As I mentioned earlier, I think this is the approach that won't work. There must be something along the lines that Dutchess County is trying to develop and that has gone a little farther in other countries and perhaps in other areas of our own country. I think this is the direction in which the Dutchess County experiment is going, and I think it is a very wholesome direction.

DR. JONAS N. MULLER: Briefly, this is partly in response to Dr. Grad's comment and something Dr. Bennett said earlier. He indicated that the original group of 70 pre-care patients who were admitted to the hospital inpatient service, increased over a six- to eight-week period to approximately 100. He proceeded to suggest to us that this increase represented the course of the illness or the failure of the other alternative facilities of the community. One of the important considerations to be examined is the predictive value of the pre-care evaluation itself, the question of the extent to which this pre-care evaluation and the nature of the pre-care service was a contribution to the change in the status of patients during this period. Are there measurable criteria for pre-care referrals, and to what extent can there be? We need such criteria in order to examine this whole question of the role of pre-care in a more precise way.

DR. LAWRENCE C. KOLB: My comment is essentially an effort to counter Mr. Forstenzer so we cannot escape the very important implications of Dr. Roberts' point of view. It may be that Dutchess County is a feudal society, but the very same problem holds in other parts of the state that are not feudal societies. We have been undertaking a somewhat similar experiment in Metropolitan New York. Some have said of this urban community that all the feudal lords have left and all we have is a bedlam society. I know of no clear indications that any members of the community have taken part in our effort to establish good after-care service for our patients. I do believe we must ask Dr. Hunt and Dr. Bennett to suggest to us what measures they would bring, now or in the future, to stimulate the

interest and active participation of their community in the program they have set forward.

One other comment: Dr. Maclay has mentioned the Manchester experience. I am somewhat concerned about this matter since Dr. Silverman was in my office this past week and described the Manchester experiment to me. In talking with Dr. Silverman, I raised the question about the care of their older patients, and he told me that they are greatly aided by a nearby specialized geriatric unit. This would, of course, change considerably the interpretation of the use of the beds, if another unit is taking patients that are cared for in mental hospitals in other areas.

DR. ROBERTSON: Thank you very much.

I am afraid I have to impose a limitation of five minutes apiece on Dr. Bennett and Dr. Hunt, in that order. I am saving Dr. Hunt for five extra minutes in the cold storage because I suspect he has something pungent to say to Dr. Ewen Cameron.

DR. BENNETT: I will answer Dr. Esselstyn first. There is no fee schedule in pre-care. We have not even attempted to establish one. Sometimes persons have asked us, in the course of pre-care, what the fee would be. At one time it seemed fairly feasible to try to use that opportunity to get things that we needed for the inpatient part of the hospital. We have not done this to any extent; we have not implemented it.

How intensive is the medical care? I shall leave that for Dr. Hunt, because he will have to include it in answering Dr. Cameron.

What is the role of social service in pre-care? When there is time, the patients come to social service first when they come into the hospital for pre-care. Social service gets a little vignette of the problem and then brings the patient to us for the consultation. This is important to us because, as I think I said before, those patients who are not admitted either to inpatient or to day-care centers are then followed by social service, and if they sit in on the consultation, if they have been in it from the beginning, they have a personal interest in it and they have a greater tendency to follow it up intelligently. Some phone calls are so urgent that the psychiatrist does not have time to bring social service into the case before acting.

As for group therapy, I haven't particularly noticed that it helps if all of the persons involved are from the same community. But in the day-care center, to a certain extent, we have been drawing families in, particularly over week ends, for a form of group therapy, including the patient with the family and sometimes groups of two or three patients and families together, where they can see the similarities and parallelisms in the cases and can help each other in solving these problems on the outside, where the patient is not within the hospital.

Dr. McKerracher asks if it wouldn't involve the local medical physicians more if we could set up our Dutchess County Unit in conjunction with one of the general hospitals. Surely it would. There is no question about it. The local medical physicians would go into the general hospitals to see their patients probably almost daily under those circumstances, and if the psychiatric unit were a part of the general hospital this would be a tremendous advantage. Occasionally they come to see their patients at Hudson River, but this is still all too seldom, in spite of the pressures we have been trying to bring on them. I am afraid that part of the reason for this is economic. It is pretty hard for them to travel a matter of even three or four miles to get up there, and lose the time from their practice to do it, when in 90 per cent of the cases they are not going to be paid for it.

As to the question about which patients are excluded, this is entirely on a medical basis and on an age basis. At least half of the children in Dutchess County are filtered through the Dutchess County Unit, and the physician in charge of the children's unit comes down to interview the youngster and see if he is a candidate for the children's unit. In the majority of cases, the children then leave us and go up to the children's unit, and we lose track of those.

Aside from the children, the only ones excluded are patients with tuberculosis and the serious and severe medical or surgical cases which are temporarily transferred to the medical-surgical service of Hudson River State Hospital and then come back to us when the surgical or medical emergency is past.

Except for those, we have everybody.

What are the roles of social service and the psychologist in the

churning process? They are utilized as ancillary services, believe me, to their fullest extent. We use our one psychologist constantly and repeatedly for carrying a case load of selected individuals for psychotherapy. He is involved in after-care along with the rest of us. The patients come back to see him, not after discharge but after they have been put on convalescent care, as they do all of our physicians on an after-care basis.

Social service is absolutely invaluable in this speeded-up process we find ourselves caught up in. When it is a matter of a job for a patient as one of the most important factors in getting him out of the hospital, social service is then called on promptly to see what is available, to find a place downtown for the patient to live in, to follow him up, to see him repeatedly while he is still in the hospital before going, in order to get the thing eased off and squared away before the patient leaves.

Dr. Pleasure's findings, of course, are parallel to ours all the way through, particularly in the matter of the impossibility of trying to keep out of the hospital patients in certain age groups who are not primarily psychiatric. The answer always is, as it was with him: "What else can we do?" This is the final answer as far as the community is concerned. Unfortunately, the community setup is such that there isn't anything else that can be done.

Dr. Muller asked about the predictive value of pre-care. Of the patients who were originally sent to day-care, community clinic, and one thing or another, most of the small percentage of this group who after six or eight weeks did wind up as inpatients came from day-care. One of the most important reasons for shifting them from day-care to inpatient care was that their families, who had been taking care of these individuals during the night, were becoming more and more afraid of possible suicidal tendencies. They increased the pressure on day-care, and we were brought into the picture again, and many of these patients had to be brought over to the hospital on this basis.

If it became impossible for the patients to attend the day center because of difficulty of transportation, they, too, came in as patients.

DR. HUNT: Would you regard these as failures? I think very

often, at least from the reports I get, these are not failures at all. In a great many cases the patient had not become any worse, but family tolerance had reached a crisis.

Even if the patient does have a crisis in his condition, all of this preliminary contact, while trying other things, has smoothed the way so that the patient's attitude and role when he does come as an inpatient are very different from what they would have been had he simply been committed in the first place. In most cases this is not wasted effort, but a very useful preliminary to a period of hospitalization, and it renders the period of hospitalization more likely to be successful than if we had not gone through the failure prior to hospitalization.

Of course, there is not time to react to all the stimulating comments made. I will address myself to a few of the more specific questions.

First, of all, I hope this is the last word which needs to be said on this matter of community involvement. I had thought it was clear by implication in my prepared remarks that I was not blaming the community but was blaming ourselves. I will now make this explicit. Only in a dream world could I have hoped these things would just happen of their own accord. I now recognize quite clearly that the failure is ours. We simply have not exerted as effective, as aggressive a leadership in stimulating these developments as we might have done. We could make excuses as to why we did not, but the fact is, I think, that the blame is on leadership. This is our function. We cannot expect the community to do this under its own steam.

There certainly is not time to review in detail the entire gamut of intensive medical treatment, and it probably would not convince anyone anyway. I think it quite pointless to try to defend the service in detail against the stereotype of its just being another lousy state hospital. The data which will be presented this afternoon I think will be a much better answer on the results, which speak for themselves.

I will not for a moment pretend that the results are comparable with those of the best medical and surgical practice, but the data

will show that the results in terms of patients who get well and get out and function are entirely comparable with those of the allegedly best psychiatric services given anywhere in the Western World. Of course, they always have been, but this stereotype does persist in the face of all data. We are quite sure our results are comparable.

Measured in terms of dollars, or in terms of ratio of personnel to patients, it is a very bad and very weak service by the usually accepted standards of what is optimum; but measured in terms of clinical results obtained, it stacks up just as well as the best allegations from the best places.

We do have, in effect, a tissue committee. Pre-care, in effect, is a method of screening commitments, whether they should be carried out or not. In our particular situation, pre-care is voluntary. There are no teeth in it. We do not have at present in New York State the social attitudes and the statutory authority to impose mandatory screening of the kind that is in effect in Kansas. That may be quite desirable. We do not have it. So far it is entirely voluntary.

We have an additional tissue committee function in the form of an automatic review of all patients who are still in the hospital six months after admission. This is most revealing, first, as to how very few there are, and then as a really critical study of what goes on in the patient, in the family, and in the hospital in our treatment situation. How do we justify having this patient still in the hospital six months after admission?

I have a notion, partially in response to Dr. Grad's remarks, that the real key to emptying hospital beds is to make sure that people do not get in. I have a notion that, until we have better proof to the contrary than is now available, a great many of our claims for a given procedure to empty hospital beds are exactly like the advertisements for reducing pills which state: "If you take this pill, we will guarantee you will lose weight, provided you also follow the diet." As to our treatment procedures, I will guarantee any treatment procedure anyone cares to name to empty state hospital beds, provided you allow me to prescribe the diet or the intake, as to what is allowed to be taken in and what is not. I hope we will see the time when we

have treatments that will empty beds. So far, I am afraid our experience may be repeating that of the past 150 years—the better the service we give, and the more effective our results, the more customers we will get.

This is the discouraging note that is bothering me. I hope I am completely wrong, but I am afraid that now, with our present technology, weight reduction depends on both the diet and the pill.

DR. ROBERTSON: Thank you very much indeed, Dr. Hunt.

Thank you all very much for a very delightful morning. I would like to apologize to those who could not be called upon, and I hope they will have something to say this afternoon.

REPORTS ON THE EVALUATION STUDIES BEING
CONDUCTED BY THE MILBANK MEMORIAL FUND
ON THE EFFECT OF THESE SERVICES

Tuesday Afternoon Session

Chairman: ALEXANDER ROBERTSON, M.D.

DR. ROBERTSON: It is my pleasure this afternoon to call on Dr. Gruenberg and his team to report on the evaluations of the work in Dutchess County of which you were, in the best possible sense of the word, so delightfully critical this morning. In order to try to get as much discussion as possible, this will be the order of events: Dr. Gruenberg, followed by Mr. Kasius, will present one set of data, and there will then be a brief period of discussion; during the second half of the afternoon, Dr. Gruenberg and Dr. Sohler will present another aspect of the study.

DR. GRUENBERG: I should like to start by saying I felt this morning's discussion and references to the evaluation studies were very reminiscent of some work that was done by a sociologically minded friend of mine who was a Second Officer on a P. & O. liner, and entertained himself on the long trips from London to India by studying the interaction patterns of passengers and crews. He and his colleagues worked out a very systematic sequence of events: at first, the passengers hardly spoke to each other; later in the voyage they began to circulate much more and became acquainted with some

members of the crew; in mid-passage there was a period when they stopped talking to one another and there was very little interaction; and then toward the end of the voyage things speeded up a great deal and many new friendships were made by the end of the trip.

I got the feeling some of you must have had, that perhaps the service people and the evaluators had stopped talking to each other at this mid-voyage point and a certain let-down had occurred in the progress of the venture. I think this has not actually happened to any significant extent, but perhaps we are wondering where we are going and how we are getting there.

I would also like to point out that the evaluation of this particular project does not have quite the role that is sometimes implied in the discussion. We do not have a situation in which evaluators are applying well-established devices for finding out whether the people conducting a particular service are accomplishing what they set out to do. We are not like the examiners at the end of a college course who know what the students should have learned and know how to find out whether they have learned it. As a matter of fact, we are in at least as experimental and adventurous a situation as those who are organizing the services. In some respects we have even less precedent and less experience than the service team to guide us in selecting the relevant information as to whether or not the objectives which they are seeking have been achieved.

Let me point out, in recapitulating what has been said at previous conferences, that there are at least three varieties of questions to which we might have addressed ourselves. Some were touched on this morning. The first group of questions has to do with whether the organization of services did what it set out to do. That is, did the doctors treat the patients in the Dutchess County Unit instead of using the heterogeneous services of the Hudson River State Hospital? Did they emphasize short-term hospitalization in their treatment patterns and in their orientation with the patients? Did they make frequent use of community resources? Did they carry out sensible procedures for easy admission to the hospital? Have they used sensible procedures to hasten the departure of patients from the hospital? Did the patients leave the hospital earlier than in previous years?

Secondly, we can ask whether the services had the consequences for the health of the patient which were intended. It is not enough to get more patients out of the hospital more quickly. It is not enough to make it easier for patients to come into the hospital and to reduce the proportion of involuntary admissions. It is not enough to develop a revolving-door pattern of hospital utilization and to make frequent use of community facilities. All these things have been done, and measures of the extent to which they have been done can be provided.

While these developments are of some use in themselves, they are of small value compared to what is obtained if the patients with psychotic illnesses in Dutchess County recover more rapidly or experience less severe disability than they would have under other conditions.

The third type of question one might ask in an evaluative way is whether the new services have cost more, have given greater satisfaction to the professional staff and to the patient, and were easier to use than other services. What is the nature of the change which has occurred in the organization of the psychiatric services? How does the experience of being a patient here differ from that in other hospitals? These are questions about the way in which the service has been organized.

So the three groups of questions ask whether or not they did what they tried to do, whether they got the results they sought, and how the service to the patients was affected. Each of the questions is legitimate, and we have touched a little, but only partially, on each in these studies.

There is a fourth area which should be mentioned: Value traditionally has something to do with monetary costs. Such costs could be measured in dollars, man-hours, or manpower losses resulting from illness. Our research group has not tried to make any independent appraisal of costs.

I have pointed out these different questions, and most of what we want to report to you is our approach to the questions regarding consequences for the health of the patient. However, I would like to mention a few figures to emphasize some points made at the end of this morning's session about the speed with which patients move through the services.

At the time the Unit started, and for some time previously, about one third of all the admissions to Hudson River State Hospital came from Dutchess County. For many years Dutchess County has had one of the highest admission rates to mental hospitals in the country. The population of Dutchess County represents about one tenth of the population served by the Hudson River State Hospital. The beds occupied by Dutchess County patients today are about 9 per cent of the beds existing in the hospital. So the census of the hospital gets its fair share of Dutchess County residents as compared with the rest of the hospital district, which is a very large area extending along the Hudson River from the northern end of the Bronx to up around Vermont.

During the 12 months ending in March 1962, the hospital as a whole increased its convalescent care case load from 125 to 202. Dutchess County cases were about one sixth of the convalescent care case load at the beginning of the year, and were one quarter of the case load by the end of the year.

Patients in family-care placements from the hospital increased from 145 to 182 during the year, a gain of 37. All of this increase was from the Dutchess County Unit, which now supervises more than one third of all the family-care placements of Hudson River State Hospital.

These are very crude indices of the increased activity in the Unit.

In addition, Dr. Bennett referred to the fact that the first-admission rate had gone up 20 per cent during the past two years. The first-admission rate for the hospital as a whole has gone up 10 per cent during the same period of time. So, in spite of having a very high admission rate when the project started, the admissions are continuing to grow faster than those of the rest of the hospital.

Ten per cent of the hospital district's population produces one third of the admissions, one third of the family-care placements, one quarter of the convalescent-care placements, and yet is less than 10 per cent of the hospital census.

One other point, which was mentioned this morning and which I would like to re-emphasize, is that the annual number of admissions is now greater than the number of beds in the Dutchess County service, which means that by a fallacious method of averaging you

could say the average hospital stay of Dutchess County patients is less than one year. This is fallacious, because over 350 of those beds are occupied by long-stay patients, and the large number of admissions actually goes through about 150 or 160 beds. It is very unusual for a comprehensive mental hospital service to have more admissions than the number of beds during a year. This is a very crude, old-fashioned type of index which still has some use.

With the aid of Mr. Schulman of the Columbia Department of Psychiatry, we have begun to accumulate some information about the way in which the social structure of the Dutchess County Unit creates new working conditions and new conditions for being a patient as compared with existing conditions in the rest of Hudson River State Hospital and in other mental hospitals. This work has just begun, and as yet we have no report on it.

We now turn our attention to this question: Is there reason to think that the mental health of people with mental disorders in Dutchess County has been in any way improved by the development of the Dutchess County service?

From some points of view this is the major question. We have a population living in Dutchess County, for which special services have been provided. The special feature of these services is simply that it is for the residents of that county and that it will provide—in addition to the conventional services available in a state hospital—what Doctors Hunt and Bennett referred to as pre-care, that is, readily available psychiatric consultation when there is a question of whether a person does or does not need mental hospital services. It is a decentralized, flexible, adaptable unit, as you heard this morning. We of the research staff are asked to find out whether the patients are better off as a result of this reorganized service, better off, that is, in terms of their mental disorders. The difficulties from this point on arise from trying to decide which characteristics of which people are most likely to have been affected in a positive way by the program.

In his presentation this morning, Dr. Hunt outlined briefly for you his concept of the way in which a properly oriented mental hospital-community psychiatric service program could minimize

the development of secondary disabilities associated with chronic psychoses, and limit the development of what some have called institutional neuroses and what others have called the social breakdown syndrome.

Since the expected benefits were of this nature, it was decided to concentrate on measuring the frequency with which losses of personal self-care abilities and useful social roles have been reduced in the presence of chronic psychotic illnesses.

We have had to find a compromise position between all the various manifestations of the social breakdown syndrome or secondary disabilities which might be studied and the kinds of information that can be collected on a fairly wide scale. We have also had to define the population in which loss of self-care abilities and useful social roles might be expected to be prevented or mitigated by this program.

In studying this problem we decided that there were two distinguishable populations, and that they would have to be approached quite differently. First, we assumed that there would be a reduction in the incidence of new cases of chronic deterioration among both discharged patients and patients in the hospital, including newly admitted patients. The population at risk of becoming newly deteriorated or newly chronically disabled in the presence of chronic psychiatric illness is defined as the population of Dutchess County for which this facility has been designed. This is one of the features which makes this project and this study rather unusual: that we have sought to evaluate the benefits of the service with respect to the total population of Dutchess County, rather than the more usual method of evaluating it with respect to just those who happen to have used the facility.

However, this is a formidable task which we have had to approach through a series of phases which are now partially completed. We have thought of the entire population of Dutchess County as being at some unknown risk of developing chronic psychoses, and we have thought of the population with chronic psychoses as being at some unknown risk of developing chronic deterioration of personal and social functioning. The evaluation studies are directed to the task of finding methods for measuring the frequency with which Dutchess

County residents with chronic psychoses develop chronic deterioration of personal and social functioning.

We know that there are a certain number of people with psychoses which are not chronic in nature and do not carry with them any significant risk of deterioration. We also know that none of the procedures which were introduced are likely to reduce the incidence of psychotic illnesses in the population or the duration of the illnesses. Furthermore, we know that not all people who develop psychotic illnesses in Dutchess County come to this particular facility.

With all these limitations, we have decided to follow the *incidence of deterioration of personal and social functioning* arising among the population of Dutchess County who do seek some form of psychiatric attention. We have studied, first, those persons who have been in the Hudson River State Hospital, and we began this investigation in June 1960. Our goal was to set up a list or roster of all persons who had received psychiatric treatment from the hospital since 1955 and who were residing in Dutchess County.

On the basis of this roster, all persons who still lived in the county and who were not on the chronic services at the Hudson River State Hospital were regarded as at risk of deteriorating. Then we tried to develop a procedure for finding out how many of these patients or ex-patients had in fact deteriorated in their personal functioning. This could be looked on as a follow-up study.

This is obviously the most important question, and the one emphasized over and over again this morning in the discussion. Later we shall describe to you how far we got in our effort to develop an adequate measure with respect to this particular phenomenon.

I want to pause a moment here, though, to point out that we haven't got any definite data on this question, and we only think that we are now at a stage where we can make a useful, more or less reliable, and valid measure. Hence, we have not yet really begun to evaluate the most important single accomplishment of the service groups.

However, we have another question, which isn't nearly so important, on which we have quite a bit of data. The second question has to do with the patients who were already on chronic services

when the program started. They can be regarded as patients who need rehabilitation or protection from the continuation of chronic institutional experience. These are the patients the Unit inherited from the chronic service of Hudson River State Hospital when the Unit opened in 1960.

We thought they might be rehabilitated more rapidly than they would have been had there been no Dutchess County Unit. It was also thought that among those patients, not seriously deteriorated as yet, the rate of occurrence of new cases of deterioration could be slowed down.

As you will see, in fact, the recovery rate from serious disability among the Dutchess County men has been faster than among their controls during the last two and one-half years of the service.

Mr. Kasius will elaborate on the details of that kind of data regarding these patients, and after that I will tell you about the progress of the incidence study.

MR. RICHARD V. KASIUS: When the Dutchess County Unit was established, it inherited the Dutchess County patients who were already on the other services of the hospital. In planning the evaluation of the Unit, two hypotheses were developed pertaining to this group of long-stay patients:

1. They will show greater improvement in social functioning than they would have if they had remained in the other services of the hospital.

