STUDIES OF THE FORT LOGAN PROGRAM

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INTRODUCTION

Our goal is the development of an elaborate potential for program description, evaluation, and improvement at Fort Logan. In reviewing the output from this evolving organization, it became evident that it would be unwieldy to cover in detail the 40–50 papers written over the past three years. Since many of these papers were written as specific questions arose and were not part of a single co-ordinated effort, it seemed best to give some data in each of three salient areas. In this way you will get a picture of "what is happening at Fort Logan" without being flooded by a mass of data on the diverse questions that have been examined.

This paper is divided into three sections. The first covers some of our material available on admissions and on nonadmissions to the Center. Since evaluating individuals referred for admission to our state hospital was a basic departure from the policy of the original Colorado State Hospital at Pueblo, there has been a good deal of interest within the Center regarding its effect on our admission picture. We thought, too, that since this is a fairly unusual procedure for state hospitals in general, there might be value in presenting these data.

The second section summarizes some of the data available on three problems, especially critical in an open, decentralized, therapeutic community institution:

1. suicide in an open hospital;
2. team leader turnover;

3. what kind of patient responds well in this particular therapeutic community.

The third section describes some evaluative studies of patients' responses to our program. We will present data on three aspects of this problem:

1. length of stay;
2. condition at discharge;
3. the readmission picture.

In all cases, we regard our efforts as essentially exploratory. The focus of our work to date has been the development of machinery for self-study and evaluation. The following material illustrates some of the ways we have used this mechanism. It does not as yet represent a comprehensive effort at program evaluation.

ADMISSIONS AND NONADMISSIONS

A Preadmission Evaluation Policy

Before Fort Logan instituted a pre-admission evaluation, almost all patients entered the state hospital under commitment and all who were committed were accepted for treatment. The policy of pre-admission evaluation was aimed toward three main goals:

1. to encourage voluntary admissions;
2. to avoid unnecessary hospitalizations;
3. in case of hospitalization, to make use of day-patient status whenever possible, i.e., to encourage minimal hospitalization.

In looking at the relevant data, we raised two basic questions:

1. How well have we succeeded in achieving the stated goals?
2. How has such a basic innovation in policy influenced our relationship with the professional community?

In raising the second question, we assumed that screening one's admissions does not always result in harmonious interagency relations.

It is important to remember that we have no information on how Fort Logan functioned before these policies went into effect. Fort Logan began with these policies. We must be careful, therefore, not to ascribe causal relationships between the policies instituted and the results observed. For the present we must content ourselves with reporting what we have found, assuming that a probable relationship exists between pre-admission screening and the results obtained. As

we develop a more complete picture of our patient population and the Center's operation, we may find appropriate comparison data. Or, as policies change, we may be able to observe changes from the already established base line of functioning.

Voluntary Admissions

In developing the Center, we have tried to project the image of a modern, open, progressive mental health center where patients would come willingly with the expectation of receiving help. We felt that one index of our success in communicating this idea would be the percentage of voluntary admissions. Over the past three years, 89 per cent of all admissions to both the Psychiatric and Alcoholism Divisions have been on a voluntary basis.[1] On an over-all basis, then, we seemed to have reached this goal rather well.

Looking at the percentage of voluntary admissions for each of the three years modifies the first impression slightly. While the voluntary admissions to the Alcoholism Division amounted to 89 per cent in the first year, they have gradually climbed to 94 per cent for the 1963–1964 fiscal year. The Psychiatric Division, on the other hand, had almost 97 per cent voluntary admissions the first year, and these have gradually dropped to 80 per cent. While voluntary admissions could hardly have increased in this division, it is noteworthy that they did not automatically stay high. Some of the decrease is attributable to an increasing number of transfers from the other state hospital at Pueblo. These usually come to us on a committed, involuntary status. Nevertheless, this trend should be watched closely over the coming years. It would be disconcerting if a new institution could not maintain a high rate of voluntary admissions.

Unnecessary Hospitalizations

In a strict sense, we cannot say that we have prevented a single unnecessary hospitalization; that is, we do not have a situation in which a patient was approved for admission and then some procedure was instituted that made hospitalization unnecessary. The patients with whom we are dealing, however, have been referred to us or have referred themselves for admission to a state hospital. In analyzing our data, we assume that most, if not all, of these people would have been admitted if there had been no pre-admission evaluation.

Looking at the overall picture first,[1] we find that 67 per cent of all applicants to the center have been admitted. It is important, however,

to consider the Psychiatric and Alcoholism Divisions separately. Over the past three years, the Alcoholism Division has admitted 86 per cent of all applicants, while the Psychiatric Division has admitted only 51 per cent. Moreover, most of the nonadmissions to the Alcoholism Division have been accepted applicants who did not appear on their appointed admission date. Since the Alcoholism Division does only telephone screening and does not perform a pre-admission evaluation, this lends some support to our impression that most referrals to the Center would be admitted if it were not for the pre-admission evaluation. Still, we must be cautious in interpreting the figures since the patient populations of the two divisions comprise two fairly different groups.

The data show that referrals from psychiatric hospitals and private psychiatrists are the most likely to have been admitted, ranging from 83–61 per cent of patients referred by these sources. Since the percentage of admissions from Pueblo is inflated slightly by transfers, our past experience shows that 61–65 per cent of patients referred by these sources are admitted. Thus, in the judgment of our staff, over one-third of the patients coming from the most expert of our referral sources did not need admissions to the Center. If the picture presented by this finding is representative of patients admitted to state hospitals across the country, it would mean that a substantial number of admissions could have been prevented through the use of a pre-admission evaluation.

Even more dramatic are the results on patients referred by friends and relatives, private physicians, and nonhospital sources. Here only 35–39 per cent of referrals were found suitable for admission. In the judgment of our staff, almost two-thirds of these patients would have unnecessarily begun treatment if a pre-admission evaluation had not been done.

While it would be highly desirable to have data on the subsequent fate of those not admitted, unfortunately, at this time, we do not have a comprehensive register of psychiatric patients in Colorado. One possibility is that those we do not admit are treated elsewhere. We do know, however, that it is unlikely that many prospective patients enter the other state hospital at Pueblo. The few who do are usually transferred to us. Therefore, while nonadmissions may seek private, Veterans Administration, or short-term service in the acute and intensive treatment hospitals in Denver, it is unlikely that a substantial number of them later received long-term hospitalization elsewhere.

Day Hospitalization

Our philosophy has been to minimize the institutionalization of patients admitted to the center. Dr. Alan Kraft mentioned that over half of our patients are admitted directly to day-hospital status. In addition, approximately three-quarters of all patients spend some time in day hospital during the course of their treatment.

Again, if our patient population is typical of state hospital populations across the country, these statistics suggest that at least half of the patients admitted could have been treated adequately in a day hospital facility. Of course, one reason we can use this approach with so many patients is the compact geographic area served by Fort Logan. Virtually all of the area is within one hour's drive of the Center. Such a favorable situation is clearly not the case for many state hospitals.

Interagency Relations

When an institution pursues a policy of choosing whether or not to admit patients, such a policy is bound to have repercussions in the referring community. A reaction is expected, particularly when many members of the community have been accustomed in years past to sending patients to the state hospital without being questioned whether admission was necessary. We have data from two studies available that investigate the effect of this policy.

One study looked into the adequacy of our evaluation procedures with the two institutions which provide the largest percentage of referrals.[2] Thirty-six consecutive cases in which patients had been referred to Fort Logan but not admitted were intensively reviewed.

The committee investigating these cases found that complaints such as the following were leveled at the psychiatric teams:

1. the admission policies were too vague;
2. the teams selected only patients they thought they could help;
3. involuntary patients were not accepted;
4. teams made snap judgments in diagnosing cases and disregarded the findings of the referring hospital.