2. They will leave the hospital at a faster rate than they would have if they had not been in the Unit.

Methods

Our first step in the evaluation procedures was to identify all the patients from Dutchess County in the hospital, except those in the admission, medical and surgical, and tuberculosis services, in October 1959, before the Unit opened. There were 449 such patients. As a control group, from which we hoped to estimate what the Dutchess County patients' experiences would have been if they had not been in the Unit, we selected for each Dutchess County patient on each ward the non-Dutchess County patient on that ward closest in age.

In this way the study and control groups were individually matched by age, sex, and ward location in October 1959.

The patients from Dutchess County covered a wide age range. The oldest was 97 and the youngest 18 years. In general, it was an elderly group, the median age of the males being 59 and of the females 61. The dates of admission ranged from 1907 to 1959.

The construction of an instrument to measure the social functioning of these long-stay patients selected for study was necessary for this evaluation. As a preliminary step, a random selection of attendants was interviewed concerning the behavior of specific patients under their care. This served to define those areas of patient behavior and activities which the attendants felt they would know about and the vocabulary they used to describe them. Following these interviews, we drafted a form which asked specific questions about each patient in a randomly selected group, and had the attendants fill it out. Making the modifications suggested by this trial run, we prepared the final version of the schedule.

The plan of the study was to obtain by means of the schedule a description of the behavior of these patients during selected observation weeks. These weeks occur every six and one-half months. The schedule was in three versions, each appropriate to one of the three shifts into which the hospital day is divided. Thus, for each patient during each survey week we would have a set of 21 forms, seven from each shift. Some questions were asked for all three shifts, and others for only one or two. The behavior and activities covered by the schedules may be described by the major heading of each question.

We grouped the following questions as "troublesome behavior": Was the patient regarded as suicidal or were steps taken to see that he did not harm himself? Did the patient in fact harm himself? Was the patient put in restraint or restricted to a particular part of the ward on physician's orders? Was he controlled at night or did he wander and resist returning to bed? Was the patient noisy, threatening, or assaultive? Did he resist eating and did he need much help? Did the patient soil or wet himself, or was he escorted to the toilet but did not soil? Was the patient mute, or did he speak only when spoken to? Did he resist getting up and getting dressed, or did he re-

quire much help? Did he resist going to bed, and, again, did he require much help?

There were additional questions covering more minor manifestations of troublesome behavior, and an explicit statement was required for absence or presence of any of these.

As to socially integrated behavior, we asked about the patient being away from the ward staff and for how long. Did he earn any money? Did he work, and for how long on each shift? Did he attend occupational therapy? Did he do any reading or writing? Did he participate in recreation and of what kind? Did he handle his own money?

We obtained the co-operation of the ward supervisors in instructing the ward staff on how to check the statement describing the most troublesome and most integrated behavior of the patient on that particular shift. During the survey week at the end of each shift, the schedules were returned to our hospital research office, where they were edited for missing or unclear answers. When the attendants for that shift came on duty the following day, they were asked about these questions and corrections were made.

During each survey some patients were on leave or convalescent care, and a few had been discharged. To obtain the information for these patients, interviewers went to the patient's home immediately following the survey week and, from interviews with the patient and his family, filled out the same type of schedule.

Comparability of Study and Control Groups

The two groups, Dutchess County and non-Dutchess County patients, differ in one basic and unavoidable respect, and this was pointed out by Dr. Lemkau at the meetings three years ago. The hospital is in Dutchess County, and most of the county patients are quite close to home, but the control patients are a minimum of 30 miles from home and for most of them the distance is much greater.

When planning the evaluation, we considered some method of using part of the group of Dutchess County patients as a control by not transferring them into the Unit, but administratively this was not possible. Because of this difference we probably should think of the

non-Dutchess County patients as a "comparison" rather than a "control" group.

We gathered information from patients' records on diagnosis, marital status, date of admission, place of birth, and when he last had a visitor, for evidence of comparability of the study and control groups.

The median length of time in hospital since admission was nine years for the Dutchess County patients and 12 years for their controls. Patients with a diagnosis of schizophrenia constituted 45 per cent of the Dutchess County group and 55 per cent of the controls. Slightly fewer than 20 per cent of the patients in both groups had a diagnosis of senile or cerebro-arteriosclerotic psychosis.

The Dutchess County male patients were in good agreement with their controls on these various characteristics, except that a considerably larger number of the controls had a record of never having had a visitor, an expected consequence of the difference in residence. There was greater disagreement between the two groups of female patients. The control patients included a larger number of foreign-born, of schizophrenics, and of patients never visited, while among the Dutchess County female patients there were more who had been admitted in the last five years and who had been visited in the past year.

Subsequent investigation disclosed that much of this difference between the study and control groups resulted from the inclusion among the controls of some patients who had come to Hudson River State Hospital from other state hospitals in mass transfers a number of years earlier. Most of these were from hospitals serving New York City, and the transfers had been made because of overcrowding. There was reason to believe that these patients were probably more deteriorated than the Dutchess County patients with whom they were paired. After several surveys it was evident that, in general, their level of functioning was poorer than that of the other members of the control group and that of the Dutchess County patients with whom they had been matched.

Since we felt this might bias our findings in favor of the Dutchess County patients, it was decided to select another group of patients as

alternates to these transfer patients. This was done, starting with the survey in August 1962, and we expect this new group of control patients will furnish a more valid comparison with the Dutchess County group.

Another investigation, into the age matching of patients, disclosed that although the distribution by age of the study and control groups was comparable, the individual matches by age were occasionally not as close as we would have wished. There were several reasons for this. The matches were made on the wards from birth dates given on the ward cards, and it was found in some instances that this date was incorrect when checked against the date in the hospital record room. In other cases there were not enough non-Dutchess County patients of suitable age on a ward to provide the proper matches to the Dutchess County people. We established a difference in age of under 10 years between study and control patients as the maximum permitted, and replaced the 20 control patients who failed to meet this requirement.

Quality of the Data

Since almost the entire study of this cohort of long-stay patients is based on replies given on the schedules, some reference should be made to what we know, or are doing, about the accuracy of these data. The survey staff is greatly indebted to the attendants and nurses throughout the hospital who filled out, during the first six surveys, approximately 100,000 schedules. The large majority have done a very good job, despite the fact that for many of them it is a time-consuming addition to their work which must be done at the end of a busy eight-hour shift.

The major difficulty in appraising the answers is the lack of any independent observation of the behavior of the patients. We might be able to place another observer on a sample of wards but, because the observer would not know the individual patients in whom we are interested and because of possible adverse reactions on the part of the attendants who regularly fill out the forms, this does not seem feasible. Having another attendant on the same ward, where more than one attendant is on duty, fill out a duplicate set of forms has been

considered, but it would be almost impossible to prevent consultation between the two when making out schedules at the end of the shift. Another suggested method of verification is to interview doctors, nurses, or the patients themselves, concerning the behavior and activities of a sample of patients, and compare this information with that from the schedules.

The most promising approach to this problem is to identify those attendants whose observations of the patients on their wards differ to a marked degree from the observations of these patients by other attendants during the survey week. But we cannot be sure that the deviant replies do not represent more conscientious and more accurate appraisal of the patients' behavior or that discrepancies between replies of the attendants necessarily imply error. Utilizing this approach, however, we may be able to obtain some estimate of over-reporting or underreporting of the prevalence of the various types of behavior and activities of the patients in the study, although it is unlikely that we will be able to make corrections in the responses concerning the individual patients.

Control of the quality of the information on the schedules can be established to a limited extent during the process of edit and review while the survey is in progress. There is evidence that an occasional attendant fills out the form in a routine manner, for example, giving the same answer on a given question for all patients on his ward. Where this has been detected, members of our research staff have discussed this with the attendant, in an attempt to motivate him to a more conscientious performance.

Another problem has sometimes arisen when an attendant is substituting for another on a ward and does not know the individual patients. Here we have tried to help the attendant identify those patients showing any instances of unusual behavior which should be noted on the schedules, and occasionally permitting no answers to questions where there is no other alternative.

Summary of Findings

The Dutchess County males did better than their controls on seven measures: 1. the occurrence of soiling or being escorted to toilet; 2.

starting conversation; 3. working; 4. being away from the ward; 5. occurrence of new cases free of troublesome behavior; 6. occurrence of new cases of adequate functioning; and 7. placement on family care. The Dutchess County females have done better than their controls on only two items: the number being placed on family care and the number doing work in occupational therapy.

Movement out of the Hospital

I should like now to refer briefly to the data we have bearing on the second hypothesis—that Dutchess County patients will leave the hospital more frequently than they would have had they not been in the Unit.

For these patients the most common method of leaving the hospital is by dying. At the time of the fifth survey, in February 1962, 57 deaths had occurred among the Dutchess County patients and 53 among their controls. This constitutes about 12 per cent of the original cohort. Projecting this over the five-year period of the study yields an estimated mortality of 30 per cent at its conclusion. The absence of any real difference between mortality in the Dutchess County patients and their controls is a crude indication that the two groups were well matched with respect to health.

If we consider patients leaving the hospital alive in February 1962, about two years after the Unit was opened, 38 Dutchess County patients were on family care, compared to seven of the control patients. Twelve Dutchess County male patients were either on convalescent care or had been discharged, in contrast to five of their controls. Among the females the difference was smaller, 19 of the Dutchess County females and 16 of their controls being on convalescent care or discharged. During the 26 months between the first and fifth surveys, 19 Dutchess County patients were discharged, of whom 12 had not been readmitted by the fifth survey, and 13 of the non-Dutchess County patients were discharged, of whom nine had not been readmitted.

In summary, more Dutchess County males have been returned to the community than have their controls, but the numbers are small and the difference is nonsignificant, while between the two groups of

female patients there is even less difference. There is a marked excess of family-care placements among both male and female Dutchess County patients.

Changes in Behavior and Function

The investigation of the first hypothesis concerning these patients—that they will show greater improvement in social functioning in the Unit than if they had remained in the rest of the hospital—is based upon these schedules. The discussion which follows concerns the results from the first five semiannual surveys between December 1959 and February 1962.

There are numerous ways in which the large mass of information we have accumulated on these surveys might be analyzed. One of the simplest, which will be mentioned only briefly, is to compare the Dutchess County patients and their controls at each survey on the prevalence of the various types of behavior and activities covered by the schedule.

In the initial survey in 1959, the Dutchess County male patients displayed less noisy, threatening, or assaultive behavior than did their controls; this has continued and in the later surveys this difference between the two groups has increased slightly. Since the third survey the Dutchess County males have a smaller proportion of patients reported as never initiating conversation, and a similar difference has occurred with respect to soiling or being escorted to toilet on the last two surveys. In the area of disturbed behavior, the only real difference among the female patients has been a higher percentage in the Dutchess County group considered self-destructive or suicidal by the ward staff.

The male patients in the Unit have included, in the most recent surveys, a larger proportion working for more than two hours during the survey week than did their controls. They, also, since the second survey, have had more who have been away from the ward more than three hours, and, since the third survey, have done more work in occupational therapy. Comparisons of the female patients with respect to activities disclose real differences only in a greater number of patients in the Dutchess County Unit doing occupational therapy.

None of the other items shows a significant difference in prevalence.

Another technique we have been using is the grouping of responses from several questions to produce two scales as a basis for classifying the patients. One, which for lack of a better term we call the troublesome behavior scale, is constructed as follows: Patients are classified as showing severely troublesome behavior if any *one* of these items is reported during the survey: regarded as actively suicidal; harmed self; put in restraint or seclusion; required physical control at night; assaultive; resisted eating a meal; soiled or wet; resisted arising; resisted going to bed; or did not speak during the entire week.

Patients are classified as showing moderately troublesome behavior if any one of these items is reported: steps were taken to prevent self-harm; patient was held or restricted; patient wandered and resisted returning to bed during the night; required much help with a meal; had to be escorted to toilet; required much help arising or dressing or going to bed; or never initiated conversation during the week.

Patients receiving neither of these ratings were considered as showing no troublesome behavior.

Among the Dutchess County male patients, the percentage with very troublesome behavior was about 20 per cent in the first two surveys, and decreased to between 9 and 12 per cent in the next three. This experience was more favorable in every survey but the second than that with the male controls, who showed 28 per cent with very troublesome behavior in the first survey and 20 per cent in the next four surveys. Among both female groups the percentage with very troublesome behavior varied between 23 and 29 per cent, with no consistent differences between the two groups.

Among male patients, troublesome symptoms are becoming less common and this is more marked in the Dutchess County men than in their controls. The prevalence of patients free of troublesome behavior was 45 per cent among the Dutchess County males in the earlier surveys and rose to 60 per cent in the later ones. Their controls had about 40 per cent with this rating in the first survey and a maximum of 49 per cent observed in the last one. Among the female patients there appears to be little difference between the two groups,

between 42 to 47 per cent being found without troublesome behavior.

The second scale we have constructed is designated the function scale. Ratings are made for this as follows: Patients are classified as having a low functional level if *all* five of these items are always reported during the survey week: never being away from ward staff; doing no work; doing no occupational therapy; doing no reading or writing; and participating in no recreation.

The best rating is given to patients with evidence of an adequate functional level. To receive this rating the patient must be reported as being away from the ward staff at least once for over three hours; either working two hours or more or working at occupational therapy at least once; reading or writing for one hour or more, or participating in active recreation on one or more shifts.

Patients with neither of these ratings are classified as showing an intermediate functional level.

The percentage of patients with a low functional level is usually less than 10 per cent, and there have been no real differences between the Dutchess County patients and their controls in this respect. The prevalence of an adequate functional level among the Dutchess County males was the same as that of their controls, 14 per cent, in the first survey. During the subsequent surveys this decreased among the control patients to under 10 per cent, but there was a slight increase in the Dutchess County group. Thus, the experience of the Dutchess County males in respect to function was significantly more favorable in three of the last four surveys. The percentage of females with this rating has been about 12 per cent in the Dutchess County patients and slightly less among the controls.

Another approach to evaluating the experience of the Dutchess County patients and their controls, utilizing these two indices, is to consider the incidence of new cases of the poorest or best ratings at each survey. At the third, fourth, and fifth surveys, between 5 and 12 per cent of the patients for whom very troublesome behavior had not been reported on any prior survey received that rating for the first time. There is no significant difference between these rates for the Dutchess County patients and their controls. The rate of new instances of low functional level is almost constant over all surveys at

between 1 and 5 per cent. In all surveys after the second, over 30 per cent of the male patients in the Dutchess County Unit who previously had been reported as having some troublesome behavior were reported free of such behavior for the first time. This was consistently higher, in two surveys significantly so, than the rates between 10 and 25 per cent found for the control patients. Among females in the Dutchess County Unit this rate decreased from 36 per cent in the second survey to 10 per cent in the last two. The incidence among their controls was always lower, but the differences were not significant. The rate of occurrence of new cases of adequate functional level was higher for Dutchess County males (between 5 and 17 per cent) than for non-Dutchess County patients (1 to 7 per cent) in all surveys, with the difference being statistically significant in two of them. Among females the rate of occurrence of new cases in this classification were slightly higher for Dutchess County than for non-Dutchess County patients, with the values roughly paralleling those observed for the male patients.

These findings might be interpreted to mean that the Dutchess County Unit is no more successful than the other services of the hospital in preventing the occurrence of severely troublesome behavior or loss of function. The Unit does seem better able to promote reduction of troublesome behavior and improvement of function, primarily among its male patients. More analysis of these findings is needed to see how successful the Unit may be in maintaining improvement in these patients and how much regression may occur.

Summary

After two years of operation, the Dutchess County Unit seems to be starting to induce improved social functioning among its male patients as compared with their controls. This conclusion may have to be modified when more detailed analysis has been made of the effect of the "transferred" patients among the controls, mentioned earlier, after the new controls have been followed for a few surveys. However, it is probable that most of the differences among the two groups of male patients will persist, although the differences may be narrowed. A similar effect on the female patients in the Unit is not

apparent. This may be due in part to the problems created by the increasing number of senile female patients in the Unit. It may also result from Dr. Hunt's promise when the study began that he would do all he could to stir up the rest of the hospital so the patients in the control group would not remain static. It should also be noted that many of the things we are looking for are of low frequency, and very marked differences would be required before we could conclude that real differences exist.

It is obvious that at present we do not have conclusive answers concerning the effect of the Unit on its long-stay patients. But it is likely that, if significant improvement is going to occur among the Unit patients, it should be observable after two or three more surveys.

DR. ROBERTSON: The papers are now open to discussion, but unfortunately for only about 30 minutes. I shall then ask Dr. Gruenberg and Mr. Kasius to reply briefly, to end this section of the session.

DR. HERMAN B. SNOW: Were the people in the control group and in the Dutchess County group similar as far as being on open wards, or having the same sort of programs in occupational therapy or recreation, or did the programs vary?

DR. PLEASURE: You offered one hypothesis to explain why the men showed greater progress as a result of your program than the women. I have another explanation from observation in my own hospital, which is that female patients normally get better treatment from female nurses and attendants than men do from other males. The men started from a lower level and, therefore, showed a greater improvement when treatment was intensified. This is not an original observation. In our culture, men think it is demeaning to do personal, intimate things for other men that a woman, as part of her normal maternal role, does as a matter of course. The warm individual interest which we see so frequently in normal women, which is partly instinctive and thoroughly acceptable in a woman when dealing with other women or men, is rejected by males when coming from another male, for fear of appearing effeminate. For this reason, I think it is frequently advisable to have female nurses and attendants on male wards. With the intensification of treatment, and the acceptance by all concerned of the need for warmth and human interest, the men seemed to improve more because they had farther to go.

DR. ROBERTS: I was wondering, sir, if any record was kept of the staffing patterns in the Dutchess County Unit and the rest of the hospital at each of these six-month intervals. I am a little confused as to whether or not the staffing of the Dutchess County Unit is on the same basis as in the rest of the hospital. I believe basically it is, but I am not sure.

DR. ROBERTSON: Would you like to respond to those three, Dr. Gruenberg?

DR. GRUENBERG: In reply to the first question, as to whether the controls are similar to the Dutchess County patients, they came from the same wards. These controls were picked before the project started. Dutchess County cases were found throughout the hospital, and a control patient, nearest in age to the Dutchess County patient, was picked from the same ward. So they were on the same wards initially. Of course, in the last few years they have not been on the same kinds of wards.

The question as to staffing of the Unit cannot be answered in a simple way. The total staffing in the Unit is proportional to the number of beds in the hospital occupied by the Dutchess County Unit and the number of admissions from Dutchess County, because the hospital staffing ratio is different for the admission unit and for other services. However, in the Dutchess County Unit, this kind of ratio cannot be applied because, as described this morning, the staff available is spread among the chronic and acute patients. You cannot say whether the chronic-patient staffing pattern is the same as in the rest of the hospital. It might be less, because the staff may be paying more attention to the acute cases and less attention to the chronic; or it might be more, because the additional staff allocated to the admissions service is mixed in with the chronic-patient staff. There is no distinction in staffing.

Dr. Pleasure may be right on this question about why the men do better. I would also point out that many of the Dutchess County patients who came from the chronic wards of the hospital are under the care of a woman doctor, which may also make a difference. But there are other factors that we would have to take into consideration. I shall mention only two of them to indicate that we are not at all satisfied with any explanation at the present time.

One is that the chronic-female services in the rest of the hospital may very well have made much more progress during the last few years than the chronic-male services have. The quality of two of the large male services seems not to have changed to nearly the same extent that the two main chronic-female services have changed. They are greatly transformed. From my personal observation, the amount of activity is much greater now than it was a few years ago.

The other factor which is very important in interpreting these data is that there is a much greater tendency for older women to stay on in the Unit than for older men to remain. This has meant some crowding of the female services in the Dutchess County Unit. As a consequence, a larger proportion of the Dutchess County male patients have actually been transferred into this new service. There are still a number of Dutchess County female patients on the wards of the rest of the hospital who have not been transferred because no bed was available in the Unit. We suspect that these are good patients whom the staff liked and didn't wish to transfer, and that they probably have a very good prognosis.

DR. BROWN: Was any analysis done of chronic schizophrenics versus chronic senile patients?

DR. JONES: At this kind of meeting someone always has to get up and talk about "the Hawthorne effect," and I take on this role for the moment.

Having been in two decentralized units in the past, I know the tremendous effect this has on the total hospital. I think Dr. Brooks will bear me out that he suffers heavily from this effect. The specialized unit, of course, receives a great deal of hostility and a great deal of status, and all kinds of feelings are aroused. We are not immune to this kind of effect—not even Dr. Hunt with his preoccupation with the chronic patients.

I wonder if the chronic patients in the hospital as a whole and the chronic patient in the special unit do not in fact have different kinds of significance. I think it very difficult to remain detached from the social forces which one really unleashes in this kind of situation. I would like to know what, if anything, you can do to try to control this situation.

DR. GRUENBERG: This last point is not clear to me. I assume what is referred to is that any change might lead to improvement by itself. This effect has been observed in many industrial experiments regarding production. Certainly, change can lead to improvement by itself, and no one can say that the improvement in the men is not a result of the fact that they were put into new kinds of experience, regardless of the nature of the experience. Even when, as I suspect, we will be able, a year or so from now, to say more categorically how much improvement has occurred, in which diagnostic groups, you will not be able to say that there is no effect simply from being in a special unit. This may affect the staff attitudes. It may affect the morale. It may, in fact, be the only operative variable. Not only that; you will not be able to say what other factors might actually have produced the effects. All we will be able to say is whether there was a change.

We will not be able to attribute the change to any specific feature of the special Dutchess County program. We will not be able to isolate effects and say: Did pre-care help? Did friendly visitors help, if there were any? Did Dr. Bennett's personality help? Did Dr. Hunt's attitudes help? We will not be able to tell you what made any difference, if there is any difference. I think we will be doing well if we can tell you whether there is a difference or not. This is really all we are undertaking to do.

There may be a hidden question in Dr. Jones's remark. I am not sure, so I will attribute it to him whether it is there or not. That is, the attitudes of the different members of the hospital staff might affect the way in which they give us information about the patients. This is a possible source of bias which we cannot absolutely eliminate. The only way to check on it that we have thought of is, as mentioned earlier, to take a random sample of both the Dutchess County and the control cases, to interview everybody who has had contact with those patients during the period as well as the patients themselves, and to estimate how much validity we could attribute to the reports which have been given us by the attendants. We are in a peculiar position here in validating our data and trying to eliminate bias. That is, we are using, so far as we know, the best source of information available. No one knows better than the attendants what

the patient did during the last eight hours. How can you check on them? If someone else were used as an observer, you would use the attendant to check on the other observer because the attendant knows the patient better. We have no one in a better position to answer the questions than the attendant, and he is the one we are asking. To get at the question of bias and variability and invalidity of responses, we would have to use a whole set of other kinds of data and try to make judgments on the subject.

There was another question on diagnosis.

MR. KASIUŠ: Answering the question whether the chronic senile patients did better or worse than chronic schizophrenic patients: Among the females the senile patients did very much worse; among the males the difference was less marked. We have looked into this a little, but it is rather complex because diagnosis is confounded with both time in the hospital and age. In general, the schizophrenic patients did better than the senile patients, other things being equal.

DR. PAUL H. HOCH: I think the studies at Hudson River are of great importance, not alone for the Hudson River State Hospital but for the implications they have for the state hospital service in general. Even though the statistics which were quoted are, if I may say so, not very impressive, a great deal has been accomplished, and I am pretty sure that those who organized the program and executed the program are on the right road.

A number of issues come up, however, which I think will have to be considered in this connection. Some of these issues have already been alluded to this morning.

Suppose you wanted to introduce this type of system in all the hospitals in New York State. It is obvious that this would mean vastly increased personnel, especially professional personnel, in the hospitals. I think Dr. O'Neill made a quick estimate of this. If we add up all the personnel who would be involved it would mean about 2,000 more people would be needed throughout the state.

This leads me to the following point, which I would like to emphasize: Even if appropriations were obtainable, the personnel are not obtainable. I think there is a great deal of preoccupation now with newer psychiatric administration, with smaller hospitals, and

with treating people in different settings; but it has been forgotten that one of the main elements here would be the personnel necessary to carry this out.

Therefore, two issues arise: You will have to have more personnel—and it is highly questionable where we will obtain this personnel in a reasonably short time—or the personnel we have will have to be utilized differently.

This brings up another issue in which I am especially interested in relationship to this experiment at Hudson River. It is obvious that the way these patients are treated is progress. It is progress from the humanitarian point of view. It is progress from the social point of view. Nevertheless, this is still not treatment, especially in a disorder like schizophrenia. If you discharge a patient into the community, he is still a schizophrenic. He probably has some different symptomatology outside, but he is still a schizophrenic. This has to be faced. Therefore, it should be very important to see to what extent the new organization of the hospital could be profitably linked with better treatment methods.

Here I would like to emphasize to some extent what Dr. Cameron said this morning in a somewhat different way. We have been preoccupied, and probably justly preoccupied, in the last few years with how hospitals should be organized, where mental patients should be treated, and what better organization we could possibly provide for them. At the same time, I think we have not paid sufficient attention to our treatment methods, our treatment stereotypes, especially in relation to the type of patients we are treating in state institutions, will have to be reviewed and will have to be, I think, scrutinized in the same way and with the same intensity that we devote to different social organizations.

For instance, the number of chronic schizophrenic patients in the community is becoming a very troublesome issue. You may discuss profitably here to what extent new approaches prevent deterioration of patients in the hospital. In addition, you may discuss profitably how many active schizophrenics there are in the community who are not properly controlled and who, if we continue in our present way, will soon provoke countermeasures and

counterreactions from the community. The treatment of the chronic schizophrenic in the community would be an extremely important issue, and should be far more intensively pursued than it has been in the past.

I am very glad that this study was made, and I hope that some of the studies which were considered by the group in the hospital and by the Milbank group will lead, at least in New York State, to the reorganization of some of our hospitals so that they will be more effective therapeutically. I think what has essentially been contributed here, so far as I am concerned, is that in many instances the patient has been prevented from becoming a so-called "chronic chronic schizophrenic." I would like to emphasize that the schizophrenic is always suffering from a chronic disorder, even in patients who show an acute manifestation.

DR. PAUL V. LEMKAU: Was there any comparison of the Dutchess County and control cases as to the amount of contact with their families or others in the community, or any comparison of number of visits by family to patients?

DR. GRUENBERG: I think we would have to look and see if the information is there. We know that the information is there for the controls, but I suspect that the record-keeping on visitations on the wards by relatives in the Dutchess County Unit is probably not accurate. We have no way of knowing when a patient leaves the hospital and goes to visit a relative. We do not know what he does during his hours away from the ward staff. We could ask him, but we don't. This would be a much more complicated procedure than we have carried out. Because there was an obvious difference between the two groups to begin with, since the patients who do not come from Dutchess County and the control group have very little chance to do any visiting themselves or to be visited, we did not think of this as a useful measure. We assume there is a big difference here, but we are not keeping track of it.

DR. BROWN: Are you prepared to compare your results with other studies analogous to it? With chronic patients being brought into the Boston Psychopathic Hospital, on the whole, the experience is rather analogous. Patients in the hospital for 10 or more years,

average age approximately 40 to 50, were brought on the ward for intensive and active treatment. One striking parallel that comes to my mind is that one-third were discharged in from six to nine months, mostly to family care. It was said that they were "cured" and sent out. The type of program is essentially the one Dr. Hoch spoke about. They were sent out by social workers' efforts; psychologists and drugs played a rather limited role.

DR. GRUENBERG: The social worker staff at the Dutchess County Unit consulted me on a number of occasions about the possibilities of more family-care placement. I think there is no doubt about many patients in the Unit being well enough today to go on family care.

The truth is that nobody wants to go on family care in a mountain farmhouse miles and miles away from the city of Poughkeepsie. The social workers, as I indicated, have increased the number of family-care placements, but in the city of Poughkeepsie, very few people are willing to take patients at the present rate of reimbursement by the state. That is the main limit on this placement today. At the present status of patient-functioning, we could pick out from our survey many patients ready to go on family care if there were places for them in Poughkeepsie.

DR. ROBERTSON: Thank you very much indeed.

(Brief recess.)

The second part of the afternoon, Dr. Gruenberg and Dr. Sohler are going to continue with their report on the evaluation.

DR. GRUENBERG: The population of Dutchess County is around 170,000. At the time the service started, there were about 450 residents of Dutchess County on chronic services in Hudson River State Hospital. The percentages that Mr. Kasius gave you were percentages of this group who had one or another characteristic: who got better or got sicker or had any particular symptom manifestation. There was a similar group of 450 controls.

I would like to make two comments concerning these data. One is that if we had not had a control group, we could have impressed you very well. The other is that if we had had *only* the control group and had told you about Dr. Hunt's general program for the chronic

cases in Hudson River State Hospital, we could have impressed you very well, too. But what we did was to try to find out whether the race between this decentralized Dutchess County Unit and the rest of the hospital showed a winner. They are both moving, and the patients are being slowed up in their deterioration, I think—although I am not sure. It does not look very bad if you look at it from that point of view.

To say the statistics are not impressive as to progress in patient care is a mistake. There is good evidence in these data of progress in patient care, but the Dutchess County Unit is doing only about twice as well in getting patients out of the hospital as the rest of the hospital is doing. The rest of the hospital is getting chronic patients with a poor prognosis out at a moderate rate, too. Some crash programs can show better results on chronic patients.

However, as I indicated earlier, the main feature of this type of revolving-door policy—the main hope for it—has not been so much that it would be of benefit to the chronic patients as such, but that it would be of benefit in the prevention of chronic deteriorated personal functioning.

Before going into some of the more complex issues, I should like to try to explain to you one index of this on which we have good data where the findings are suggestive.

Measurements have been made of the rate at which people go into mental hospitals in the community and of the rate at which they leave mental hospitals. The measurements tell you the proportion of admissions during a given year which has left the hospital within 12 months after admission.

However, this does not really tell you what you are most interested in. What you are most interested in is the number of people who become permanent residents, so to speak, of the institution each year. There may be a small number or a large number in your admission rate. You may have a very high turnover, proportionately, of your admissions if you have a very high admission rate. You may have a relatively low turnover of your admissions if you have a low admission rate. But the really important question, I think, in the light of today's notions as to what a better service can do, is the num-

ber of patients who settle down and make hospitals their homes.

We have tried to measure this. It is not hard, but you cannot get it out of the ordinary way of organizing hospital statistics. You have to do special work in the record room, and then you can get it. If you ask yourself how many people who are residents of this county become 12-month residents of the hospital—12 consecutive months in the hospital in any given year for the first time in that person's life—you can get that number. You can count that number every year. Mr. Kasius and his assistants have been getting it since 1950 for the Hudson River State Hospital. What it shows is that this is a remarkably steady number whether you take 12 months, or eight months, or four months as your criterion. There are some odd variations from year to year which we do not know how to explain, but, on the whole, the number of such new chronic cases does not vary much from year to year (*see* Figure 1).

During the last two years, this number has shown some tendency to drop with respect to people who spend 12 or 20 consecutive months in the hospital for the first time in their lives; and one would guess from this that it will continue to drop because of the rapid rotation, the "churning process" Dr. Bennett referred to earlier. The number has to be quite big before you can be sure there is a drop. At present, it is too small to make a big noise about. He is certainly working in the right direction, and at the present time the number of new chronic residents in the hospital each year is going down, in spite of the enormous rise in the number of people who pass through the hospital for varying periods of time.

But we are not only concerned about the frequency with which patients become chronically institutionalized; we also wish to know whether patients become chronically deteriorated in personal functioning, whether or not they stay in the hospital. To measure this, we must take account of both a rising admission rate and a higher discharge rate. We expect the admission rate to rise as the hospital becomes more acceptable to the community, and more and more minor and early illnesses come to clinical attention. The hospital has deliberately modified its policy about the conditions for discharging patients or releasing them to convalescent care, on the ground

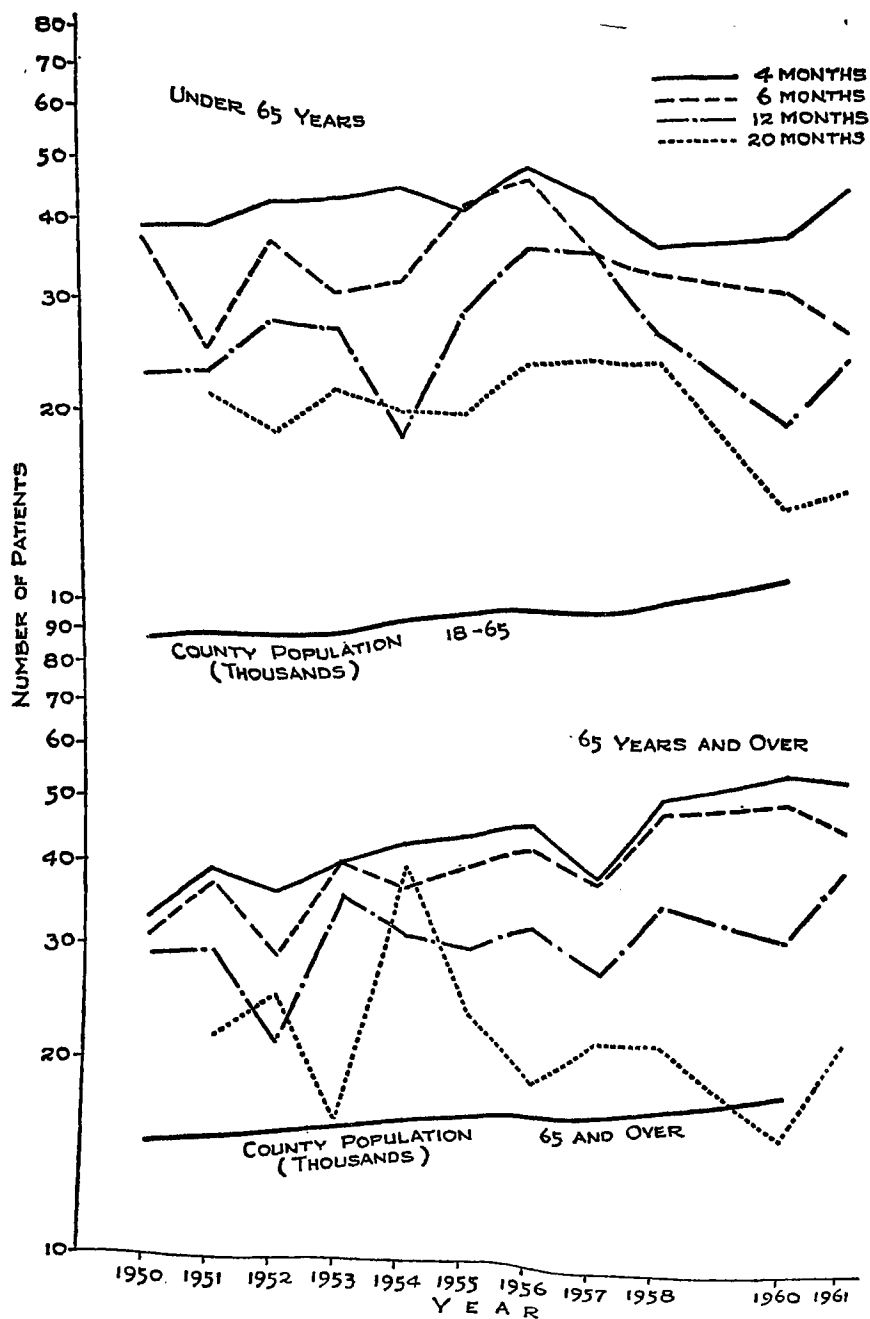


Figure 1. Number of Dutchess County patients in Hudson River State Hospital experiencing specified duration of continuous hospitalization for the first time, by age and year.

that it is not good to keep them too long. If the patient lives fairly near the hospital, and if the doctor will be accessible to the patient after his release, the hospital can afford to let the patient go out on trial while he continues to have rather serious symptoms. This is in contrast to the usual policy of mental hospitals.

Consequently, we cannot use the admission rate or the discharge rate as any measure of success or failure in preventing chronic deterioration of functioning. We would like to know whether the number of new cases of chronic deterioration of personal functioning among the people being served by the hospital is going down, regardless of whether the patient stays in the hospital or is living elsewhere. To answer that you must be able to state who is becoming chronically deteriorated and there is no established measure of this phenomenon at the moment.

So we addressed our attention to getting a measure of how many people with chronic psychoses developed chronic deterioration of personal and social functioning each year in this population of some 170,000.

Ideally, one would like to survey every member of this population of 170,000 once a year to find out whether he is functioning adequately or not. Then one could give the people who are functioning badly a clinical examination to find out which ones have a psychosis, in contrast to those who are functioning inadequately because of kidney disease or heart disease, for example. This plan is not practical, however, and we gave it up very quickly.

So we said to ourselves that the people who deteriorate with chronic psychoses are likely to have received some clinical attention at some time from a psychiatric specialist or psychiatric agency, although they may not have received it recently. We went back to 1956 and tried to list everybody living in the county who had received some psychiatric attention since 1955. This, of course, includes the 450 cases that Mr. Kasius has already told you about. In addition, we needed to know about people who have had psychiatric treatment since 1956 but were not in the hospital in September 1959.

Dr. Sohler has devoted a lot of time to making this list. After she describes to you how we got this list together and how we organized the interviewing with the co-operation of the County Health Department and social workers in the community, I want to give you a picture of where we stand now with respect to whether we can give you some numerical evaluation of the frequency with which this condition arises.

DR. KATHERINE B. SOHLER: In order to measure the incidence of psychiatric disability in Dutchess County, we have set ourselves the formidable task of following all county residents who have had psychiatric attention since 1955. This includes the cohort of long-stay patients discussed by Mr. Kasius, who are surveyed twice a year. All other patients we plan to interview once a year. We have made a register which is simply a list of the patients to be interviewed and selected information about the patients needed by the interviewers to conduct an effective interview.

When this register is complete, it will enroll all Dutchess County residents over 15 years of age who have been seen since March 31, 1955, either by a psychiatrist or at a psychiatric facility; who have been seen, that is, at least once, and who have had a case record opened.

In order to be registered, a patient does not need to be treated or even diagnosed. The only requirement is that he was seen once. Actually, very few are undiagnosed. In some psychiatric facilities, a person may not even have seen a psychiatrist, but usually his case has been reviewed by the psychiatrist in charge.

We are not limited to Dutchess County facilities. The patient may have had his care elsewhere.

Our definition is broad, then, and our register is quite inclusive. Children are excluded only because they are not at risk of entering the Dutchess County Unit.

Alcoholics we still register, but no longer interview. It was decided recently that alcoholics would not benefit from the kind of care they receive in the Unit; that is, deterioration cannot be prevented by the Unit. Therefore, we excluded from our study all alcoholics without other psychiatric diagnosis.

In addition to the Dutchess County Unit itself, we get names from Harlem Valley State Hospital; the All-Purpose Mental Health Clinic in Poughkeepsie—the community clinic; the Day Care Center; and the Veterans Administration Hospital in Montrose. In time we hope to gain co-operation from all private psychiatric institutions, the psychiatric facilities of general hospitals, and all private psychiatrists.

The register is ahead of our interviewing program. So far almost all interviewing is confined to Dutchess County patients who have been admitted to Hudson River State Hospital.

From each facility we obtain an initial list of all patients who were in that facility in 1955, and then reports of new admissions from Dutchess County. If we can, we also get a carbon copy of the standard statistical sheet—the admission sheet for the hospital or the termination form for the clinic.

A committee was set up by Dr. Hoch in 1960 to supervise the register's handling of confidential information about patients. We keep our register under lock and key. We carefully screen our clerical staff. When they are available, we try to employ record room clerks from other institutions to compile our lists and to obtain any information that we may need from the medical record.

We do need some information from the medical record which does not appear on the standard statistical sheets. In particular, we need to know the names of relatives who are informed that the patient has had psychiatric treatment, since the interviewers must not inadvertently tell this to anyone, even to a relative, who did not previously know it. They also need to know about ancillary conditions that would complicate the interview or affect the patient's reliability as an informant—deafness, language barriers, and so forth.

We divide the year into 10 interview periods, in each of which a 10 per cent sample of the register is interviewed. Patients are randomly assigned to a five-week interview period according to the terminal digit of the patient's case number. If the patient is back in the hospital when his turn comes, his behavior is recorded for one week by attendants. If the patient is out of the hospital when his

turn comes—most of our patients are out of the hospital—an interviewer obtains the information retrospectively from either the patient or another member of his household, usually in the patient's home. By far the greater part of our information is obtained from the patient himself, or at least in his presence. If patients are on family care, their behavior is reported by the caretaker. If patients are on convalescent care, we tend to interview the custodian, but this is not a rigid rule.

Interviewers are expected to exercise judgment about the reliability of the patient as an informant and, if in doubt, to interview a relative or some other member of the household. This is sometimes easier said than done. If the patient lives alone—and we have quite a few who live alone—the interviewer must do the best he can. One of our patients, for example, is severely retarded and has a speech defect. He lives alone in a shack, and his only neighbors are an obstreperous dog and another mental defective who also has a speech defect.

The questions we ask the interviewers are the same as those asked the attendants in the hospital described earlier by Mr. Kasius, but the approach is different. The interviewers are expected to exercise judgment and tact, and obtain the maximum information without alarming or offending the patient.

Many of our interviewers are already known to the patient. Those on family care and convalescent care are seen by members of the Dutchess County Unit Social Service, usually the regular worker at the time of his regular visit. A small sample of clinic patients is being interviewed by social workers in the All-Purpose Clinic, and usually the social worker conducting the research interview is the one who handled the clinical case. Former hospital patients who later attend the clinic or the day-care center are interviewed by their own social workers in those facilities. These interviewers are well qualified to hold the patient's confidence and to assess his reliability.

The chief hazard of this arrangement is that the interviewer may be tempted to sacrifice research standards to clinical considerations or to his own comfort in the interview. He may be afraid of spoiling his rapport or rattling the patient by asking certain kinds of ques-

tions. This problem we try to handle by briefing sessions and demonstration interviews.

Discharged patients not under the care of social service are interviewed for the most part by nurses of the Dutchess County Health Department and staff members of the Visiting Nurse Service, a private agency. Most of this work is done as a public service with the blessing of the agencies concerned.

The overflow and the more difficult cases are handled by highly skilled supervising nurses from the Public Health Department, acting as our overtime employees. Some difficult cases are handled by a male nurse who teaches at Dutchess Community College and who has had both state hospital and public health experience.

These nurses are seldom acquainted with the patients they interview. Very few state hospital patients are known to public health personnel. We do not fully understand why. These few are assigned to a nurse who does know them.

The public health nurses have been very helpful to us, not only as interviewers but as detectives. Their experience in public health work is highly relevant to our program. They are adept at tracking down the elusive and persuading the reluctant. They are well known at such organizations as the Salvation Army, the Police Department, and Welfare. Their association with the Health Department gives them easy access to homes without explaining what they are after until they make contact with the patient.

Also, their participation in this project has helped to break down the well-known "iron curtain" between state hospitals and community agencies. Nurses from the County Health Department and Visiting Nurse Service meet once a month with psychiatrists and social workers of the Dutchess County Unit and representatives of other agencies, to discuss cases and solve interviewing problems. New insights have been disseminated, and the nurses have begun to take a far greater interest in all cases with a history of mental illness.