The reviewing committee concluded that these complaints were justifiable in approximately one-third of the cases; that is, they felt that about one-third of the patients not admitted should have been admitted. These results led to a thorough revision of our admission policies in order to clarify which patients should be admitted.

The fact that the study was done, and the clarification of admission

policies that followed, apparently resulted in an improvement of relations between the Center and the other psychiatric hospitals. However, no follow-up study has been made to see if a smaller percentage of nonadmissions now would be judged to warrant admission.

These findings also throw additional light on the implications of the number of nonadmissions discussed in the earlier section on Unnecessary Hospitalizations. If the findings of the review committee were representative of all patients not admitted from psychiatric hospitals and private psychiatrists, it would mean that one-third of the 33 per cent who were not admitted, or roughly 11 per cent, actually needed admission. However, even with the estimated correction, this is still a substantial reduction in admissions.

A second study, still in progress, is focusing on the general image of the Center in the professional community, and is not aimed specifically at evaluating the impact of our admission policies. While it is still too early to report any findings, impressions from this survey show that the dissatisfaction with our lack of clarity and consistency in admission policies extends beyond the two hospitals studied.

The implication seems clear that it is not enough to plan and establish a progressive institution. One must pay constant attention to the ways in which the Center interacts with the community. The necessity of dealing with this problem is even greater in a decentralized institution because a greater number of staff members represent the Center at one time or another in the community.

SPECIAL PROBLEMS IN THE THERAPEUTIC COMMUNITY

Suicide

Since the hospital is entirely open and many patients return home evenings and week ends, there are many more opportunities for suicide than in the traditional state hospital. Unless we can exercise extremely good judgment in dealing with the potentially suicidal patient, we face the unhappy prospect of depending more and more on surveillance and inpatient hospitalization.

There seems little doubt that we have experienced a high rate of of suicide. Through March of 1964, we had a rate of about 1,060 suicides per 100,000 admissions.[3] Compared to the 1960 rate for the general population in Colorado of 13 per 100,000, this is, indeed, alarming.[4] However, when compared to rates based on populations showing previous suicidal behavior, the figure is not so surprising,

although no less a cause of concern. For instance, Tuckman and Youngman found a rate of 1,951 per 100,000 among Philadelphians who had previously attempted suicide.[5]

Our concern with the problem is reflected in the fact that the research department has already made three studies of various characteristics of patients committing or attempting suicides.[3,6,7,8,9] In addition, a committee composed mainly of clinical staff has been intensively examining each fatal or near-fatal case. With many variables to study and few actual instances—some of the early studies had an N of only 11—there are many suggestive trends but no conclusive results. Rather than trying to review all the studies, allow me to discuss a small portion of the analyses. The importance of bringing up the problem—besides its intrinsic cause for concern—is the likelihood that it will be of increasing concern in other state hospitals as the trend toward openness and partial hospitalization continues.

One clear trend to date is that all suicides have occurred off the hospital grounds.[6] All but one have been committed in the patients' homes. A perference for home rather than hospital as a focus for succussful attempts is especially striking since well over half of the reported instances of suicidal behavior (81 out of 141) took place on the grounds of the Center. One important implication is that it is possible to discourage successful suicidal behavior even on the grounds of a completely open institution. The essential problem is the recognition of clues that would allow the staff to intervene in cases in which the suicide is planned for off the grounds as effectively as they apparently do in attempts made on the grounds.

So far, the best predictor of the patient suicide rate of the individual teams has been the team's average scores on a staff morale survey.[10] The higher the morale of the team, the lower the suicide rate for the team. We have already had many discussions about the possible direction of the relationship, i.e., whether low morale leads to suicidal behavior or suicidal behavior leads to low morale. Very likely further study of this association will reveal a complex interrelationship. Incidentally, the morale survey was devised for other purposes and was found to relate to suicide rate only because it seemed a reasonable association to investigate.