The patient also may benefit not only by improved communication between the services and the pooling of information about his case, but by immediate service as a result of the research interview.

If a nurse finds the patient very upset, she may refer him to Dr. Bennett for pre-care or to the day-care center. This may mean, of course, that our subsequent findings are influenced by the improved service or earlier care resulting from the existence of the program.

The interviewing program, then, contributes to improved communications between the hospitals and the community, while evolving effective techniques and a well-trained staff for the study of psychiatric disability both within and without the hospital walls.

Incidental to its main purpose, the register is recording information which is roughly comparable to what is being collected by other psychiatric registers, in Monroe County, for example, and by Mr. Patton's statewide register for New York State. Unlike the other registers, we are also gathering information about patients who never return to care. These data may be useful to the epidemiologist as well as to those who plan for better services in the future.

DR. GRUENBERG: That gives you some idea of the operation entailed in getting the kind of information we want.

Before this was started, the staff was joined by three young people fresh out of college who were looking for summer jobs. I wasn't sure this type of follow-up could be done, but I took them on and the three of them started running around in automobiles trying to locate these people and find out what difficulties were being encountered, knocking on the door and introducing themselves as from the hospital, and finding out how the patient had been doing. They proved the feasibility of the procedure. It has grown, as you have seen and heard.

Early this summer, two years after we began trying to get this operation rolling, we decided we had reached a point where we could find out whether we were getting any data that could be used. For that purpose I took one of the 10 per cent samples. As Dr. Sohler explained to you, we have the whole population we are interested in divided into ten 10 per cent random samples. Each one gets its interview during a particular five-week period.

I should mention—I do not know whether he wants to take credit for it or not—that I got this general design and notion from a conversation with Dr. J. N. Morris in London a few years ago, just

before we planned this study. In talking over this problem, he pointed out that the ideal plan would be to get the whole community organized and all your informants organized with a lot of preparation, and then for one day or one period of several days get a complete prevalence count of the phenomenon we were interested in. This would be better from the point of view of a single count, and might even be better from the point of view of what we are doing, but for various practical reasons of staffing and organizing we decided to believe that this is equivalent to each person's having a chance to exhibit the phenomenon, of being counted, during his arbitrarily selected observation period. These five-week observation groups are spread evenly throughout the year among our whole population, and our interviewers are constantly at work gathering data, but always on the patient whose turn comes up during that particular period.

We selected a 10 per cent sample that was due to have been interviewed last June, and I have analyzed this in a crude fashion to get some idea of where we stand. I excluded all those cases in our register who came from other sources except Hudson River State Hospital. I did this for two reasons. First, we are very incomplete with respect to some of these other sources at this time, but we are absolutely complete with respect to people who have been in Hudson River State Hospital. Second, people who have had other kinds of psychiatric attention I estimate are at even a lower risk of illustrating the kind of deterioration we are concerned about. I wanted to get ideas about the following: Do we have a big enough population? Is the phenomenon frequent enough to be observed? Are we adequately covering the population that we decided to cover?

This 10 per cent sample gave us the following data:

There was a total of 164 people, which means that there are at the present time 1,640 people in that population of some 170,000 who, at some time or other, have been in Hudson River State Hospital. However, we had to subtract 55 of these as not being at risk. I will explain that to you in a moment. That leaves approximately 109 at risk, yielding an estimate of approximately 1,000 people in this category.

Of these 109, from the interview data we can say 20 have some significant sign of deterioration. I shall tell you more about that in detail in a moment. We can say definitely 25 have no signs of deterioration whatever; that is, during their observation week they functioned more than adequately and had no troublesome symptoms. There is a group of 33 unknown at that particular moment, and there is a group of 31 on whom we do have information and who have only very mild evidence that something might be wrong. The 31 people in this very mild category had slight evidence. For example, if they did not read or write, or take any part in any active recreation, and did not happen to go to a show or turn on the television for a few hours, they would be put in this very mild category. Assuming that they did work, that they were away on their own a good part of the week and had no troublesome symptoms, the fact that they had one little thing wrong would put them in this mild category; but everything else was all right. I have not considered these people as seriously deteriorated.

Of the deteriorated group of 20, one was very severe. By very severe, we mean that the patient had some serious troublesome symptom at least once during the week, and that he had no function, that is, there was no work, no play, and he was never alone (never on his own). There was only one such person, and that person was in the hospital at the time.

There were five severe cases. That means they had either a very troublesome symptom and a low level of functioning or no functions and some mildly troublesome symptoms, but one or the other was at a very low level. All five of them were in the hospital.

There were five who were moderately deteriorated, as we called it. This means they had some troublesome symptom but had very good functioning, or some very troublesome symptoms but were functioning at a high level, or were functioning at a low level and had mild symptoms. There were five of them, and three were in the hospital.

Nine were mild cases. That means either that they were functioning adequately and had some mildly troublesome symptom, or that they were functioning a little less than adequately and had no

troublesome symptom. Of these nine, one was in the hospital.

Altogether, therefore, you see, there were 10 people outside the hospital, eight mild and two moderate, a total of 10 people outside the hospital who were somewhat deteriorated.

Taking this whole group of 20, the next step was to see if we could estimate how long these people had been at that particular level of functioning. Before trying to get a history from their families and friends, we decided the simplest thing to do was to read the medical record in complete detail. This I did. I tried to be very careful not to draw undue inferences from the record; yet, even so, certain things stood out quite clearly.

You recall I said there were 20 people with some signs of deterioration in this population of 170,000. Of these 20, eight clearly were at that same level of deterioration prior to 1960. Half of those eight were in the hospital when the project began and had been continuously in the hospital since then. The reason they are not in the cohort study is that when the cohort study was drawn they were either on the admissions service or the medical and surgical service, and people who at that time were on one of those two services were not included in the cohort. So we pick up an additional four whom you might consider as being in the cohort. The other four also had been clearly ill and clearly at the same level of deterioration in their functioning prior to 1960.

During the calendar year 1961, we could locate five new cases of deteriorated functioning. During the calendar year 1960, there were four cases that had an onset of this condition, from a study of the medical record. In two or three cases I was unwilling to commit myself as to the year of onset; but at this point we stopped this preliminary analysis because the whole object is simply to find out roughly how many you can expect in each of these categories. The answer is that each year 40 or 50, and maybe 60, people in Dutchess County would become newly deteriorated in personal functioning and would be detected by the methods we are now using.

I will give you a little background information about the people on whom we did not have these data. You will remember that I removed 55 people from the table before we started. These 55 included

13 alcoholics. We did this partly because it is a practical matter and partly because the Unit has changed its policy radically with respect to simple alcoholic cases. If there is any other diagnosis, of course, we keep them. If people are admitted briefly because of alcoholism with no other psychiatric diagnosis, the Unit has tended to discourage admission, for we feel we do not have very much to offer them. They are also the hardest cases of all for us to follow. They are not at risk of deterioration from chronic psychoses until they show some other manifestation. That is a significant group in size, though.

TABLE 1. PRELIMINARY CALCULATIONS ON THE PREVALENCE OF
DETERIORATION IN DUTCHESS COUNTY RESIDENTS WHO WERE
FORMERLY HOSPITAL PATIENTS, JUNE 1962

A random 10% sample contains	164	persons
Dead or emigrated	42	
Alcoholism, uncomplicated	13	
Remain for investigation	109	
Significant deterioration	20	
By level		In hospital
Mild	9	1
Moderate	5	3
Severe	5	5
Very severe	1	1
	20	
By date of onset of the deterioration		
Before 1960	8	
During 1960	4	
During 1961	5	
Undetermined	3	
	20	

Ten patients had died by this time, by June 1962.

Twenty-two of 164 people who were former patients had moved out of the county. They were not part of our population any longer. Some people might argue about these migrants, and there is a good argument there. We maintain that we shouldn't include both in-migrants to Dutchess County and out-migrants from Dutchess County. The out-migrants from Dutchess County can no longer benefit by Dr. Bennett's service. They live some place else now. We are counting everybody who has moved into the county recently and

excluding everybody who has moved out of the county. They must make a real, permanent move to fall in this category. People away on visits are not treated in this way.

The by this time unknown seem to be a very large group, but they are not an index of our potential, that is, how many unknowns we would have if we continued to pursue this objective. Only three of our unknowns are outright refusals. We have enough information about these three cases to know they are not seriously deteriorated. They are paranoid. They do not want to be bothered. We have contact with relatives and we know more or less how they are functioning, but we do not have this detailed information, so we call them unknown.

The "not located" constitute a group of 10. This is a very hard group to make smaller, but it could be done.

The other 23 of this group had not really been tried. That is, no contact with them had been attempted. Of those, we know the location of 10, but for various administrative reasons efforts had not been made to reach them. The other 13 have not even been looked for. No interviewer who has been given the assignment has taken the trouble to say, "Today I shall try to find this case." This is a manpower problem. We do not have quite enough people to keep up with the load.

Coming back to the table again, I want to emphasize the main numbers here. It comes to four or five or maybe six new cases in the 10 per cent sample, which gives us a crude measure that probably 40 to 60 new cases of chronic deterioration occur each year in this population.

I call it "chronic deterioration," in spite of the fact that we have not actually measured the duration of this episode of deterioration. However, I am convinced that this is a soluble problem. Each of these new cases should be followed periodically, perhaps monthly, for several years until we know whether it is chronic or simply an acute episode of failure to function.

In summary: I have tried to describe the method we have developed, the preliminary findings based on the sample, and my general impression that this is now a soluble problem. What remains unsolved is probably soluble.

I have the impression that we do not have to try to follow 100 per cent of the population who have had psychiatric treatment. With the numbers we are getting, we will do adequately with something less than 100 per cent. This means we can concentrate our available interviewers on a smaller number and get rid of some of our unknowns.

I think that we have a fairly objective measure. There are still problems of reliability and validity to be investigated, but my own impression, from having worked with this group for two years, is that if it is worth the trouble, it can be done. It is a lot of trouble, but it will give you a good measure of the frequency with which the ex-psychiatric patient does fall apart and become troublesome in the community.

I believe this study will answer Dr. Hoch's question as to how many of these patients are troublesome to other people in the environment. I did not realize this question was going to come up, so I haven't examined the data from exactly that point of view. But of these 20 people, my recollection is that no more than two or three showed episodes involving acting out that was very disturbing to other people. There was no episode of serious assault, but some argument or fight might have occurred which placed some people in this group. This is a question which I believe is now answerable. I believe we have a technique which, when improved, will give us useful clues as to what is going on.

I should emphasize the fact that 40 to 60 cases of new chronic deterioration arise each year still does not tell you whether Dr. Bennett is succeeding or failing, because we have no idea how frequently such deterioration in functioning arises in other populations. In order to answer that question, one would have to have some sort of similar measure on another population which was not receiving this type of rapid, intensive service.

DR. ROBERTSON: The papers are again open for your discussion.

DR. HAROLD C. MILES: This is a very stimulating discussion to a person who is involved in operating a register in another area.

I should like to suggest that there obviously is need to take advantage of opportunities in different communities in which different

types of services already are in operation, to study the results of these different services. This would introduce a large number of technical problems which would require a great deal of study and effort. But I think the measurement of deterioration, or something similar to it, must be applied from community to community, because I do not have much hope that, in one area like Dutchess County, it will be possible to introduce in succession all of the different kinds of therapeutic approaches which might conceivably make a difference in this measurement, or other measurements, of the impact of services.

This morning we heard a great deal about the need for an intensive type of psychiatric service akin to the services of departments of surgery and departments of medicine in general hospitals with high standards. When Dr. Hoch and Mr. Forstenzer are presented with the possibility of underwriting this type of service with tax funds, and when boards of supervisors of counties are presented with the same possibility, they would like to know what the results will be. For example, if you hospitalize patients in general hospital psychiatric units at three to four times the cost of hospitalizing the same patients in a state hospital, is there any difference in the results?

This is a plea to make use of the psychiatric registers in places like the State of Maryland, Monroe County, and Dutchess County, to get some intercommunity comparisons.

MR. ROBERT E. PATTON: I was not able to follow all of the figures as Dr. Gruenberg presented them. I was particularly wondering if you could select from them a comparison between the number of deteriorated patients in the community and the number of deteriorated patients in hospitals. It seems that the vast majority of the deterioration is in hospitals, which brings up the possibility that release from hospital may be a very valid and practical measure of the prevention of deterioration.

DR. GRUENBERG: I do not think it is a very good measure of deterioration, but I will be glad to answer your question. The reason it is not a good measure of deterioration is that it has so much to do with policy, family attitude, and doctor's attitude. The very severely deteriorated patients we found, with no function, giving plenty of trouble, were in the hospital. The five with severe symptoms were

also in the hospital. But of those with moderate symptoms, three out of five were in the hospital, and of those with mild symptoms, one out of nine was in the hospital.

DR. GRAD: Do you have a comparison of the ratio of patients in the hospital to the number of public health nurses?

DR. GRUENBERG: No.

DR. JONES: I want to ask one question, because these figures seem to be so much at variance with the figures of Dr. G. W. Brown on the London sample. There the disturbance within the family was very great, and there seemed to be a serious question about the advisability of these patients being at home because of the effect on the economy of the family, and so on.

Again, I want to get clarification from Dr. Grad, if I may. From what little her group has published, it seemed to me they were sounding a warning note about releasing chronic patients to the general population. I am muddled now because Dr. Gruenberg's figures are so impressive and so encouraging. Is there a difference in the type of patient in the relatively rural or nonurbanized population that might in some way explain the apparently greater problem in London?

DR. GRAD: I am very reluctant to speak before we complete our study. We are measuring the effects on the families of patients treated at home and comparing them with the effects on the families of patients treated in the hospital. We find that if there is a very careful selection of patients going into the hospital, taking into account the problems that they cause to their families, then we can reduce the extra burden put on families. So, in comparing two samples with different types of service, we are doing what Dr. Miles was just advocating. We find that in various aspects of family life and functioning—income, employment of other members of the family—the families are slightly worse off when they have the patient staying at home, but not significantly so. A community care service can relieve severe family problems by carefully selecting the patients who are going into the hospital.

DR. BROWN: The findings at this point are that 1 per cent of the population has been or is in Hudson River State Hospital since about 1956, or roughly 1 per cent.

DR. GRUENBERG: Not alive and present and without alcoholism. It is less than 1 per cent.

DR. BROWN: What about the total register? What per cent, cumulatively?

DR. GRUENBERG: That would be almost twice as great. We do not know. I would estimate it to be almost twice as great.

DR. LEMKAU: I was very much interested in a rather passing remark that Dr. Sohler made—that very few state hospital cases were known to the public health nurses. In Montgomery County, Maryland, 30 per cent of the patients coming out of state hospitals are known to the public health nurses. That county has approximately one public health nurse to 4,000 population. What is your distribution of public health nurses in Poughkeepsie?

DR. ROBERTSON: Dr. Patrie, would you care to answer that question?

DR. LEWIS E. PATRIE: We have 15 generalized public health nurses for Dutchess County exclusive of Beacon, a population of about 162,000. That is a ratio of 1 to slightly over 10,000. There are also two visiting nurse services which provide home nursing. This low ratio partly explains the difference. Dr. Gruenberg has suggested another explanation. He indicated that the population at risk of entering the state hospital probably represents all economic groups of the population, whereas the group visited by public health nurses is more narrowly limited to the lower socio-economic level. Although many of our services are available to all, most of our service is to those who are not so well off financially.

I am glad to have a chance to stand up, and I want to say that our agency is very happy about the relationship with the Dutchess County Unit. The nurses show increasing interest and enthusiasm for this sort of activity. We also benefit from the consultation service that Dr. Bennett and his staff are providing.

DR. ROBERTSON: Thank you very much. I think this note of collaboration between the mental health and public health services is an appropriate one on which to call the public proceedings to a close, unless Dr. Gruenberg wishes to say something more.

DR. GRUENBERG: I would like to comment on two points.

One is Dr. Lemkau's point that 30 per cent of former mental hospital patients are known to public health nurses in Montgomery County. I am not sure the data are comparable. Convalescent-care patients were not included in the group we turned over to our nurses, and 30 per cent is not very different from "very few" when you are trying to contact all families of state hospital patients. I don't really know what our percentage is. We just know we have to make a new contact with the majority of former patients.

As for Dr. Jones's comment and his comparison with the London study, I would like to make this point: I do not know all the facts by any means. I was rather favorably impressed, as Dr. Jones was, by the results on this 10 per cent sample so far. However, I think the policies are very different. Dr. Bennett does not hesitate to consider hospitalization for very minor reasons. In our program there is no effort as such to keep patients out of the hospital. I think it is very confusing to compare a program where the main object is to cut down the admission rate and a program where the main object is to get appropriate use of the hospital for constructive purposes. I do not know what you would find if you asked the same question in other areas.

DR. ROBERTSON: Thank you very much. I do not want to close without repeating my thanks to all of the speakers, and once again especially to Dr. Hunt whose presence at the Milbank conferences in his present capacity may be at an end, but which we have every hope and expectation will be repeated in other capacities in the future.

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PARTICIPANTS AT THE ROUND TABLE
ON PROGRESS REPORT
OF THE DUTCHESS COUNTY UNIT

THIRTY-NINTH ANNUAL CONFERENCE
OF THE MILBANK MEMORIAL FUND

September 18, 1962

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II. DECENTRALIZATION OF MENTAL HOSPITALS

SEPTEMBER 17 AND 19, 1962

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INTRODUCTION

The transition of state hospitals from custodial institutions to open, therapeutic, community-oriented, comprehensive psychiatric services requires significant and difficult administrative changes.¹ These changes were characterized by Dr. Frank G. Boudreau, then President of the Fund, in his letter of invitation sent to the participants of this Workshop:

“In the past few years a number of overcentralized state mental hospitals have been experimenting with a plan to decentralize their operations. The ‘section plan’ has existed in several states for some time and has been a response to the excessive size of hospitals and the depersonalization of the staff-patient relationships. The ‘section plan’ breaks the overly large hospital into ‘sections,’ each of which is a more or less comprehensive psychiatric institution; patients on admission are assigned in rotation to a ‘section’ which takes comprehensive responsibility until the patient is discharged.

“In addition, in a few states an additional step has been taken by allocating a portion of the hospital’s district to each section. By this means it has been hoped that the ‘sections’ will become more closely integrated with the services and professional workers in the subdistricts with which they are identified.

“These localized sections of our mental hospitals have

been operating with considerable success where they have been tried. They have also begun to develop a number of new administrative problems. Some of these problems seem to stem from the decentralization of the large hospital's authority and control. Others seem to arise from the steps which bring the mental hospital into closer interaction with local resources." The Workshop was called "to give this group an opportunity to exchange frankly their experience with these administrative and organizational problems, and their current and projected plans."

The participants were assured at the opening of the meeting that the stenotypist's script would be used only to prepare this report, in which no remarks would be attributed by name. Previously, the co-ordinator had visited all the participants, and other representative leaders, concerned with new patterns of psychiatric service organization. This helped him bring to the Workshop an up-to-date acquaintance with current developments. The agenda for the Workshop emerged from the survey's initial listing of the issues raised by these innovations, and that same listing has become, with revisions, the framework for organizing this report.

The co-ordinator takes responsibility for having selected and summarized the lively discussion according to his best judgment as to which points would be of most value to those working in the field.

The most striking feature of the meeting, as a whole, was the fact that the participants had become interested in the various features of decentralization from diverse viewpoints and varied motives. One participant said that he had no interest in decentralized comprehensive units, but found them to be a good way to intensify the development of an open, flexible hospital responsive to and in close relationship with its community counterparts. This could not be done in a 5,000-bed hospital. Another saw the comprehensive units as the best way to make use of a staff, short in both numbers and prior training, to bring the patients into closer participation with the staff's work. Others saw the decentralization into comprehensive units as a method of raising standards and of justifying increased personnel because of more intensive patient care. These diversities of motives

are touched on in some detail in the chapters on transition and on evaluation, but in spite of their importance they did not dominate the discussions. Despite these diverse starting points, the experiences had so much in common that most of the time was spent in exchanging views on the general principles involved, and the largest part of this report attempts to synthesize them.

One important difference in the experiences reported has been preserved in this report. For some participants the topic was the "section plan," which consists of breaking the large mental hospital into comprehensive sub-hospital units, while for others it was breaking up the very extensive hospital districts whose residents must be served so that a more or less independent component of the larger hospital serves a smaller area. In the long run, while both lead to about the same pattern of operation, the section plan is described in the first chapter because it is older, and because it has succeeded in introducing some improvements without simultaneously allocating subdistricts to the comprehensive units. This pattern makes sense to the hospital administrator who is preoccupied with the problems of internal hospital administration. The breaking up of hospital districts makes sense to the hospital director preoccupied with integrating his services with those of the communities his hospital serves.

These two patterns tend to fuse in time and result in decentralized, comprehensive units attached to their own localities. The third chapter describes the changed functions of central hospital administration, with particular emphasis on the switch from line-to-staff functions of the senior professionals. The varied methods of change in different types of mental hospitals are described in the fourth chapter. The participants agreed that while hospital administrators can learn from the experiences of those who have gone the same way before, no standard road can be constructed and each institution will have to work out its own sequence of steps.

In the final chapter, those parts of the discussion which touched on the values of the new system, on ways of objectifying and testing the values of decentralized units, and the paucity of available techniques for providing solid evaluations of new administrative arrangements are summarized.