Because we found that teams differ in their suicide rates, we then looked at how they affectively responded to suicidal behavior.[3] They were discovered to differ markedly, for instance, in how they feel toward patients who exhibit suicidal behavior.[8] Some teams reported

as high as 66 per cent of their feelings as "sympathetic," while others were as low as 25 per cent. Some reported very few "angry" feelings—as low as 5 per cent—while others reported up to 37 per cent angry responses. While not significantly related to the rate of successful suicides, the preponderance of sympathetic responses was associated with milder suicidal behavior, while angry responses were associated with more severe behavior, i.e., aimed at completed suicide rather than mild injury and attention-getting activity.

Just as teams are found to vary in their response to suicidal behavior, so do individuals. While data are still insufficient for studying the response of specific individuals, we have found that staff tends to be more sympathetic and less rejecting, angry, or frightened if the suicidal behavior is by a member of the opposite sex.[7]

These are just a few of the findings worthy of further exploration. Our intent here is not to offer a detailed study of suicide but to mention several of the many possibilities for research available in a state hospital setting. The goal of this particular type of study is to identify eventually those patients who have a high probability of commiting suicide. We may then be able to find ways to intervene therapeutically in individual cases.

Loss of Team Leaders

Since the teams enjoy considerable autonomy of functioning in a decentralized hospital, it is crucial that they have stable leadership. Much concern was expressed when five of our six team leaders left after only a year's service. The opportunity afforded by an exit interview with these individuals was used to gain some insight into the problem. The interviews were conducted by Drs. Polak and Gaviria, who had the confidence of the departing team leaders and could assure them of the confidentiality of their remarks.

From these interviews, the investigators were able to identify some 20 areas of dissatisfaction.[11] Prominent among these were the feeling of losing part of the traditional role of the psychiatrist (through minimizing individual therapy) and the stress associated with administering treatment for patients through a team of other people. In general, the team leaders felt unprepared for their roles as team administrators and were uncomfortable in asserting their leadership on the teams.

Also involved were feelings of uncertainty regarding supervision of other disciplines on their teams, and what their proper relationships were to the department heads of other disciplines. They felt that

their areas of authority had not been delineated sufficiently and that they sometimes lacked support from administration in dealing with clinical department heads.

They were also made uncomfortable by the fact that, while they are responsible for the care of all the patients on their team, they have to rely not only on their own judgment but also on the judgment and actions of many of the other team members. Their lack of control over many situations in an open setting made this anxiety even more acute.

These and other findings resulted in a list of recommendations designed to alleviate the situation. The recommendations resulted in the creation of a Department of Psychiatry to help strengthen the planning role and group identification of the psychiatrists. There have also been efforts by administration to clarify the authority and responsibility held by individuals within the center. Other steps are now being taken to orient new team leaders better when they arrive.

Apparently there is still room for improvement, because a few more team leaders subsequently left. Areas of psychiatrists' dissatisfaction, we hasten to add, had absolutely nothing to do with the subsequent departure of Drs. Polak and Gaviria!

This study of team leaders points up some of the inherent stresses generated by a decentralized administrative structure of the treatment program which emphasizes teams' developing a therapeutic community approach. Unless more of the key individuals who work in such a setting come better prepared, or more disposed, to evolve along these lines, this whole movement in the mental health field may develop much more slowly than is necessary. It is not enough for a few mental hospital administrators to have new ideas; unless they can find the staff to develop these ideas; the innovation in mental health could turn out to be nothing but new buildings housing traditional programs. We may find we have only participated in an architectural revolution with little actual change in practice. I doubt if the movers of this revolution would find this a satisfactory achievement.

Types of Patients Who Respond

We have, of course, wondered if there were certain types of patients that did well at the Center and certain other types that did not respond so favorably. We are not ready to assume that a therapeutic community type of treatment works equally well with everyone. Neither

are we in a position to claim that our approach works better than another one would, with certain patients. What we can report at present are some of the characteristics associated with treatment success or failure at our Center. One study took a few basic demographic variables, i.e., age, sex, education, and marital status, as well as diagnosis, and investigated the relationships of those variables to the response rating made at the time of discharge.[12] Among its findings were: the affective psychoses were rated as responding best while those diagnosed as character disorders were rated lowest; married individuals responded better than single ones; the older patients were rated as more improved than the younger ones; there was a complex relationship between education and response, with male depressives with 13 years or more education responding best, while female depressives with less than 11 years of education responded best among their sex. Without attempting to review all the possible interpretations and interactions in these data, this illustrates one of the kinds of studies we do, i.e., simply looking at many of the variables commonly available and studying their relationship to various outcome criteria.

A second study used another interesting approach to the problem.[13] This study looked at some of the same variables, i.e., age, sex, and education, but also considered the patient's team and predominance of patients' characteristics on the team. In a sense, this approach considered some of the characteristics of the patient's milieu as well as the patient's characteristics.

When considering the educational level of the patients on a team, for instance, the investigator found that those teams having proportionately more patients of more than high school education did best with them and more poorly with others. Another team that had proportionately more patients who did not complete high school did best with that subgroup of their patients.

Thus the patient's response may be not only a function of his individual characteristics but also a function of the characteristics of the group with which he is receiving his treatment. Obviously, more research needs to be done along this line, but the implications of this finding could provide an empirically based rationale for structuring the patient composition of a team on the basis of variables other than geographic area. Finding a solution to this problem becomes very much like deciding the composition of a therapy group, i.e., should it be heterogeneous or homogeneous, and in what dimensions and to

what extent? Whatever the complications involved, it does raise some basic questions regarding the model of the therapeutic community as a replica of the composition of the community at large.

OUTCOME OF EVALUATION STUDIES

Length of Stay

Before reporting any of the findings on our patients' length of stay, we should define what we mean by "length of stay." In Fort Logan, where a wide range of treatment statuses are available, it is ambiguous to report that a patient stayed there for a year. Knowing only that much, you would not know if he had been an inpatient for a year, a day patient, an evening patient, a halfway house patient, an outpatient, or—more likely—had had some combination of these treatment modalities. Consequently, we prefer to report not only how long a patient has been at our Center, but also where he spent his time. The time reported is time on the books, not days in attendance.

Although we analyze our data in detail, we have adopted two summary concepts for simplification: "total length of stay" and "intensive treatment length of stay." "Total length of stay" includes the time between the patient's admission date and his final discharge from the books of the Center. Typically this includes time in a variety of statuses, *including outpatient status.* "Intensive treatment length of stay" includes only the time spent on an inpatient, day patient, or family care patient status during a single admission. This combination is generally less than the total active time on the books and obviously cannot exceed the total time figure.

Since the Center only opened in July, 1961, we have no patients with very long lengths of stay, as is true of most other state hospitals. Consequently, our length-of-stay figure will increase as our history becomes longer.

With these qualifications in mind, we find, first, taking all discharges from the Psychiatric Division during all three years, that the average total length of stay was 144 days. The average intensive length of stay for the same group was 107 days. If we look at only those patients discharged during the fiscal year 1963–1964, we find the average total length of stay was 159 days and the average intensive length of stay was 118 days. Comparable figures for the first two years were 122 days total length of stay and 92 days intensive length of stay.

These figures illustrate how our average length of stay at discharge

is increasing as the Center grows older and patients with longer lengths of stay are discharged. It will probably be at least another three to five years before these figures begin to reach a plateau.

Another way of looking at the movement of our patients is by admission cohorts. The first year's admissions (1961–1962) had 72 per cent discharged by the end of the year, and now have 83 per cent discharged. Only 2 per cent of this cohort is currently on inpatient status and none has remained as an inpatient during the *entire* time period. Other studies of patients who are on inpatient status two or three years after admission revealed that not only had none remained as inpatients continuously, but all had several changes of status during their stay, with one individual having made 20 changes during the course of his treatment.