1. THE COMPREHENSIVE UNITS

THE WORK PATTERNS IN THE UNIT TEAM

When a centralized hospital is reorganized into comprehensive units, a new spirit develops in the wards. Patient and staff morale improve, an atmosphere of optimism becomes general, staff and patients show an increased involvement in the life of the wards, the patient census tends to drop, the length of stay of newly admitted patients becomes shorter, and there are other signs of a new, and generally more desirable, pattern of work.

These changes seem to come from an entirely new set of working relationships which develop in the decentralized units, or sub-hospitals. These new relationships appear to result from certain major changes in the methods of work.

First, each unit is comprehensive in the services it renders and does not look outside itself for help when the patient's condition changes.

Second, as a sub-hospital unit, the unit staff supervises itself; each worker has only one boss. For example, a nurse is responsible only to the unit leader rather than to both him and the director of nursing in the hospital's central administration. In this way, supervision of each worker is unified.

Third, neither patients nor staff ordinarily move from one unit to another but stay in the same unit as long as they are in the hospital, thus largely eliminating interservice transfers.

Since each unit is supposed to provide a comprehensive service, all occupations are represented on its staff: psychiatrists, psychiatric nurses, social workers, psychologists, occupational recreational therapists, psychiatric aides and attendants, housekeeping and secretarial personnel. Since the unit's personnel include all special skills present in the hospital staff, it is comprehensive, and it is expected to be able to meet all the ordinary needs which patients present throughout the course of their hospital stay. Exceptions are noted at the beginning of the third chapter.

This staff and its patient load occupy the physical facilities assigned to it by the parent hospital. The unit then operates very largely as an independent entity. In order to ensure none of the units being in any way a specialized service, the means of assigning patients to each unit must have no connection with diagnosis, age, duration of prior hospital stay, particular service needs, or behavioral problems. Some arbitrary rule must be developed in each hospital which makes patient assignments without bias regarding any of these factors. Then each unit will have a cross section of the entire hospital population (with the exceptions noted at the beginning of the third chapter).

The number of staff members who are involved in the care of each patient, and who must co-ordinate their work in the care of a given patient, is reduced. Simultaneously the number of colleagues any given staff member must learn to work with is limited to the number working in his or her unit. Staff members do not turn for instructions to the higher ranking members of their own profession in the central office. They work out their problems at the unit level. This places more responsibility on the staff in each unit. It leads to more frequent interoccupational consultations at the unit level. Decision-making about the transfer of a patient to another service is replaced by decision-making about what to do regarding the patient's new problem. The people who decide what to do are the people who must do it! Hence the energy which would otherwise be used to

formulate a problem so as to justify a transfer must be used to formulate a course of action to meet the patient's needs. Communication networks are greatly reduced. There is rarely a need to communicate a decision that something should be done since the decision-makers and the "doers" are the same people.

In hospitals where interservice transfers are common, a staff is frequently confronted with a transfer from another service as it succeeds in emptying a bed by discharge to the community or transfer to another service. Since transfers between units do not occur in the hospital with comprehensive units, every time the unit staff succeeds in discharging a patient to the community it reduces its inpatient census by one. This experience of having the work load lightened by their successes enhances staff morale. The staff becomes happier to see patients leave the hospital. The census tends to drop. In some hospitals the price of success in rehabilitating patients has been the receipt of patients from other hospitals or other services which have not been successful in their rehabilitation program. Success was penalized, not rewarded! In some states it has been necessary to persuade the state administration to stop interhospital transfers in order to allow the staff to experience the benefit of their increased successes.

The change in the patient's life is even more marked. The number of staff members that will deal with his case is sharply reduced. He is rarely seen by any staff member except those of his unit. He more readily finds out who is responsible for his care and participates more readily in his own treatment. The patients he spends his time with are in the same unit and stay with him until they or he leaves the hospital. Hence he comes to deal with fewer people, and the possibilities for sustained relationships with both staff and fellow patients increase.

All of these factors make the unit less impersonal and more intimate than services tend to be in centralized hospitals.

All of the special skills and resources needed for every patient in every phase of each disorder cannot be provided in each unit. Some are needed too rarely to be provided. And, as will be described later, it is not possible for all of the legal, administrative, and social re-

sponsibilities of the director to be delegated to each unit. Furthermore, the broadened responsibility placed on each unit team is often greater than it can be expected to carry without help and consultation, whatever the team's professional skills and experience.

SOME ADMINISTRATIVE PRINCIPLES

Everyone knows that a task divided is a task made easier, but the fact that different ways of dividing the same task can make a great deal of difference in the way the task is carried out is not always so obvious. In general, a task requiring the combined efforts of a number of people can be broken up into specialized functions so that each person does a particular part of the job unlike those parts done by the other workers; or it can be divided purely quantitatively, with each person doing the same work as everyone else. A simple example is the way in which three men might paint a house. The specialized function way would be for one to scrape and clean the surfaces, the second to paint the large surfaces, and the third to paint the trim. The quantitative way would be for all three to scrape and clean until the house was fully scraped and cleaned; then the three would paint the large surfaces until they were done, and then all three would do the trim work until it was done. Alternatively, the house could be quantitatively divided into thirds and each man could pursue whatever sequence of work he preferred. One might clean and scrape only what he thought he could finish the same day, while another might decide to scrape and clean his whole area before moving on to the next step. One might prefer to paint the large surfaces first, the other the trim first, and the third to complete each area before moving on. In many situations it may not make much difference which of these methods is used. If we add a fourth man, an administrator or foreman or contractor, who decides how to divide the work, he will be confronted with a choice on each new house and with each group of workers. He may always use the same method, regardless of changing circumstances, or he may exercise judgment. He can exercise judgment because the job can be done in a more or less satisfactory way by several alternate means of dividing the tasks.

In discussing the ways of dividing the task of patient treatment and rehabilitation in the mental hospital, those who had had experience with both the highly centralized structures and the decentralized general purpose units stressed that the attitude of the hospital staff was greatly influenced by the manner in which their job assignments were defined. The mental hospitals have made a practice of specializing each person's assignment to the maximum, and perhaps this has become a symbol of "efficiency" in some sense. But when a person's assignment is made in more general terms, as part of a team's responsibility for its share of the patients, his attitude toward his work is entirely different from what it is when he is assigned a purely specialized function.

A recurring problem in hospitals (as well as in other institutions which provide services to people) is how to keep the staff oriented toward the patients and their needs, rather than toward task performance per se, while gaining the added efficiency which comes from appropriate specialization. Specialized units tend to lead to work that is task-oriented, while smaller, more comprehensive units are believed to encourage an atmosphere which orients work toward the patients as people and their needs.

The concept that a heterogeneous team can function differently if it carries the major authority and responsibility for continuous patient care has certain administrative consequences which need to be faced. The role of the specialist tends to become diffused, and this upsets those who think that each occupational group must have a clearly defined, unique set of functions. If an occupational therapist is out, there are others who can do some of the same work. If the social worker isn't available when a family member visits, a nurse can talk with the family member. A new kind of general ward personnel emerges and, although each stems from a different professional training and background, and hence brings to the team different highly developed skills, all, in fact, perform many of the same functions and move toward becoming a more general type of professional.

Such modification of functions by the staff is referred to by some as "role-blurring." This is a term frequently used to describe the changed pattern of work. As a consequence of these experiences some

people working in these units have begun to question the validity of some of the professional specialized occupations, and ask whether there may not be a need to re-think the whole question of occupational definitions and classifications.

It is also obvious that the way a group of people is organized affects their behavior and their thinking processes. For example, discontinuity of services affects the way each physician sees mental disorders, the way his concepts regarding the nature of mental disorders develop, and his view of his colleagues. This can be seen clearly by examining the work assignments of a psychiatrist in various settings—in a chronic unit of a large state hospital, in a receiving unit of a metropolitan general hospital, and in a small, comprehensive psychiatric unit serving a community.

The psychiatrist in a chronic unit in a large state hospital has no direct contact with the community from which the patient comes. He deals with particular cases presenting only a few behavioral types; he is professionally removed from his colleagues who deal with the new, presumably more hopeful cases, and assumes the role of caretaker to the less hopeful. His skills in dealing with the life situations of patients (and his fellow staff members) are bound to be affected by his post. Hierarchical stratifications in these state hospitals inevitably arise, since they are based on factors such as competence, distance from the outside community, and community values. Hierarchical stratifications encourage differences of perception among staff members, arising from segregation of patients by behavioral types. For this psychiatrist never saw the patient at admission, knows little of his initial adjustment to hospitalization, and thus cannot perceive that some patients' dilapidated condition is related to earlier reactions to their initial symptoms by relatives and staff. And he may never see the patient progress through the earlier phases of treatment and know how he responds. However, should the patient improve, this psychiatrist may well be the only clinician who sees him return toward compensated functioning. This fosters a belief that only those working on chronic services have a real understanding of the seriously ill mental patient.

In contrast, the chief function of a psychiatrist in a metropolitan

hospital receiving unit is that of making dispositional decisions. A physician in such a setting, though he interacts briefly with many behavioral types and stages of illness, does not see what happens to the patients he sends on to state hospitals. He has direct contact with the community, which his chronic ward colleague does not have. (Even this community contact is one-sided because it occurs when the community is extruding from its midst the variant from its prescribed norms, so the "community" he sees—the family, friends, or others of the patient's world—may be angry, guilty, despondent, rejecting, intolerant, and frustrated because of inability to cope with the sick person's problems or behavior.)

These two examples of special-function psychiatrists ordinarily know little or nothing about each other's respective roles; they rarely communicate meaningfully with each other, and current barriers make their ever doing so unlikely. Obviously this type of specialized function can lead to extremely unrealistic stereotypes of what those in other special-function positions do.

Other illustrations of such special functioning could be cited. A particularly important example is the chief of a university hospital psychiatric service. Because his center selects and keeps patients entirely according to its own standards, he can readily develop extreme notions about both the receiving ward of the metropolitan hospital and the chronic service of the state hospital, and these notions are bound to be communicated to his trainees, staff, and patients.

Psychiatrists whose functions are limited are likely to remain trapped in their roles for their professional lifetime. Within the large mental hospital, too, special functions are assigned to each service and to each staff member. Even those with good original training, no matter how hard they try, cannot keep a clear perspective on the consequences of their decisions regarding the treatment of patients and the implications of moving them, if their work never leads them to see what happens to patients after they are transferred to other services. Such a perspective is not communicated effectively through textbooks; it develops only from the relationships and patterns of work that people experience. And patterns of work in the examples given are determined by how the psychiatrist's assignment is defined.

Such excessively narrow specializations of professional function all have a common tendency; they limit the capacity of the individual professional to function efficiently, effectively, and relevantly. Over long periods of time this tendency is strengthened, resulting in restricted vision and judgment. In contrast, the psychiatrist working as a generalist in a small, comprehensive hospital unit team serving a local community is spared this restriction. He can develop an accurate perception of mental disorders and their management because both the size and the administrative organization of his unit demand that he be responsible for the comprehensive and continuous care of every patient the community presents.

Thus the nature of a work assignment can affect the worker's perceptions, attitudes, and approach to his work. However, the changes in both patient and staff behavior have been so dramatic in some institutions that there is reason to believe that something more fundamental has occurred. These intimate, flexible staff teams seem to operate in an entirely new way. New human forces appear to be unleashed by these changes and lead one to think that this development introduces something like a new dimension, intimately linked with the organization and structure of the institution and the definition of functions and roles of people in the institution.

Some tend to identify this change with what was called "moral treatment" in the past century. Whether or not Connally and other advocates of moral treatment got similar results in whole or in part a century ago, our understanding of the problems now is quite different. Connally saw moral treatment in terms of a personal relationship involving his medical authority and superior moral understanding of the problems of the patient—superior to the patient's understanding and to that of the other people around him. An intense personal identification with the patient enabled him to get something new from the staff. Some members of the staff had this capacity, and he recognized it and enabled them to develop it. He encouraged certain people to use themselves as individuals in their relationships.

In contrast to Connally's methods, the new unleashing of energies discussed here has to do with administration. Administration is seen

as the process whereby human beings are organized to accomplish a task. One concept of the "best administration" is that which minimizes the individual's work. It decreases the difference between having Mr. Jones or Mr. Smith in a given position; operations are routinized to the maximum, and the more they are routinized, the less thought and the less human and personal endeavor are necessary. This principle (with perhaps certain built-in balancing and controlling devices) is optimal in making an automobile on an assembly line—*nobody cares who makes it*. But if a hospital is organized in this manner it will also minimize the functions of *staff members* and *patients* and will *tend to produce minimal functional responses*. If each activity and each responsibility is "rationalized" to the maximum, so that there is very efficient administration on paper, the spontaneity and the individual human capacities of professionals, of non-professional staffs, and of patients tend to be destroyed.

From this point of view, a highly centralized mode of administration—with narrowly defined assignment of tasks to be executed in identical fashion, regardless of who is carrying them out—has a dampening effect. A dampening occurs because this kind of role definition forces each member of the organization to keep a tight rein on his personal, human inclinations to respond to visible needs in his own way.

This is the opposite of an organized group of people working together in such a way that there is a minimum of arbitrary definition of what each person is supposed to do, that is, of his *roles*.

Maximizing the function of each individual in the organization is the objective of decentralized administration. Accomplishing this is neither magical nor simply mechanical, but a new synthesis of ideas and experiences. Those who have initiated the creation of smaller comprehensive units have been intent on making it possible for the personnel responsible for the care and treatment of patients to use a larger part of their abilities and energies in providing treatment. In smaller, more comprehensive units, the responsibility for treatment and for administrative decisions becomes unified at the service level: The patient deals with fewer staff members; the staff relates to fewer patients and to a smaller number of colleagues and community

agencies. The organization in a decentralized institution is more capable of fitting itself to the individual and his needs, rather than requiring the individual to adapt to the institution's standards, methods, and roles.

CHANGED HUMAN RELATIONS

The *raison d'être* for the decentralization of large mental hospitals into subunits is the need to improve the treatment and care of patients in all possible ways. Decentralization is not introduced as an end in itself, but arises from an appraisal of the functions within the institution that promote treatment for patients and from an attempt to maximize them. Breaking the hospital into smaller comprehensive units enhances the staff's capacities to perform those functions considered essential to treatment. Hence the day-to-day flow of interactions between patient and staff, which is the core of treatment, make up the part of hospital functioning which can be expected to benefit from the changed pattern of organization. Decentralization, by facilitating the individualization of services, helps to prevent some of the dehumanizing effects of institutions.

Some individuals feel more comfortable and function better in a centrally organized institution with a clear-cut line of authority, whether they possess the clear-cut authority themselves or fit themselves to such authority. Others prefer to work in a situation where there is a possibility for a "staff" type of relationship, i.e., wherein they are relatively removed from the problems intrinsic to a chain-of-command line relationship. The decentralized organization, by virtue of its much greater flexibility, contains within itself many types of organization and can thus find places for people with different needs.

Decentralization is the result of new views as to what is important in the treatment of the mentally ill. These views center about the belief that there are untapped vital therapeutic forces in both the patient and the nonprofessional staff, which are kept from maximum operation by highly centralized and "compartmentalized" patterns of administration. The way in which decentralization seems to un-

leash these forces is elusive, perhaps, just as the dynamics of psychoanalysis were new and elusive at the turn of the century. It might even be argued that the therapy of the social milieu is not new, that it existed in American psychiatry 100 years ago. Although principles similar to those of moral treatment are used today, they are being used in a new configuration and in a new setting. Recovery is being obtained in settings using these forces where previously it was unlikely. The organizational structure which was appropriate for a 200- or a 500-bed hospital in 1860 may have been reasonably centralized, but the hospital was small enough to permit the use of moral treatment then in vogue. Today, however, this same centralized organizational structure is still being used, but in hospitals twenty times as large as those of a century ago. Not only is it unsuitable for such large hospitals (which by sheer magnitude seem to have dictated qualitative changes as well), but it also destroys the opportunity to provide the same kinds of moral treatment, let alone improve it.

Because decentralization seems to unleash forces that have obviously been present earlier, it is not always easy for the observer to decide whether what is new is a more effective treatment or an administrative structure which reflects a new understanding and use of social relationships as therapeutic forces.

Since each decentralized unit has its own "central" administration, it may be asked whether the administrative machinery is increased by leaps and bounds, with new administration set up in addition to what already existed. If the goal is to have the units provide treatment, why not keep some administrative functions centralized and decentralize only those which are essential for treatment? This question makes sense only if administration is seen as something which is different from treatment, though, indeed, they may be more accurately viewed as one and the same. Good administration is not only essential to good treatment, it *is* good treatment. The surgeon, as therapist, is an administrator: he provides the means whereby his patient may have the best chance for recovery.

A fear has existed that the diversity of individuals coming into a small treatment unit might require a greater range of services than the unit can effectively provide. This fear appears to have been more

theoretical than real. Actually, failure to meet specific individual needs is more readily detected and more readily corrected by a unit team organization than it is in a larger and more centralized framework where responsibility for patient care is more diffused. Thus treatment in a comprehensive unit is more likely to be planned in the light of the individual's interactions with his environment as well as on the basis of his disease processes.

Adaptability of the staff of the comprehensive units has a counterpart in the adaptability of facilities. Whether a mental hospital requires its own elaborate medical and surgical services, gymnasias, churches, and movie theaters when such facilities are readily available in the adjacent community depends on the prevailing concepts. Thus, if a general hospital expects the mental hospital to accept its patients when they develop serious psychiatric complications, the general hospital might equally be expected to accept psychiatric patients when they become physically ill. Why build hospitals within hospitals? The prevailing concepts regarding mental illnesses and their treatableness and the prevailing social philosophy determine these administrative patterns.

Decentralization is not a definitive solution to the problems confronting psychiatry. The history of the treatment of tuberculosis is somewhat instructive. There were many discussions—often with more heat than light—of the organic, social, and psychological implications of the disease, similar to today's discussions of mental disorders. This was true even when the etiology of tuberculosis was already known (unlike the present situation with respect to the etiology of most mental disorders). The organization of hospitals and methods for improving the administration of treatment were important concerns. Today there is almost no discussion of the best ways to organize tuberculosis hospitals or treatment services, since effective treatment is available.

Progress can be made by analyzing administrative practices and organizational behavior, and the productive applications of this knowledge, but settling the most important issues regarding mental disorders awaits greater knowledge regarding their nature and causes, and the discovery of more effective treatment and preventive techniques.

2. THE SUBDISTRICTED COMPREHENSIVE UNITS

In one hospital, the local legislative leaders nominated volunteers who worked with the staff that organized each decentralized unit. In another, the local government has hired the director of a decentralized unit to work part time as the director of its own county-operated services. Groups of volunteers in one state are coming from long distances to work in a particular unit of the hospital. Joint planning sessions of hospital staff and local agency staff for handling patients after long periods of hospitalization are being held in some localities. In one hospital, staff members are traveling hundreds of miles to visit former patients and to consult with local professionals about psychiatric problems with which they are confronted.

These patterns tend to develop when each unit has its own sub-district.

A comprehensive unit assigned to its own subdistrict has all the advantages of the other comprehensive units, but those advantages are intensified and new ones emerge. Personnel become intensely identified with the communities they are serving. The unit's name designates that of the community served. The speed of transition is accelerated and eased because the interruption of old lines of communication to the central offices of the hospital is replaced by the opening of new lines of communication to the other professionals in the community. Barriers between hospital and community break down.

The best single index of this is the sharp rise in admission rates, reflecting an increased readiness to use the hospital facilities. Judges, police, physicians, social welfare workers, and others in responsible professions who have problems on their hands, work more closely with the hospital. Many changes are due to a new set of attitudes that develop, reflecting the fact that people get to know each other better and work together more closely. Some hospital staffs have the impression that people in the community accept admission more readily and speak more freely about their hospital treatment, both to physicians and to others, even in social gatherings. This is particularly true of those who have been to day-care units (which develop more easily with geographic decentralization). Present knowledge of community responses is entirely impressionistic and much remains to be learned about them.

The comprehensive units previously described obviously present certain advantages for patient care and for more effective use of today's knowledge regarding effective care of mental patients. But they may continue to be oriented mainly toward their functions as parts of the larger hospital, and tend to see themselves as confronted by the same set of problems as are the other units. When such units are given the assignment of providing services for a subdistrict of the larger hospital's district they become more and more oriented toward the community (or group of communities) they serve, and think of themselves less and less as being like the other comprehensive units in the hospital.

Decision-making about patient care has a better opportunity to become integrated, through consultation, with the physicians and the agencies in the local district where the patient and his family live. The relationships developed from a conference on one case gain strength in subsequent cases because the frequency with which any hospital physician or social worker deals with the same general practitioner is increased. This leads to increasing communication networks outside the hospital, drawing both staff and patients into a larger complex of relationships than do those comprehensive units which do not have their own districts. Relationships with representatives of the community, which usually flow through the hospital

superintendent's office, are more frequently dealt with at the unit level. The comprehensive unit which was a fragment of a larger hospital becomes more like a hospital itself, with its own identity, its own communities to serve, and its own set of external relationships. It remains an element of the larger hospital, but becomes more like one of a group of affiliated hospitals than a sub-hospital. Through the affiliation, it obtains the needed special services, special technical guidance and consultation, and over-all administrative support. Hence the functioning of the unit chiefs is more like that of hospital superintendents, and the hospital superintendent's functioning becomes more analogous to that of a commissioner of a hospital system.

The unit serving the community in which the large hospital is situated (the large hospital's "home" community) inevitably has a different relationship to its community than do the other units. This is partly due to the distance from which the patients come. But it is also due to the fact that the bulk of the employees in all the units come from the local community. The unit's interaction with the superintendent is also different because both are related to the same local community in their external relationships. This is particularly true where the hospital is the chief local employer. The local unit chief and the superintendent must maintain relations with certain key community leaders. In units serving distant areas, the superintendent's role in representing the hospital can, to a large extent, be taken by the unit chief. In some hospitals organized this way a practice is made of assigning personnel to units which serve their home community or communities where they have personal ties.

New devices arise whereby the hospital is able to learn from the community what has happened to patients before they came to the hospital and what happens after they leave the hospital. Patients are treated in the light of the extra knowledge gained.

With two smaller groups of people working together—a smaller group in the hospital and a smaller community—there is an opportunity to get to know each other better. Doctors in the hospital get to know general practitioners in the community quite well. Judges get to know the doctors with whom they are dealing.

Volunteers want to work in "their" unit—the unit serving their own community. There is more feeling of proprietorship and they want to provide services to their unit. Of course, fewer volunteers come from distant communities than from nearby ones but ordinarily volunteer groups never come from distant communities.

Community relationships can be strengthened when local comprehensive units are being planned for particular communities, since each community can play a role in planning and implementing the creation of its new unit.

The unit which serves the hospital's home community can undertake to provide a wider range of services than can the other units whose patients live at a greater distance. Day hospital care is an obvious example. Consultations regarding potential admissions, sometimes referred to as "pre-care," are more readily provided. After-care services are possible on a more flexible basis, as are consultation services to local agencies.

The unit serving the local area of the hospital tends to become more richly varied in the services it provides, either directly or in co-operation with general hospital units or voluntary outpatient clinics in the local communities. It is, therefore, in a better position to get full accreditation for residency training than some of the other units.

A comprehensive unit assigned to a district distant from the mental hospital can do a much better job of integrating its work with the patient's home community resources than can the staff on the specialized service in the centralized hospital. But the contrast between what happens in the comprehensive unit serving the immediate community and in the other units shows that this improvement is limited and can only partially overcome the difficulties produced by the intervening miles between the hospital and the community it serves. These situations dramatize the fact that no long-range planning can regard this pattern as doing more than the best possible under the circumstances. Where population density has risen sharply, long-range planning can look forward to replacing some of these units with new hospitals in the communities they are to serve. But in sparsely populated areas the problems associated

with distance are bound to remain important in providing comprehensive, flexible, continuous psychiatric services. Distance can be partially overcome by better transportation and by trunk telephone lines. But interactions between a comprehensive hospital unit and the community served are still dampened when most of the people live far from the hospital buildings.

In a comprehensive unit identified with a community, patients tend to act more for themselves and as members of the team; thus, in a sense, they add to the pool of available manpower for therapeutic goals. The redefinition of roles and the generalization of function (i.e., the "role-blurring") that has taken place thus extends to the role of the patient himself.

Linking the units to communities in the hospital's district will generally require the units to be of different sizes. This does not seem to be a matter for undue concern. In some decentralized hospitals, one unit team might be able to handle effectively only a 150-bed unit, while another might function just as well with a 300-bed unit.

The community's organization is probably the deciding factor in determining the size of the unit. Certainly the hospital community is in large measure a reflection within the hospital of community elements outside. The outer community helps mold the hospital by its sense of contact and by its acceptance of the hospital. The time required for travel from the community center to the hospital affects the intensity of interaction.

Selecting subdistricts for assignment to units requires careful planning. In rural areas, districting the units to correspond to communities where certain ethnic, religious, and other demographic features predominate is sometimes of value. In a metropolitan population, this may be a disaster. Consultation with the community and its leaders, including legislators, is not simply a device to gain support, but a necessary step toward the recognition of the hospital's purpose, which is to serve the needs of a community's patients. Treatment objectives cannot be fulfilled with such things as "ghettos" in the hospital reflecting the composition of an urban area which is in the midst of efforts to undo these patterns of ethnic

isolation. Where these situations are seen as undersirable, the hospital cannot reflect them.

A hospital serving a rural population with other values may come to different conclusions. In some parts of the country, large areas are populated by people whose primary language is not English. In southeast Colorado, for example, over 75 per cent of the patients sent to the hospital are Spanish-speaking. If the team members of a unit assigned to such an area are chosen with regard to the same Spanish-American background or to their ability to speak Spanish, there can be interesting developments of a salutary nature. For one thing, English-speaking employees begin to learn Spanish; the patients teach them. In addition, in-service education programs can develop with help from outside educational institutions which send in people to give courses not only in the Spanish language but in Spanish culture as well. In such a situation the hospital unit seems to form an identity with the community it serves. Perhaps such a type of segregation or organization is only temporarily welcomed by the community, as "segregated but equal" was initially welcomed in some parts of the country. Obviously, in New York and some other places, integration is definitely being asked for, and anything short of it invites conflict. On the other hand, by integrating one must quite surely violate the principle that the hospital should relate to a part of the city. Therefore, selecting sub-districts may present a dilemma.

The lines of reasoning which led to geographic decentralization of hospitals has varied. In some hospitals it began with the idea that the hospital was too big for effective internal organization. In other places, the reasoning started with the idea that the communities the hospital was serving were so different, one from the other, that the hospital ought to relate to them with different styles of working to fit an urban area, a rural community, a Lutheran county, a Catholic county, and so forth. The scattering of different ethnic groups, and different economic organizations and the different distances from the hospital were all thought to be natural factors, dictating ways in which the operations of the hospital could correspond to the ecology of the community. This kind of reasoning

lay behind decentralization at Clarinda, Iowa. In New York State the geographic distribution of the population is such that certain areas contain aggregations of large populations homogeneous with respect to economic levels, national origin, and other characteristics. People have moved into these areas sometimes with and sometimes without the help of real estate agents and restrictive covenant laws. There the ideology which calls for mixed schools, mixed hospitals, and mixed communities exists side by side with the reality that people live in segregated communities.

If districts cross neighborhoods and never correspond to a community, they cannot meet needs which correspond to neighborhoods. This contradiction is made even more complex by the fact that the ecology of the large city is constantly changing, so that today's homogeneous area may be tomorrow's Babel.

A variation on the subdistricting problem has arisen when particular religious groups have requested segregated facilities in the hospital to enable their patients to observe religious practices more easily.

Sometimes these ethnic, religious, or economic areas correspond to political subdivisions, and sometimes they vary independently. Political subdivisions can be crucial in determining the size of the units which will serve them. Political subdivisions within the area become particularly important if they operate mental health services of their own with which the comprehensive hospital unit wishes to interact to improve continuity of patient care.

3. THE CENTRAL HOSPITAL ADMINISTRATION

SERVICES WHICH REMAIN CENTRALIZED

Certain hospital services tend to be maintained at the hospital level, as they are difficult to incorporate into comprehensive units. Factors influencing judgment on this question include the frequency with which a particular service is needed, the level of professional competence required, and the complexity and expense of the equipment or personnel needed to carry it out.

Usually children's wards, or at least schooling for children, and medical and surgical wards are services retained under central control. Some hospitals with decentralized comprehensive units maintain centralized special-function admission services, alcoholic services, or maximum security services.

RETAINED CENTRAL FUNCTIONS

Those who have been operating mental hospitals with decentralized units for the provision of comprehensive and continuous treatment generally seem to prefer to place all administrative functions which involve decisions about treatment at the unit level. However, some functions of hospital management, especially those

having to do with co-ordination and allocation of resources, are retained as a service to the unit staffs so that they can concentrate on patient care. Other functions continue as those of the central office because they are regarded as responsibilities of the superintendent, which cannot be delegated. But even where responsibility is not delegated to the unit, the unit team has been asked to participate in decision-making to the largest possible extent.

Budget

Budgeting has remained centralized in nearly all of the hospitals; but in several, unit teams submit their own budget proposals annually, and are given periodic reports on their expenditures so that their thinking about running their units includes knowledge of budgetary factors. In one hospital, a unit was spending its budget for drugs at a rate which would have exhausted its funds before the end of the fiscal year. When the hospital director pointed this out at a meeting of unit heads, and also pointed out that another unit was underspending its drug budget, the two unit heads agreed to recommend a central transfer of the surplus in one unit's budget to compensate for the deficit in the other. This episode illustrates that the unit system is compatible with administrative problem-solving at the interunit level, even on issues which remain a central responsibility. This method is based on the principle that people generally arrive at sensible decisions when given the facts.

Breaking down the hospitals' budget so that each unit's budget is shown separately and unit heads can be provided with periodic statements of expenses does not appear to increase the work of the accounting department personnel significantly; and it is thought to help greatly in welding each unit team and strengthening its capacity to take responsibility.

External Relations

When a court-remanded case is admitted, when a dangerous patient runs away from the institution, or when other special patient situations occur, the central office comes into the picture because these patients are a concern of the community as a whole, in con-

trast to most patients who are a concern only to themselves, their families, their physicians, and sometimes a service agency. The central hospital administration usually continues to take responsibility for all transactions concerning special category cases with court, legislative, or other non-service official agencies of the larger society.

Continuing Line Functions

In one state, the director of occupational therapy for the state hospital system requires institutional reports in a certain form and at a certain time, in order to carry out particular statewide functions, such as the preparation of statistics and research reports. When the doctor in charge of a particular unit saw no value in reports in this form, he persuaded his occupational therapist to prepare reports "our own way." In this situation the hospital's central administration had to say, "For this function, I am under orders from the commissioner and I am passing these orders on and you will have to comply."

Professional chiefs, having become "staff" to the superintendent and central administration, still find that they have certain responsibilities defined by the hospital system as a whole, which bring them into "line" types of contacts with their colleagues in the work units.

Medical Records

In several decentralized hospitals steps which had been planned to break up the central record room and keep patient records at the unit level have been opposed. The opposition argued, first, that these documents are looked at every so often by the Joint Commission on the Accreditation of Hospitals, a fact which tends to make the superintendent hesitate to give up his control over the patient "file"; and, second, that superintendents sometimes need to refer to clinical records in the course of their own work. Decentralization of this function has occurred; when it does, provision for maintenance of standards is needed and accessibility—when required by central administration—is maintained. In some hospitals with comprehensive units a duplicate set of records has remained

centralized, but this means having two sets of records, one on the ward and one in central records.

Those working in hospitals with no central medical records report that central administration rarely needs to refer to the records. The central administrator assumes that the doctor on the unit team, being closest to the case, is best able to provide any needed information—in most cases by telephone. Only on rare occasions does the administrator need to send for the record to review it himself.

Placing all medical records in the decentralized units also reinforces channeling of communication from the outside directly to the unit; where records are kept in the central office, the central administration tends to deal with outside inquiries itself. Inactive records, too, can be stored in the unit, which will handle inquiries, even if a patient has been out of the hospital for 20 years.

To those who have been through these debates in several newly decentralized hospitals, the fact that some very large centralized hospitals have for decades kept all medical records on the services and wards with the secretaries and doctors, and not in the central administration office, came as a surprise. This is an example of a curious paradox: Those who make new efforts to create comprehensive units and to decentralize certain main-office functions encounter what appear to be strong and valid arguments against moving a function from the central office to the units, only to find that this very same function has, in fact, been carried out by services in conventional hospitals for many decades, with no need ever felt for maintaining them centrally. (This paradox is an example of Blinder's law which states that mammals have trouble believing in the possibility of anything which is not either directly behind or in front of them. It also illustrates the corollary, that travel broadens the mind.)

Personnel Administration

Losses of personnel and temporary absences due to illness and vacation force the superintendent to develop a personnel policy which reflects his perspective on the operation of comprehensive units. Three methods of dealing with personnel losses and absences

have been used: 1. reallocation of personnel through sharing or reassignment; 2. the use of a pinch-hitter; and 3. allowing the unit to meet its personnel needs through a shifting of roles.

The sole occupational therapist in one comprehensive unit moved at a time when no replacement was in sight. Central administration's inclination in this situation was to move in an occupational therapist from another unit of the hospital. However, a direct transfer is feasible only when there are hospital units staffed with several occupational therapists. When the ratio of specialists is one to a unit, it is possible for two units to share the time of one specialist. Hospital superintendents have done both of these things, sometimes splitting the time of personnel and sometimes reassigning personnel, to see that each hospital unit is adequately staffed.

A technique for meeting the problem of a temporary loss of specialist personnel used in several hospitals is to bring in the specialist department chief (occupational therapist, social worker, nursing supervisor, etc.) as a sort of pinch-hitter. Then for a period the specialty chief can fill in part of each day himself, thus keeping in direct contact with the service role of his colleagues and, in the long run, getting to know the various ways in which the different units are operating so that he can be of more help in consulting with unit personnel and in recruitment.

A third approach to this problem, which is advocated by some directors, is to keep the responsibility for dealing with the situation at the unit level. The unit may find occupational therapy aides to do the work and can, if it wishes, see to it that occupational therapy goes on during the interim period without having any special personnel. This is likely to occur in units where "role-blurring" has been present.

Encouraging such flexibility is compatible with a recognition of the fact that each specialist has something to offer which other staff members do not have. When the truncated team grapples with the problem, its members tend to become more aware of the advantages of specialization and of the possibilities of some of the special skills their colleagues bring to the team, and of the ways of working being incorporated by other staff members. The role-blurring which re-

sults leads to a specific type of anxiety which can be extremely disruptive if it is not recognized.

As a professional begins to accept roles which he previously thought of as those of another profession, or considered inappropriate for professional people, he broadens his skills and adaptability. But this broadening may be of a kind which undermines his own picture of himself as a professional specialist. To the extent that he depends on his professional identification for his sense of identity, this can be a threatening change since he will, more or less consciously, become uncertain as to whether his colleagues outside the hospital, whose approval is important to him, would approve of his functioning in such a "nonprofessional" way. Furthermore, the fact that his teammates are taking on some of *his* roles—which his training had led him to think were the exclusive prerogative of his own profession—increases his anxiety.

The central administration must, therefore, encourage or create mechanisms by which the individual staff members can be continually reassured that the new ways of functioning are compatible with their specialty identification. This is easily done through meetings of specialty groups on a hospital-wide basis, and by assisting and encouraging people to attend membership meetings of their professional specialty association, whether local, regional, or national. However, even when these problems are taken into account, it is wise to anticipate that pressures will cause some staff members to retreat into the defense of narrow specialty identifications at various times, some consistently and others only sporadically.

The personnel policy the superintendent and his advisers favor must be made clear to each and every department head, with a special effort directed to orienting the professional chiefs. Unless the superintendent is able to help these central office men and women identify with their roles in a hospital organized on the unit principle, conflict and ineffective execution of work will occur.

The tendency for each unit team to want a part in selecting and controlling its own membership creates another problem. It seems to team members, and to the heads of the teams, that effective functioning, as well as simple consistency, demands that they select their

own personnel and deal with problems of staff performance within their own units. On the other hand, objections have been raised to the idea that units should have complete autonomy in selecting and controlling personnel. It is argued that the superintendent must see to it that all units are adequately staffed; the units, if given their heads, might attempt to recruit staff members from other units of the hospital, and this could touch off repercussions affecting the whole hospital. In reply, it is pointed out that interunit recruiting is currently being tolerated by a few hospital directors. In some of these hospitals, however, intra-unit cohesion has developed so strongly that personnel have refused promotional opportunities which require shifting from the work unit.

Personnel Training

The pattern of residency assignment in decentralized hospitals varies widely. In one hospital, where residents are affiliated from a university program for six-month periods, each resident is assigned by the superintendent to a single unit for the entire six months. In another hospital, not accredited for residency, two years of post-residency employment are required to fulfill the resident's contract with the state; these post-residency psychiatrists are assigned to units by the superintendent strictly on the basis of the hospital's needs. In other hospitals, with accredited residencies and a large training program, the interrelationship of the training program with the units is complex; the resident's assignment by the training program to a unit puts him under a dual authority. This pattern produces half-time assignment to a unit, and half-time assignment to lectures and other academic programs. In one such hospital the resident spends the entire three years in one unit, while in another he is moved year by year through several, but not all, units. Another hospital is accredited for one year of residency, and rotates a resident in this time through several specialty services (criminals, alcoholics, medical, surgical) while he remains identified with a comprehensive unit to which he was assigned in the first place. While on each special service, he is assigned to work with the patients from his basic comprehensive unit.

These systems seem to serve well enough from the viewpoint of

those working in them, but the accreditation authorities are accustomed to being able to see blocks of time spent in outpatient work, clinical neurology, and children's services.

The psychiatric resident in the hospital organized into comprehensive units can obtain the needed working experiences with fewer rotations during the course of the residency. He needs a period of assignment to each specialized service in the hospital, but will be able to gain experience regarding all the other fields of knowledge and skills in any of the comprehensive units, for each unit incorporates the remaining full range of patients and treatment methods.

Since the units vary considerably in the emphasis each places on mastering different treatments and different diagnostic criteria, it is desirable for a resident to be assigned to two or more such comprehensive units during the course of his residency. In the hospital made up of comprehensive units, as well as elsewhere, the resident needs to be given responsibility for patient care and be assigned to necessary, not superfluous, duties if he is to get a meaningful experience. But here, as elsewhere, it is necessary to guard against assignments which simply meet the institution's needs for coverage without taking account of the appropriate sequence and range of experiences the resident needs for proper training.

There is no evidence that the amount and quality of professional educational activities at decentralized mental hospitals have been in any way compromised. On the contrary, there is general agreement among those who have had experience with decentralization that new opportunities for clinical education arise with the opportunity to work with the same patient throughout the different stages of his disorder.

The administrator of a decentralized hospital has a problem in teasing from the mixed experience of his residents how much time is spent in each of the required categories. Those responsible for the evaluation of the hospital for accreditation also have a problem in documenting the adequacy of the various experiences the trainee receives in a comprehensive unit hospital, according to the prevailing criteria. There appears to be a need for new specifications for accreditation of hospitals for training, which define adequate train-

ing in psychiatry taking these comprehensive services into account.

Training programs in state hospitals for affiliated nursing students highlight some issues involved in creating comprehensive units. Student nurses are usually on affiliation in psychiatric nursing for a short period, commonly three months. It is hard to carry on a training program for these students in each comprehensive unit without disrupting the ongoing nursing program. One way of dealing with this problem is to rotate the duty of providing training experiences for the affiliates among several units, so that this is an occasional, rather than a perpetual, burden. In hospitals with comprehensive units assigned to particular geographic subdistricts, schools of nursing in that area send their affiliates to those units. Thus the student nurse learns in the area of the hospital which serves the community in which she either lives or goes to school. This has worked well where it has been tried, and has led to better co-operation between the state hospital and the affiliated general hospital. Additional nursing schools have shown an interest in a state hospital affiliation, on the condition that the students will be assigned to the unit serving the district where the school is situated.

NEW FORMS OF CENTRAL OFFICE FUNCTIONING

Policy Formulation and Implementation

A unit was overspending its drug budget. When the unit chief was notified of this by central administration, he held a meeting with his team. This discussion continued at a ward meeting where patients and aides participated. For the first time the patients and aides heard that a certain number of dollars were budgeted for drugs. They took up the problem. One of the patients said, "I see patient X is not taking his pills, but is spitting them out." The group decided what to do about the patient (therapeutic action) who was wasting money (administrative concern).

This incident illustrates how a situation which is brought to the attention of staff and patients is thought of as an administrative problem (how to manage the drug budget); by becoming a ward level

situation—with the active involvement of the patients in making an “administrative” and “therapeutic” decision—it is turned into a means of improving staff-patient understanding and brings to light facts about the situation which a directing administrator and no one on his staff could know. Furthermore, the “problem” dissolved!

In another hospital a patient, in a comprehensive unit which was open, delighted in running away and having people chase after him. A point was reached when the unit team said, “We just can’t keep this up forever. Shouldn’t we transfer him to the security unit?” When such a unit exists, this is what happens at times. One might point out that something is being missed in the unit’s approach to this patient and his problems, but if the opportunity for transfer exists it will be utilized. Ordinarily, in a comprehensive unit with its own subdistrict, the only acceptable reason for permitting transfer to another unit would be the moving of the patient’s family to another unit’s area during his hospitalization. Nevertheless, sometimes the only practical thing to do is to permit a transfer to a maximum security unit.

When such transfers are permitted, it is important to point out that they represent a failure of the unit team to provide the total range of comprehensive services that it has set out to provide. If a unit tries to operate as an open unit, it will have to find ways of dealing with all patient problems, including those of chronic elopers, just as every unit must. The superintendent is responsible for pointing out these limitations and the failure involved, and should use the episode to inform his whole hospital. This educates the staff through its failures, and also helps frame hospital policy for the future.

There are two kinds of security units in decentralized hospitals. First, there is a specialized high-security unit for patients difficult to control. This frees the comprehensive units of responsibility for such patients, but is open to the kind of abuse indicated above. At best they represent a transitional technique. Secondly, some state hospitals are responsible for the care of convicts or of imprisoned persons waiting trial, who by law must be kept under prison conditions. It is a statutory duty of the hospitals to run a prison unit. Some directors have prohibited sending other patients to the prison hospital to avoid

its misuse. A third pattern might be mentioned here: In some states, special mental hospitals are run by the prison system for psychiatric patients who are convicted criminals and for psychiatric patients with criminal propensities.

Obviously, for sound and effective administration in any organization, a director will attempt to gain compliance from subordinates through group persuasion, consultation, and support. He tries to avoid using his coercive powers whenever possible, while recognizing that executives can never abandon their directive status. The real difference, and the exciting potential of the comprehensive unit system, is the group feeling created at the unit and ward level, in which patients have a part.

Policy formulation and implementation is the most important and most complex function which is handled centrally. It is in the execution of this function that the large changes in administrative structure and work roles become most conspicuous. The highest ranking members of each profession, often referred to as "department heads" in mental hospitals, become a staff for the superintendent, and the types of line functions which this personnel has in most mental hospitals are minimized or tend to disappear entirely, depending on the way personnel replacement problems are handled.