These results suggest that those patients who remain at Fort Logan a long time are not allowed to settle into a comfortable niche. They are apparently kept on the move and frequently re-evaluated. We may be developing our own crop of chronic patients, but they are chronic patients on the move. This is encouraging in view of our concern with patients becoming chronic inpatients.

Improvement at Discharge

At the time each patient is discharged from a psychiatric team he receives a rating on the degree to which he has responded to treatment. Taking these ratings for discharged patients over the first three years of operation, we found that 67 per cent of our patients had been rated as improved, 24 per cent as unimproved, and 9 per cent fell into the "other" category. Needless to say, these gross summary figures cover a variety of intriguing, detailed figures.

Examining all three years' discharges more closely, we can separate the improved ratings into two groups:

1. those patients rated either as "recovered," "markedly improved," or "moderately improved" (39 per cent);

2. those rated as "slightly improved" (28 per cent).

Most of those in the first group were either moderately or markedly improved. "Recovered" is a scarce category, accounting for only 2 per cent of discharges over the three years. The unimproved group consists basically of those who did not change, with a regressed rating accounting for only 1 per cent of discharges. The "other" category covers patients discharged as "not treated" (7 per cent), patients

discharged as "deceased" (1 per cent), and those with "unknown" responses (1 per cent).

If we divide the discharged patients into cohorts by their admission year, we can see several trends developing over the three years. First, the moderately improved to recovered group has steadily declined from 53 per cent for the 1961–1962 cohort to 38 per cent for the 1962–1963 group and 32 per cent for the 1963–1964 group. At the same time, the slightly improved group has steadily grown larger. The 1961–1962 group was 18 per cent, the 1962–1963 was 27 per cent, and the 1963–1964, 35 per cent. The unimproved and regressed group has remained fairly steady over the years. The "other" group has grown steadily from 6 per cent in 1961–1962, to 8 per cent in 1962–1963, to 12 per cent in 1963–1964. A small but steadily growing group of patients discharged as "untreated" largely accounts for this change. They are probably drop-outs who stay too short a time for the team to feel that they became involved in treatment.

A variety of factors could be influencing the picture presented here. We must keep in mind that these are admission cohorts and consequently a higher proportion (around 80 per cent) of patients in the 1961–1962 and 1962–1963 groups are discharged at this time than those in the 1963–1964 group which has about 50 per cent of its patients still in treatment. We know from other studies that longer staying patients tend to have more favorable response ratings. Therefore, we might expect the response picture for the 1963–1964 cohort to improve over the coming year or two. However, this would not explain the drop from the 1961–1962 to the 1962–1963 group, both of which have approximately the same per cent of patients now discharged (1961–1962, 83 per cent; 1962–1963, 79 per cent). There was a possibility that the 1961–1962 results were related to the optimism during the first year's operation, but many of their patients were not discharged until 1962–1963 or 1963–1964 and were rated at those times. We have not yet examined the results to see if the first year's patients' ratings declined over later years, although the positive relationship between length of stay and response would argue against finding this.

We know, too, that raters will judge their patients' responses differently. However, since these patients were rated by different raters across all three years, this should minimize the effect of a specific rater's bias. An analysis of discharges by discharge year would be much

more susceptible to this type of bias, especially if rater bias is related to the Center's initial optimistic approach.

Another possibility is that the composition of our patients has changed over the past three years. We know that psychotic admissions rose from 50 per cent in 1961–1962 to 58 per cent in 1962–1963, but dropped back to 50 per cent in 1963–1964,[1] so this would not tend to account for the difference. Psychoneurotic admissions have dropped from 40 per cent in 1961–1962 to 22 and 24 per cent in the latter two years, while personality disorders have risen slightly from 10 per cent in 1961–1962 to 16 per cent in 1963–1964. These two latter trends would appear to be more likely contributors to the changing response pictures, but we have not yet examined the response by diagnosis over the three years.