In some hospitals with a unit system these "department heads" constitute an advisory council to the superintendent and make recommendations for policy changes as a council. They also provide ad hoc consultant services to the units on special problems of patient care and, in some instances, fill in as relief personnel on unit teams during periods of staff absences for illness or holidays or when a temporary staff vacancy exists. This service function by members of the advisory council varies a great deal and has not become a standard practice anywhere.

So far, the central administration of only one hospital has developed, in addition to the interdisciplinary advisory council staff meeting, an inter-unit hospital-wide meeting pattern at which the unit team heads, the members of the advisory council, and the superintendent take up hospital-wide or interunit questions.

It is too simple to state that the old department heads are now

simply an advisory consultative body. In setting priorities, they make policies which connote some line function. The resulting tensions are resolved somewhat by interdivision meetings, where unit chiefs who have line authority come to an understanding about problems under consideration. Thus the advisory council has become authoritative instead of authoritarian which it was in the old line relationship. The superintendent thinks pretty hard before flying in the face of his advisory council's recommendations, because the council is authoritative; it is made up of good men. However, he must reserve the right to veto a recommendation of his planning council and may, indeed, veto over half of its recommendations. This is a new situation for everyone concerned.

In exercising its changed authority relationship, central administration must be careful not to undermine previously delegated responsibilities, but must at the same time communicate its judgment regarding alternative or better ways of solving problems.

Functional Autonomy

The degree of autonomy for the unit teams is visualized differently by the various people who have had experience with the unit system. Opinions differ as to which functions should be assigned to the units and which ones kept under central control. The extent to which each has autonomy in relationship to which functions is discussed in the same way that the relationship of the Federal Government to the states or a state to its counties is discussed.

The establishment of autonomous units within a hospital rapidly brings to the surface the question of their relationship to the central authority. The essential issue is the nature of the extent of the authority which the superintendent should delegate to the units. Obviously, this is not an all-or-none question. The comprehensive unit is not completely free to decide on every issue which affects its operation, nor is it completely self-sufficient. Yet decentralization becomes a platitude unless the individual units are delegated almost complete autonomy for patient treatment. The Workshop members agreed completely that if comprehensive units are to be effective, all treatment decisions must be made at the unit level.

At the same time, most directors of decentralized hospitals believe that the central office has to retain control over such matters as recruitment and budget-making. Relatively autonomous units require a co-ordinating structure operating at a level above the units. So long as outside agencies and groups view the hospital as a single organization with a single head who has responsibility for everything which occurs in the hospital, there will be a tendency for the superintendent to supersede the unit team when dealing with these outside agencies.

There is a simple rationale for the delegation of professional (clinical) authority to the unit teams. The professional is presumed to be competent, committed to a set of binding standards, and involved with his work. A number of problems have appeared, however, in the course of working out a pattern in which clinical authority is delegated to the units while the central office retains a considerable degree of administrative (line) authority over the affairs of the units. A professional person with clinical responsibility will, in all likelihood, seek administrative authority in order to implement a treatment decision. The problem is to define what is "clinical" and what is "administrative." These two types of authority, of course, shade into one another in practice.

For example, some unit teams start with the belief that a particular type of treatment arrangement is better than another, that mixing old and new patients is better than not mixing patients. Other units reproduce the familiar organization of a centralized hospital, with separate admission and long-stay wards. If the superintendent uses his administrative authority to impose his set of treatment assumptions, he is, in effect, telling the units that their autonomy about treatment is fictitious. This arises because of the difficulty inherent in differentiating treatment roles from administration, and vice versa.

In practice the central authority has continually to exert efforts to restrain itself from telling units what to do, even if it fears that a unit might go over the cliff. Some superintendents observed that at times they wished a unit would go over the cliff, in order to have other units learn from the experience and save them from having to interfere directly. A decision to allow the units full autonomy in mat-

ters of treatment commits the central authority to accepting different treatment philosophies and approaches as they emerge among the units. In the end, this policy permits as many treatment styles as there are units. Obviously, some limits are set; if one unit team, to use a far-fetched example, wanted to revive extirpation of the colon as a treatment for mental disease, this could not be permitted by the central authority. All varieties of treatment patterns are permitted so long as they conform to current professional acceptance.

There is a tendency for unit teams to press for greater autonomy in the management of their own administrative affairs as they develop cohesiveness and gain confidence in their ability to work together as a treatment team. Such unit staffs find it paradoxical that they have responsibility for establishing and maintaining an effective treatment program but have no voice in administrative decisions regarding recruitment and assignment of personnel. The precipitous transfer of an aide who has been trained in the unit to exercise therapeutic initiative or the assignment of an unwanted professional person by the central office can undermine the morale of a unit. Although the unit teams can be expected to press for greater administrative control of their own affairs, it is likely that the central authority will find it necessary to maintain at least partial control over such key areas as staffing, budget, and representation of the hospital to the outside.

The units' professional freedom is hard on the superintendent and his cadre of central office personnel for two additional reasons: In the first place, it is difficult for one who is used to administrative authority to accept the notion that subordinates can solve problems as well as he can, especially when the solutions are different from those he favors. Secondly, in the process of decentralizing it may be necessary to assign a unit to a psychiatrist (or supervisor, social worker, nurse, or occupational therapist) whom the superintendent believes is not fully competent for such broad responsibility. Here the problem is twofold: The less than fully competent professional has to be taught to seek advice and to use advice intelligently; at the same time, the superintendent and his central office staff have to be prepared to undertake an advisory role in lieu of issuing directives.

When the superintendent can bring himself to deal with subordinates through a sharing with them of his accumulated professional and administrative knowledge, his stature is likely to increase and there is less likelihood of faulty co-operation. The same is true of the advisory council members. These central office staffs now sit as advisory or planning councils and no longer have direct administrative authority over anybody in their professions. They do not give efficiency ratings; they do not hire or fire; they only advise a superintendent on matters of policy and act as advisers and consultants to their lower-ranking colleagues and to unit heads. Yet the formation of policy has direct relevance for the work of the units. To this extent, the heads of professional departments and the clinical and assistant directors continue to influence the operation of the units. There is a major difference, however, between a body of advisers, representing many disciplines and ranks, setting priorities as a group, and a single department head issuing a directive. In the final analysis, the authorization of a budget for a public mental hospital involves a set of decision-making levels which go beyond the boundaries and interests of a particular hospital. Thus the implementation of policies adopted by an advisory council and approved by the superintendent in the form of an asking budget depends on a set of budget decisions which are made at a remote level of government.

Leadership Patterns

The superintendent's role, like that of his central office lieutenants, changes in a number of ways when a hospital is decentralized. Instead of passing through division heads, the line of administrative authority goes directly from the superintendent to the unit-team heads who have been delegated broad responsibility for patient care. Hence the superintendent is in more direct contact with the various unit heads. On the other hand, such a large proportion of decisions about treatment and administration can be made at the unit level that he has less day-to-day contact with problems which arise. That is, fewer detailed requests for decisions rise to his level. The superintendent exercises less immediate control over the way particular decisions are made because responsibility for treatment and some

administrative decisions are unified at the unit level. One consequence of this shift in control is that the organizational arrangements of the individual units come to vary considerably: One unit may be locked while another one is open; one unit may have mixed social affairs for the two sexes while another has segregated recreational programs; one unit may be using higher drug dosages than another; one unit may encourage "role-blurring" while another may insist upon maintaining a clear separation of specialists' roles. The superintendent is asked to be more of a leader, educator, adviser, and limit-setter, and less of a coercive authority. These new definitions of roles are not easy to live up to even when motivation is high, for they are at odds with much of his training and prior experience.

This new role pattern seems to require more alertness, more energy, more firmness, and more professional competence than the familiar directing role. It means focusing attention not only on expressing a correct opinion but also on the effects of expressing authoritative opinions on subordinates. It means willingness to permit and tolerate practices which the superintendent himself would not select, as well as a realistic recognition of the arbitrariness of most procedural standards which are established to enhance administrative efficiency. It means, above all, a willingness to keep up with advances in professional knowledge, a desire to impart the expertise accumulated over a long career in institutional psychiatry to unit heads, and the courage to expose himself to the scrutiny of his colleagues. In a word, it is much more an educative than a directive role.

The superintendent's role in policy formulation becomes more general. He has to set a broad framework within which others make decisions and do the directing. He has to expect new policy issues to come to the surface as unit teams change their ways of doing things as a result of personnel shifts and the accumulation of experience. Hence he has to work much harder to establish smoothly operating mechanisms for articulating policy changes as they are needed than he does to find the "right regulations" to solve the maximum number of administrative problems. He has to be oriented to change rather than to a search for stability.

4. THE TRANSITION

SPEED

In one hospital of over 7,000 patients, 4,300 patients were re-located in three days with the help of an army division. In another, relocation to form one comprehensive unit of 500 patients in a 5,000-bed hospital went on over a period of months. In some hospitals a sectional plan was introduced gradually over a period of five years.

The transition from a hospital organized into services—each of which is geared to fulfill a special function under the direction of administrative control from a superintendent's office via professional department heads—into a hospital consisting of comprehensive units run with maximum autonomy by interprofessional teams is a process involving a major revision of hospital organization. It means a major redefinition of unit relationships and staff roles, a total rupture of established lines of authority, and the creation of new lines of authority and communication. It requires an adaptation by each staff member to a new set of definitions regarding his administrative connections and a re-examination of his own functions, roles, and working relationships to his associates.

The necessary structural reorganization can be done on paper very rapidly, with staff assigned to the new comprehensive units in a matter of days or weeks. Executive decisions by themselves, however,

cannot make a program work. Participating personnel must believe in a program's goals, and accept the changed definitions of their roles. Whether decentralization is decreed all at once or allowed to occur in small steps, there is an extended period of adaptation for all hospital personnel. While many changes can be introduced by steps, others must be taken at a leap, since there is no possible way of functioning at the halfway mark.

From the experience gained so far in making such transitions, a few specific things can be said about the transition process, the most important being that it has never followed the same sequence in any two places. The speed with which various structural changes have been brought about, the amount of staff involvement ahead of time, the means of dealing with the problems which arose, and the interpretations of the changes being instituted have all varied greatly. Out of this miscellaneous experience it is possible to distill a list of phenomena which almost all, if not all, such transitions have encountered, and to record some of the methods which have been used to deal with these problems during the transition period.

CONFLICTS AMONG THE INNOVATORS

In one hospital the process of decentralization was seen by the Ph.D. psychologists as a conspiracy by the M.D.s to consolidate their authority. In another, nonprofessional staff and local leaders saw it as a move to accelerate the decline in census and thus reduce the hospital's payroll. Some have seen the comprehensive units as the means of saving the state mental hospitals from oblivion, and others have seen it as a step toward their ultimate destruction.

A common difficulty seems to be that specific actions may be agreed on without any assurance that the participants in the agreement have arrived at a consensus through the same line of reasoning. In fact, it is common knowledge that in most action situations new alignments of personal relationships occur, and everyone knows that politics makes strange bedfellows and that the army (in which everyone is presumably on the same side) brings together people who in civilian life would never be able to regard each other as companions,

much less close friends. Those who advocate the creation of comprehensive units within state hospitals find themselves associated with colleagues who have entirely different ideas about some of the secondary consequences of this transition. This is most strikingly true of the presumed consequences for the future of the state mental hospitals.

Some see the breaking up of large state mental hospitals into comprehensive units as the way to get rid of the state hospital system altogether. Others see the same move as the way to save the state hospitals from extinction by making them more flexible in meeting patient and community needs. As with all such shadowy anticipations of what the secondary consequences of a particular act may be, immediate reaction to decentralization does not depend on one's attitude to the state hospital. Thus some who wish to see the state mental hospitals come to an end resist decentralization into comprehensive units because that is seen as prolonging the life of an unwanted type of institution, while others advocate such a trend toward decentralization because they see it as the first step in the elimination of the state mental hospitals. Within the hospital staffs themselves there is a general tendency to look on such innovations in terms of whether they are likely to strengthen the state mental hospitals, since most of the staffs have at least some investment in them. These preservers of the state mental hospitals are also split into advocates and opponents, on the basis of contrasting suspicions as to whether this move will weaken or strengthen the hospital itself.

This particular situation is described in detail here because the reader is likely to have wondered which side he would be on in this matter. It is easy to see that those who line up on one side during the turmoil of transition will inevitably wonder whether those who join them (some of whom are almost bound to be people who have disagreed strongly on important issues in the past) are really trying to achieve an opposite long-range objective. This leads to tenuous affiliations. Worse still, it leads to doubt as to whether one has chosen the right side of the argument. Altogether, this aspect of the transition plunges participants into a melee of discussions and debates regarding the best course and leaves them in a state of uncertainty and insecurity. It is hard for individual staff members to make a firm

commitment to decentralization because each is uncertain if he is really headed toward the goal he would like to see achieved.

The lack of real ideological unity in the staffs which have worked together toward this type of transformation is illustrated by the amazing contrasts in the way they see particular problems and issues. The end itself is seen very differently; some see the purpose as easier administration, and others see the change as absolutely necessary to achieve certain types of treatment and patient-staff relationships which they regard as crucial. Some see the steps taken as modifying the relations between staff members, while others see those features as purely incidental to the opportunity created for new types of staff-patient relationships. Some see the reorganization of the hospital as a shifting of staff assignments, others see it as a shifting of patient assignments. All these divergences in viewpoint and emphasis tend to foster an atmosphere of uncertainty and tension.

Some see the steps taken as implying an inevitable increase in costs and, therefore, oppose the changes out of a low-tax orientation. Others see it as a way of getting better service with the limited resources already available.

The need which the new organization imposes to accept new relationships between the professions and a decrease in professional exclusiveness is sensed from the beginning and becomes a common focus for uneasiness, uncertainty, and, at times, for resistance to change.

The tensions of the transition period are likely to bring to the surface a large number of difficulties which are not related to the nature of the change but simply to its sweeping character. What was invisible, swept under rugs or locked in a closet only a few people knew about, is suddenly exposed to the light of day, and a considerable shock effect can then be noted. It may well be that the extent to which this is true depends a great deal on the speed of the transition and the way the transition itself is dramatized. The poor care on the back wards, the petty cheating which may have been going on, the existence of irregular practices and of groups of staff that have protected each other from exposure tend to come to light and may add to the tensions and dissensions arising from the transition itself.

THE SUPERINTENDENT'S CHANGING FUNCTIONS

All of this means that the leadership during the period of transition must be of a very high order. The superintendent is not spared the anxiety that accompanies the changes in function and role in the rest of the hospital staff. Indeed, it might be said that his new role is constantly anxiety-provoking, and that he is the most anxious man in the place. Everyone wants and needs a certain degree of "closure" and a fairly accurate description of his job functions. No one wants complete ambiguity of his role. It is recognized in any situation that a finite, down-to-the-last-possible-contingency-type of definition is impossible, and that a certain amount of ambiguity must be accepted and worked with. The question is, how much can any given individual or group tolerate? The hospital superintendent must clearly be able to tolerate quite a bit of this role ambiguity. He must recognize that the unit teams, or, indeed, many other individuals in the system, can perform many, if not most, of the functions he did in the old system as well as he! The superintendent is thus in the position of delegating responsibility and authority, while at the same time maintaining the "understanding" that he will be consulted and referred to "if there are any questions" among those (unit chiefs, for example) to whom he has delegated authority. The word to emphasize here is "delegate"! Authority has not been abdicated, it has been delegated.

In the decentralized system, authority must be broadly delegated. Authority can be delegated only to someone who is willing to accept it. In practice, the unit chiefs have gone to the directors of their hospital when they had any questions or felt that an urgent administrative matter was involved. This has been especially true where anti-social reactions are concerned as, for example, where a particular patient's history involved widespread community reaction, and the administrative-therapeutic decision now being made is whether he shall return to the community or not. Regarding release of patients (and a multitude of other functions as well), the superintendent has delegated authority to his unit chiefs, but they must answer to him for those special cases which involve strong community sentiments,

such as the treatment of felons. In practice, the necessity of referring to the director's authority is unusual.

The responsibility of the hospital director is fixed by existing law in most places. Though he may delegate, decentralize, and permit autonomous functions, he is still the person responsible in the eyes of the law and of the leaders of community opinion.

The legal formulations of the superintendent's responsibilities do not reflect many of the existing realities of mental hospital practices and never could have, except in extremely small institutions. It is well known that hospital superintendents cannot be directly responsible for many details of the diagnosis, treatment, and care of patients, for which they are nominally responsible. Within the framework of existing legislation, the director is permitted to delegate almost all of his responsibilities to one or another qualified staff member, and must do so. When this is done in the conventional way, to clinical director, discharge officer, admissions officer, officer of the day, and so forth, there is little to be questioned by anyone. But when all of the responsibilities are delegated to a particular unit chief with respect to a group of patients, people look back at the laws and tend to interpret them literally, forgetting that they never could have been interpreted literally. Except in the case of the criminally insane, relatively absolute power has been effectively delegated to the units. An interunit hospital-wide committee reviews these cases and makes recommendations to the superintendent.

It would be a great help in many situations if legislative bodies could be confronted with bills which more accurately describe actual ways in which responsibilities and authorities are distributed. This would be a good way of informing the legislatures of the great changes that are taking place in mental hospitals, and also a good way of reassuring everyone concerned that what is being done is accepted by responsible governmental agencies. It is sometimes helpful in changes of this type to introduce new legislation explicitly sanctioning existing practices, even though the changed practices are not in violation of prior laws.

Legislation is usually a reflection of existing practice, and if these new programs demonstrate their validity and usefulness, one might

anticipate that legislation will eventually be changed to reflect practice. Now, however, the problem is that so long as the director is given total responsibility by law, there will be a tendency for him to cling to this control. Even though this is not obvious and is exercised only in crises, it may tend to limit the autonomous units' potential. The fact that someone with authority is sitting on top watching, ready to step in and change things when his position seems jeopardized, is a limiting factor. It takes courage for a director to yield to others the control mechanisms which determine how his legal responsibilities are carried out.

The superintendent not only has to be concerned with his transitional and ambiguous role within his own organization, but must also recognize that it will take time to redefine his image with the public and with the leaders in the surrounding communities. From a person with baronial privileges and authority and unimaginable capacities to take responsibility for the daily care of thousands of patients, he becomes a delegator of these powers, a selector of people to whom they are delegated, and the spokesman for all of those to whom his powers have been delegated. The public image of the mental hospital director has never been very clear and his new role is even harder to describe.

STAGING

Staging sequences have varied enormously. The extent to which the staff, or parts of it, have been involved in initial planning has also varied a great deal. In one hospital, the first step actually consisted of a rather slow but steady growth of patient government mechanisms over a period of several years, which in itself began to make all involved aware of needs for organizational changes. Several hospitals moved toward comprehensive unit systems and had them running for a number of years without any feeling of a need to use this mechanism to produce a closer relationship to the community. Others thought of the unit system only as a way of providing services to a growing community and of facilitating communication

and work relationships with the relevant professionals outside the hospital. In Part I of this publication, the Dutchess County Unit is described; it is the only comprehensive unit in the hospital and has had little impact on the structure of Hudson River State Hospital.

During the period of transition, it is important to keep in mind all the ways in which different people can see what they regard as threats to their vested interests. Some vested interests are not readily acknowledged as they cannot always stand scrutiny, but they can lead to opposition to or deflection of instructions just the same. For example, some staff members in mental hospitals have become accustomed to the services of "working patients"; all moves to improve treatment of chronic patients, to transform mental institutions from custodial institutions into hospitals, threaten the living pattern of those staff members whose lives are made more comfortable by a working patient.

As changes begin in the hospital, it is easiest for the day-shift workers to see what is occurring and to adapt to it. But the evening and morning shifts will continue to be geared to the older system, unless they are somehow brought into the numerous meetings and conferences which must go on during a period of transition. Local labor patterns should be examined to estimate the wisdom of using a rotation of shifts occasionally, so that the night shift can become acquainted with the new work patterns.

The recent shifts in the labor force have resulted in new kinds of staffs in the state hospitals in general. The shortening of the work week means that no one works a 79-hour week, one way of providing a kind of continuity of care. The shift from a labor force which lives on the institution's grounds to a more community-related one which lives in the community ensures that employee reactions to decentralization and the transition, for better or worse, will be rapidly channeled into community communication networks.

Many unskilled jobs in the hospitals are filled by people who hold them as a second job—a practice commonly referred to as "moonlighting." Also, many jobs are held by women who are the second major wage earners in their families, and whose hours of employment must dovetail with their families' needs. Despite moonlighting

and working mothers, a policy of shift rotation has been introduced as a means of increasing staff involvement. Surprisingly, little staff turnover at the lower echelons has resulted. This fact suggests the presence of high morale, perhaps associated with a hospital organized to provide comprehensive services and identify itself with the community. If people are given sufficient notice of administrative needs and understand the need for them, they make the necessary adjustments in their home and other commitments.

COMMUNICATION CHANNELS

In the transition period the need to establish new lines of communication has to be kept constantly in focus. Special meetings to plan and implement the transition are generally not the same type of communication mechanism which will be needed when the new pattern is in operation. The superintendent has difficulties in delegating responsibility to the unit chiefs; the unit chiefs have difficulty in taking on these responsibilities; the professional chiefs are uneasy about giving up line supervision over the lower ranking members of their own professions who have been assigned to be members of the unit teams.

The members of the new unit teams find it difficult to give up the custom of turning to their former division heads when they are not sure of what they should do in a particular situation, or when they feel their feet are being stepped on by members of other occupational groups. These impulses do not die overnight. The new lines of communication within the team, where almost all of these problems will have to be solved, take time to develop. During the transition period in some institutions, central administration came to the conclusion that the development of the new patterns of team functioning and acknowledgment of team membership were being slowed up because the old lines of communication were too easy to use; administrative authority was, therefore, used to make old lines of communication less accessible to unit staffs. Whether it is wise to block or truncate old lines of communication or not, it is important to realize that every time a response is obtained from the old authority line, the

implementation of the new team function is delayed. Apparently it is extremely difficult for professional chiefs, in particular, to abandon their roles as supervisors and protectors of the people on the unit teams.

BUILDINGS AND ARCHITECTURE

Mental hospital architecture has tended to express two main concerns: the maximum visibility of every patient to the minimum number of attendant personnel the maximum amount of time; and relating patients and their activities to the space occupied by beds, similar to the general hospital model. However, the design of a good mental hospital may resemble that of a college campus more than it does that of a general hospital. The model of the general medical hospital must be modified to fit the needs of psychiatric patients. Psychiatric patients, in general, need to spend no more time in bed than anyone else. The other differences between medical and psychiatric patients' needs depend on the assumptions of those planning the hospitals regarding the needs of psychiatric patients. A college campus or motel type of model may be perfectly satisfactory, if there is no need to worry about what goes on at night and in bathrooms. If these are matters of real concern, such models cannot be used for a mental hospital. An emphasis on the patient's presumed need for 24-hour "supervision" can dominate decisions made in hospital planning. An emphasis on treatment values leads to different designs of facilities for psychiatric patients.

There are many ways in which buildings and spatial arrangement can reflect treatment values. If it is desirable to facilitate the emergence of small human groupings, dormitory size and arrangement and the location and design of activity areas can help to achieve this. Traditional plans dominated by custodial preoccupation, such as the need to segregate patients by sex, which have obvious expressions in building design, find little place in a treatment-oriented institution. The designation of "bed capacity" as the key criterion guiding architectural and building needs has become relatively meaningless, since community psychiatric hospitals offering a wide

range of services are not focused on the goal of caring for people who stay in bed. Thus a new comprehensive unit system of psychiatric architecture may emerge. Such new designs unquestionably will call for smaller groupings of patients in living situations. They may go further and help to evolve new design features reflecting current attitudes toward use of the social milieu as a therapeutic factor. "Freezing" existing successful examples of unit designs serving specific communities into the architecture can be dangerous, for a pattern which is applicable in one locale may not work well in another. Design should embody flexibility so that use of space can respond to needs emerging from the patients and the community the unit serves.

New uses for space can be found even within the limitations of existing architecture when attention is paid to treatment goals. For example, maximum contact between the staff and patients can be approached in a two-story hospital building with beds on both floors by shifting arrangements so that the entire second floor becomes bedroom space, and the first floor is used only for day-activity space. This achieves an approximation to ordinary community living where interactions are not so dependent on where beds are placed on the floor.

SIZE

Our present, often excessively large, mental hospitals are the outcome of economic pressures and administrative and legislative notions that unit cost can be reduced by larger organizations. Larger organizations tend to be regarded as capable of greater specialization of function. They are often expected to use personnel more efficiently and be more capable of surviving cuts in staff.

The concept of the large mental hospital is also the product of therapeutic pessimism: certification of patients to mental hospitals was seen as a more or less permanent solution for a person with an incurable condition. Since the mental hospitals were built to include long-term chronic patients, plenty of time would be available for the staff and patients to get to know one another. Each patient should

be placed in the type of service best able to absorb him with his particular handicap. This called for many specialized services, which imply large size.

These issues have led to the development of mental hospitals which include every specialized resource thought to be necessary. Among these specialized resources which have played a role in deciding whether a larger hospital would be "efficient," one may include the need for a director (one per hospital, the most expensive and rarest personnel category), a laundry, a power house (which for efficiency requires a railroad siding to deliver coal), a sewage disposal unit, a farm, a general medical facility with its X-ray section, and a tuberculosis isolation building.

The steady growth in size of mental hospitals in the United States has been accompanied by intermittent protests from psychiatrists, both in and out of mental hospitals, and from lay leaders concerned with the welfare of the mentally ill.

The current professional viewpoint appears to be that mental hospitals with over 1,000 beds are to be discouraged, that those with over 2,000 beds are deplorable. A comprehensive unit in the size range of 150 to 400 beds is regarded as suitable. Larger units are thought of as too cumbersome and likely to entail the same type of overspecialization of wards which has led to decentralization. Units with less than 150 beds are considered likely to be too small to incorporate the variety of skills needed in a comprehensive unit, or to be wasteful of professional staff if they do. If the staff cannot achieve its full potential because of too small a patient load, it will become discouraged or indifferent.

Exception is taken by many to the recommendations of the Joint Commission on Mental Health and Disease that present large mental hospitals are suitable in size, plant, and location for the care of chronic mentally and physically ill patients and should be used for that purpose, while separate smaller units should be created for acutely ill patients. One objection is that this will lead to first- and second-class hospitals, from the viewpoint of both staff and patients. Another is that many chronic patients need recurrent short-term hospitalization which is difficult to organize in a hospital geared to

chronic illnesses. In addition, some claim it is not easy to predict accurately which patients will require short-term and which long-term hospitalization; each hospital should be geared to deal with the variations in each patient's condition as it occurs.

The current experiments with branch hospitals in cities served by a state mental hospital are modified versions of this scheme. While advocating contiguity to the cities' general hospitals, they maintain an organic connection with the state hospital. Whether these branches can remain branches, while developing adequate functional ties to the general hospitals and the cities' agencies, remains to be seen.

Precision in recommending optimal sizes of either hospitals or comprehensive units cannot be expected. Nor is it to be expected that the optimal size will be the same in two different places or at two different times. The use of bed numbers to indicate size is of only limited value, and as units and hospitals become more comprehensive the number of beds has little relation to unit size. In some comprehensive units today less than half the active case load cared for by the unit's staff sleeps in the hospital. This is because day hospitals, after-care, and pre-care have become so active. Moreover, the medical and social work staffs are busy consulting with staffs of community agencies so that less than half of their work time is spent with bed patients at the hospital. Hence, in addition to the number of beds, one must consider the frequency of old and new admissions, pre-care consultations, after-care, home-care and family-care cases. One must also know about travel time to the communities where the patients live.

The nature of the hospital's mission and the current treatment techniques also affect judgments regarding optimal size. Missions of different hospitals depend on the other hospitals in the area and local practices regarding the uses for mental hospitals. The techniques used vary not only as knowledge grows but because of local traditions or convictions. If a hospital is expected to have a large geriatric load, it might be thought desirable to have a specialized geriatric ward in each unit. If children need to be cared for, can they live in their geographic comprehensive units and go to a com-

mon school by day, or should they be in a specialized unit?

Optimal unit size, then, cannot be specified once and for all in any numerical statement. The only rule which will be of general help is that a unit should be no larger than is necessary to make it comprehensive (generally less than 400 beds) and no smaller than to provide a challenging workshop for a staff capable of rendering comprehensive services (generally at least 150 beds).

Discussions of optimal and possible sizes for hospitals and units tend to get out of hand, to become more dogmatic than established knowledge would justify. Size is spoken of at times as though it determines how well or poorly and how expensively or cheaply the organization will function. But size of organization is not an independent factor in determining effectiveness, efficiency, cost, or pleasantness. Some social scientists believe there are laws governing the size to which different organizations tend. Others believe that the natural tendencies toward particular sizes are very dependent on the extent of specialization and other factors. The effect of size could theoretically be studied experimentally, but in practice this might prove extremely difficult and has not been attempted in mental hospitals. Simulation experiments on computers have been suggested and might prove valuable.

The sizes which will in practice become the future pattern will emerge from the interaction of the sizes thought to be optimal, the physical plants already in existence, and the willingness of society to invest in new plants and perhaps in ones judged to be more expensive.

When existing hospitals decentralize, the sizes of units will depend on judgments regarding optimal sizes under the given conditions, the existing plant and resources for modifying it, and the number of staff physicians thought to be capable of leading independent comprehensive units. An additional factor appears to be the initial size of the hospital. That is, larger hospitals tend to break up into larger units initially. Perhaps this is a necessary transitional step, even though these units are, in some cases, as big as other hospitals which have found it desirable to break up into still smaller units.

There is no reason to think that all the units in any hospital should be the same size.

In summary, our present overlarge hospitals are the result of decisions made on presumed factors of economy and efficiency. Professional judgments regarding sizes tend to deplore hospitals of more than 1,000 beds and comprehensive units of more than 400 beds. Professional judgments regarding optimal unit size show increasing dissatisfaction with the number of beds as an adequate index of unit work load. In the future, as in the past, professional judgments are not going to determine hospital or unit size by themselves, but will interact with administrative and legislative judgments regarding what is desirable and feasible.

5. EVALUATION

THE VALUE OF THE GOALS

The decentralization of mental hospitals into districted, comprehensive units seeks to increase the continuity of services to each patient and to integrate the services given by the hospital with those given by professionals and agencies in the patient's home community.

The arguments for striving for continuity of services and community integration of services are presented in Chapter 2. The meeting brought out no arguments against these goals. In fact, these two concepts—continuity of care and integration of services stemming from the hospital and those stemming from other resources—can almost be taken as axioms today. On the other hand, they have not always been regarded as axiomatic and could presumably be questioned. No objective data are available to prove them. They are generally assumed to be worth while in current thinking, and almost all differences of opinion are in terms of means and methods.

Certain social developments make it difficult to reject these assumptions. Concern with integration of services, particularly, has developed during a period when interest in the problems of mental disorders spread rapidly. The more widespread concern with, and

willingness to talk about, mental disorders grew rapidly after the Second World War. This increased public acceptance of mental disorders is indicated by the greater frequency with which the mass media of communication deal with these topics, and this frequency, of course, continues to reduce public rejection of the mentally ill and their problems. General practitioners, internists, surgeons, school-teachers, police, and welfare officials have also accepted the fact that mental health problems have a relationship to their work. So psychiatrists, psychiatric nurses, and psychiatric social workers find that their isolation—in thinking, in matters with which they are preoccupied in skills, and in functions—has decreased. Their interactions with colleagues outside the mental hospitals are more frequent and more fruitful.

During the same period, psychiatry itself has come to be concerned with a wider variety of human problems. Psychiatrists are no longer working almost exclusively in mental hospitals, because outpatient work in private practice and general hospital psychiatry has increased rapidly. In these ways psychiatric ideas and professionals have spread far from the hospitals.

Moreover, with the advent of new techniques for treating serious mental disorders outside the hospital and techniques for helping those cases not serious enough to require hospitalization, psychiatric patients have also become more numerous outside the hospitals. In some communities the number of psychiatric outpatients is much higher than that of psychiatric inpatients.

Thus knowledge about mental disorders, about the professionals who work with psychiatric patients, and about the patients themselves has been spread in our communities.

Simultaneously, urban sprawl and the postwar population explosion have dispersed our cities into rural areas, so that they envelop the pieces of pastoral countryside where many large mental hospitals were built decades ago, to be out of sight and sound of the cities. Hence, the hospitals' physical isolation has also been destroyed.

These two processes, the dispersion of the professionals, their knowledge, and their patients in the communities, together with the dispersion of the communities right up to the gates of the mental

hospitals, have transformed these hospitals, willy-nilly, from rural, isolated, special communities into parts of busy, fluid communities. Any attempt to appraise the current preoccupation with community-orientation of mental hospital services must take account of the fact that special efforts would be needed to prevent this preoccupation.

ACCEPTABILITY OF THE METHODS USED

The method used is to transform hospitals made up of specialized services—each rendering care of a particular kind, or of patients with particular problems of management, or at a particular stage in their treatment—into hospitals composed chiefly of comprehensive units—each responsible for providing all, or almost all, the indicated care for all, or almost all, the patients who need hospital care and who reside in a particular part of the hospital's district.

Community reactions tend to be favorable. Satisfaction is shown by increased participation in volunteer work, by explicit expressions of enthusiasm, and by fewer attacks on the hospitals as a whole. The communities' legislative representatives have, on several occasions, shown interest and have made visits to hospitals and even done volunteer work themselves.

This method has apparently been very successful in gaining the approval of the patients, the staffs, and the communities. Staff work satisfaction and sense of purpose in comprehensive services have been greatly enhanced, according to available testimony.

LEGISLATORS AND LEGISLATURES

Astute and able legislators look closely at mental hospital administration problems. Their astuteness does not necessarily reflect support; sometimes it is used to create well-designed roadblocks. Nevertheless, they are frequently quite aware of some of the problems of treatment and of those of psychiatry in general. Legislators are not only concerned with appropriations but also with how people

are treated. Some legislators are strong supporters of mental hospital programs and others are strong opponents. Mental disorders and mental retardation are sufficiently widespread for personal involvement to lie behind strongly held viewpoints. Personal involvement leads some to take the attitude that "through helping my own, I will help others," and others the attitude that "I resent it, I reject it." These reactions may influence many legislative decisions.

In general, however, those who appropriate money co-operate with programs, if it can be shown that the programs really accomplish something therapeutically for the citizens who become patients. Legislators may not be satisfied with raw release rates, but they are likely to ask, "In what condition are the patients being released?" Appraisal of increased release rates depends on the patients' clinical condition, their potentialities in the community, and so on. There is a great need for better criteria and standards for assessing patients going into the community. While communities, in general, are becoming far more tolerant of partially improved patients living in their midst, there is a great deal of uneasiness among legislators and other community leaders. Many people do not accept the activities of mentally disordered persons in the community on the same basis that they do those of their other neighbors; as an example of this the production of lethal traffic accidents may be mentioned.

Objective indices of success are not easily obtained. First-admission rates have risen consistently. They may be viewed as a measure of popularity in the community to some extent, since higher rates presumably mean the admission of people who would not otherwise have used the mental hospital. In all instances, the rapid rise in first-admission rates has not been accompanied by a rise in the average daily census of patients, and in most instances the census has dropped. This indicates that the rising first-admission rates are compensated for by a falling off in the average duration of hospitalization.

In some centers an attempt has been made to compute the frequency with which patients are transferred from one service to another, and it was found to have decreased dramatically. This suggests that continuity of responsibility has been achieved. It can also

be used as an indication of the increased comprehensiveness of each unit.

The rising release rates and the shorter average duration of hospitalization have not been appraised in terms of patient improvement. Is the shorter average hospital stay due to: 1. more unrecovered patients being sent into the community; 2. more rapid resolution of the symptoms which brought them to the hospital; or, 3. a reduction in what was previously an unwarranted delay in release following remission of symptoms? As the first-admission rate rises and the average duration of hospitalization falls, readmission rates generally rise, producing a revolving pattern of inpatient and outpatient care. Hence, another useful index would be the number of persons cared for in a given year.

Because many patients receive more care on an outpatient basis in this changed pattern, the average daily census and the admission rates do not measure the work the staff is doing. For this it is also necessary to keep track of the volume of outpatient work, both as after-care and as pre-care.

The rate at which long-term patients become rehabilitated and released from hospitals would be a good index of accomplishment. These figures are seldom easily available.

The number of new admissions who become long-stay patients each year is a good measure of the extent to which the hospital is successful in reducing the incidence of chronicity by having comprehensive services closely related to community services. Because the number of admissions is constantly rising, the proportion who become chronic cases could be expected to decline, since the increased admissions can be assumed to represent predominantly cases with a better prognosis. But the number who become chronic hospital cases each year from each community (taking account of changes in the size of the community's population) is a good index of the program's failures. If patients released to the community are able to function socially, even if they are not quite well, they would appear to be currently acceptable in the community, with the exception of the ones who are aggressive or act out socially. Those, of course, constitute a special problem.

COSTS

It has been argued that the comprehensive units would be able to provide more service with the same amount of staff as the specialized unit. This argument is based on the assumption that the increased delegation of authority means that less manpower need be spent in supervision and that shortened lines of communication reduce time spent in communication. The advocates of comprehensive units claim, either implicitly or explicitly, that little or nothing is gained in efficiency by special services and their more homogeneous group of patients. It is suggested that each specialized service still has such a wide range of problems among its patients that all the skills and all the facilities for patient care must be present on each special service. Another argument used for the comprehensive units is that the mixture of patients with different problems reduces the frequency of the most taxing symptoms, such as wetting, aggression, noisiness, and confusion. The heterogeneous patient group tends to minimize the formation of such symptoms and the patients themselves, because their conditions are more varied, do more to help each other.

Whether this line of reasoning is correct or not, the fact is that staffs feel they work harder and longer on the comprehensive units and insist that more staff is needed. The same staff which complains of an increased load will explain simultaneously that getting things done is easier and less time-consuming. The best explanations offered for this paradox are that: 1. the number of persons served increases, with many more being treated as outpatients than previously, more than outweighing any reduction in the inpatient load; 2. in the new comprehensive units low levels of patient care, which it has been possible to maintain on some of the specialized services, become too visible to tolerate.

It is thus possible that there is actually an increase in both efficiency of work and an increase in the effectiveness of the work done, but that the volume and standards of work increase more rapidly.

The decentralized unit puts more responsibility on the shoulders of every staff member. The unit obviously takes on responsibilities

almost as serious and difficult as those the director of a mental hospital usually has, although for a smaller group of patients and staff. He has behind him the expertise of the hospital director and his clinical chiefs; but he is expected to know when to use them and he cannot use them in dealing with the ordinary affairs of the unit in relationship to the community the unit is serving. He must be able to represent the hospital in many professional and government meetings and in dealing with medical practitioners of the community. In some large hospitals there is doubt as to whether there are enough psychiatrists with sufficiently long experience and resourcefulness to provide the kind of leadership needed. There is no disagreement that when authority is delegated to less fully qualified personnel, with due anxiety, these people, in general, mature and meet their responsibilities more rapidly than would have been expected in the specialized services. Nonetheless, this increased maturation will, in the long run, pose the same problems created by not having enough mature persons for the new kinds of responsibility: It may be necessary to raise pay standards and to deepen professional satisfactions in order to get or to hold the kind of people who are necessary to give these units the leadership and guidance they need.

The additional work entailed by pre-care services and increased after-care case loads in themselves would appear to justify increased personnel allocations. The enlarged contact with the community requires extra correspondence, stenographic time, stationery, telephone service, and transportation. Rising admission rates mean a larger proportion of staff time devoted to new admissions and readmissions, requiring staff ratios more closely approximating those of reception services. The increased visibility of the long-stay patients leads to the creation of programs for them which are more like those of intensive treatment units than those of the old chronic services.

All of these factors produce pressures for higher budgets. If the better service to patients is seen as worth while, then those responsible for allocating money will tend to see it as being worth the costs. The benefits of comprehensive units can be expected to lead to increases in cost to levels approximating those of intensive treatment or admission services.

In some hospitals, these increases in costs were met initially by grants from outside agencies. While this method can be used to get the operation rolling, in the long run the facts of increased costs have to be faced. In some jurisdictions, the appropriating bodies have made regulations prohibiting the acceptance of grants without legislative approval, since it can eventually lead back to pressures for perpetuation of the new programs at their expense. As time goes on, it may not be possible to use seed money to bypass initial resistance regarding the value of a particular innovation, since in either case agreement will have to be present before the innovation can be started. At least one hospital superintendent refused to begin the introduction of comprehensive unit organization prior to a commitment for larger budget and increased personnel. In that location the comprehensive unit system was itself accepted as sufficient justification for a budget increase.

Negative features accompany the expressions of positive support, which are perhaps related to the mood of change and more open communication as much as to any realistic appraisal of the changes as reflecting improvement. The positive support is counterbalanced by three negative features.

The enthusiasm itself can become extreme; it can lead to exaggerated optimism about what these changes can reasonably be expected to accomplish. It seems to be necessary to explain repeatedly that these changes do *not* represent a definitive treatment of mental disorders, that it is *not* possible to care for all psychiatric patients in the community, and that we *cannot* expect the need for mental hospital resources to disappear overnight. The dangers accompanying unwarranted optimism need not be exaggerated to be appreciated. They consist of underestimates of future service needs and embittered disappointment following the realization that these advances in the organization of psychiatric treatment are not the panacea by which all technical, scientific, and therapeutic problems can be overcome.

Excessive optimism endangers financial resources for continuing improvement of patient care. These advances in organization may, indeed, make more effective use of existing personnel, but they do

not reduce the need for personnel, nor can they be expected to.

Negative community reactions sometimes accompany the creation of comprehensive units oriented toward particular communities. These negative reactions stem in part from disturbances of vested interests connected with providing services and staffs for the hospitals, and in part from anxiety lest control over psychiatric patients—who are sometimes stereotyped as dangerous lunatics—be lost. While this stereotype is not justified by the facts, some psychiatric patients are dangerous people and communities are entitled to certain kinds of protection. If this protection is not provided by the comprehensive units at least as well as by the conventional mental hospital, these negative reactions can get out of control.

At the present time, objective indices are not available to appraise the success of the comprehensive unit system. Present appraisals are based on the judgments of those who have been involved in these changes in hospital organization and those who have observed them closely.

The comprehensive unit assigned to providing services for a defined group of communities appears to be a better, more flexible use of existing mental hospital structures and staffs than any which has been developed previously. While not a panacea, and no substitute for improved methods of treatment or prevention, it does make possible better patient care, according to our contemporary standards, and facilitates the integration of mental hospital services with services available in communities.

REFERENCE

¹ The Veterans Administration psychiatric hospitals have followed a similar path of administrative decentralization, but since their potential for integrating services with the community is limited they have not been discussed here.

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