We have a small amount of evidence that the patients' condition at the time of discharge is not correlated with community informants' ratings of their adjustment at a later date.[14] If this finding from the pre- and post-hospitalization scales,[15] holds up, it will tend to complicate the problem that much more.

Readmissions to the Center

One of the goals of the Center is to return patients to the community. Their ability to remain in the community is at least one index of how successfully they are continuing to function, although we certainly cannot regard it as a simple, unambiguous indicator. With this qualification in mind, we have studied several aspects of the readmission picture.

One measure taken is the simple percentage of each year's admissions who are readmissions. Naturally, in the first two years there were very few discharged patients in the community and consequently very few readmissions. In the third year of operation, (1963–1964) 21 per cent of all admissions for the year were readmissions in the Psychiatric Division and 22 per cent in the Alcoholism Division.[1]

We have made a few studies of some characteristics of readmissions to the Center. One study found that more common among readmissions were males, slightly younger, single patients, and individuals with annual incomes under $1500.[16] They were also more likely to have had previous inpatient treatment and to have been diagnosed as psychotic.[17]

Another way of looking at readmissions is to calculate the rate at

which patients discharged are returning to the Center. A study examining the percentage of psychotic patients readmitted to Fort Logan found that 23 per cent had been readmitted within a year after discharge.[18] This figure was not significantly different from that of 38 per cent which Freeman and Simmons had reported.[19] On further examination, it was also discovered that two of the discharged patients had been readmitted to Pueblo. Adding these patients raised the readmission figure even closer to Freeman's and Simmons' and made it more unlikely that we would ultimately demonstrate a lower readmission rate.

Of course, the whole problem of deciding the meaning of a readmission rate and whether or not it reflects the quality of treatment given is not settled. Certainly, because we have embraced early return to the community as an ideal from the beginning, we have made it difficult for ourselves to keep the return rate low. More fruitful than concern with the absolute rate will probably be studies examining the correlates of readmission. Hopefully, these will give us some of the clues needed to accomplish both early return and satisfactory community adjustment.

DISCUSSION

This paper has attempted to give an over-all picture of the kinds of studies we have been doing at Fort Logan. None of the areas covered was detailed, because we do not consider any of our present findings comprehensive or definitive. We believe that the primary value in what we are doing currently lies in demonstrating the range of questions to which we can address ourselves.

Part of the reason for doing varied rather than detailed studies lies in the fact that we are just beginning to accumulate enough data on the Center to probe in any depth. Also, while we have developed a fairly powerful data collection, storage, and retrieval mechanism, we have not had an equally strong data analysis capability. Added strength in this area is being developed. As a result of this limitation, we have had to rely heavily on simple studies involving a few variables, rather than more complex investigations studying the interaction of multiple variables. In addition, we strongly believe the Center needs information on many types of questions and not answers for a few. While we may develop a few areas of special long-range interests, such as the

failure and follow-up studies, we also hope to expand the capacity for solving the wide variety of problems constantly being posed. We recognize the danger of trying to do a little of everything at the risk of ending up by doing not much of anything. We also recognize the danger of not giving any sort of answer until five or ten years of study have elapsed. We hope to find a productive compromise between these extremes.

A final point we want to stress is our hope of demonstrating that a state hospital can not only function as the major mental health service facility in the network of community services, but that it can also function as a major contributor to knowledge. Perhaps we have focused too much in the past on the service burden our huge numbers of patients represent and too little on the potential resource our work with them generates in the form of valuable information. With the proper harnessing of this resource, we could well become the centers of mental health research rather than the occasional contributor. We have the most to gain in the struggle to reduce the ignorance in which we all work. We think that with enough imagination we can do much more to change the picture than was ever dreamed of in the past.

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