THE FORT LOGAN MENTAL HEALTH CENTER

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INTRODUCTION

The establishment of the Fort Logan Mental Health Center in 1961 was prompted by the inadequacy of mental health facilities in the state of Colorado, an area of about 400 square miles. With one overcrowded state hospital with a custodial orientation, few mental health clinics, and insufficient numbers of private practitioners in a state which boasted a population of 1½ million people and a healthy economy, there was considerable grass-roots support for a major overhaul of Colorado's program.

As one part of a state-wide effort to enrich the psychiatric facilities at both local and state levels, Fort Logan was established by the state and assigned the task of serving as the long-term treatment facility for the four-county metropolitan Denver area with a population of about 900,000. Its goal was to serve as the back-up facility for the already existing and newly created facilities in the area. It would receive patients who needed long-term psychiatric treatment in a state hospital setting. No one can be too sick to go into the hospital, but people conceivably can be too well to be referred to the hospital. These people might need welfare agency care or outpatient care, or some other kind of help. It would not provide services which would overlap or duplicate those of other agencies. Thus outpatient psychotherapy (except as follow-up care) and emergency admission services were not part of its assignment. These were left to two public receiving hospitals,

several private hospitals, the many private practitioners, and the local community mental health outpatient clinics. It was to be the state hospital facility serving the Denver area and, as such, would not transfer patients to the other state hospital facility.

To accomplish this goal, the center was to be a facility of about 400 hospital beds. This bed capacity (0.4 per 1000) is considerably below the national average (3.0 to 4.0 per 1000) of the ratio of state hospital beds to population served. It was hoped that: 1. immediate intensive care would prevent the buildup of a "back-ward" population, and 2. transitional forms of treatment would enable the staff to treat larger numbers of patients than would be possible if cases accepted for care were limited to bed capacity.

At the time of writing (December 1964) the hospital has been partially built and staffed, but has not yet assumed its full responsibility for the patients in its catchment area. Although only partially completed, the low buildings form a pleasant campus. From the outside it resembles a college campus or a motel far more than the usual mental hospital. Inside, the architecture stresses openness by the use of large courtyards, many large glass windows, and small cottage units. With new buildings and new staff, the center has expanded the spectrum of services so that at present it receives 75–80 per cent of state hospital admissions from the Denver area. In 1963–1964, there were 1,687 admissions of which 90 per cent were voluntary.

The remaining 20 per cent of admissions from our area go to the Colorado State Hospital at Pueblo, Colorado, some hundred miles from Denver. The courts sometimes send people they regard as "recidivists" —frequently alcoholics—there against our advice. We have found that other people are sent to Pueblo because the family, judges, doctors, or someone thinks that custodial care is indicated. Sending patients to Pueblo is not an accident. We found that the custodial solution was sought by many people in the community. We bring these patients to Fort Logan and then have to face the people who had arranged the admission to Pueblo. Other patients admitted to Pueblo State Hospital include those for whom Fort Logan does not have facilities, i.e., the criminally insane, and, until recently, children and some geriatric patients.

The center is organized into major divisions which have specific treatment functions. At present there are four: the adult psychiatric, children's, medical-geriatric, and alcoholism divisions. Within each one there is further subdivision into treatment teams.

The center was designed on the following principles:

DECENTRALIZATION

In order to provide a structure in which important decisions involving patient treatment may be made at the level closest to the patient, the center is organized into small, semiautonomous clinical units or teams. In the adult psychiatric division, each team receives its patients from a specific geographic segment of the community. The psychiatric team is headed by a psychiatrist and staffed with a psychologist, two social workers, seven registered nurses, and seven psychiatric technicians. The team leader is the central authority of the team. He is responsible to the division chief, who is, in turn, responsible to the clinical director. Department heads have no line authority, but function in teaching, supervision, consultation, recruitment, and program planning.

At present there are nine psychiatric teams. There will be 14 when the center is fully implemented. There is one geriatric team; there will be three. The first of four children's treatment teams will soon be established. The alcoholism division has one team.

THERAPEUTIC MILIEU

Drawing heavily on the experience of Maxwell Jones, Elaine and John Cumming, Alfred Stanton, Morris Schwartz, and many others, we have developed our own brand of therapeutic milieu. It is based on the concept that *all* activities in a treatment day potentially can be used by the patient for strengthening of ego functions. The role of the staff is to maximize opportunities for the patient to learn from his experiences. The setting is manipulated to be protective, yet to provide a variety of situations from which the patient can benefit. Patients' strengths are supported and encouraged. In general, the culture is antiregressive.

Although the greatest part of the day is spent in activities and informal psychotherapy, every patient is in formal group therapy. Thus there is a combination of "living therapy" and "talking therapy."

Each team has developed its own subculture within the larger culture of the center, and each has been encouraged to explore a variety of treatment styles and methods within the framework of the therapeutic community.

CONTINUITY OF CARE

Each patient is under the care of the same team, starting with his pre-admission evaluation, through his course of treatment, including his follow-up aftercare, until his discharge. So-called "treatment failures" are not transferred to other hospitals.

TRANSITIONAL TREATMENT

Each team must do much more than treat inpatients. Actually only a small part of the patient group occupies "bed" spaces. For instance, each psychiatric team has the following "spaces" available: inpatient, 15; day patient, 35; halfway house, 10; foster family care, 10; aftercare, 30. Patients may be transferred freely between these various placements within the team's jurisdiction.

Our initial experience with the use of the day hospital arose from the fact that our staff was available before the buildings were, and so Fort Logan started as a day hospital. This was a helpful experience as it taught us that half the patients referred for long-term care could be cared for in the day hospital, even when they came from locked wards in receiving hospitals or private hospitals. Our subsequent experience indicates that of all patients in treatment only one in three requires 24-hour care. For the others the day hospital is the treatment setting of choice. All of the team's patients, whether 24-hour or day-hospital, are treated together. The major difference is that the day-hospital patients come at 8:30 A.M. and go home at 4:00 P.M. The literature usually describes a separated day hospital rather than an integrated one. We have found our arrangement has several important advantages, in addition to the major advantages of any day hospital:

1. All patients needing treatment are referred to the same treatment facility.

2. There is a minimal amount of administrative work involved in transferring patients between day-hospital status and 24-hour status.

3. The 24-hour patients learn from the generally healthier day patients with whom they spend the treatment day.

4. The total number of patients treated is not limited by the bed complement. Each "bed" is used to treat three to four patients.

5. With the same team involved in the treatment of 24-hour and day-hospital patients, a larger number of patients can be treated in day hospital. Thus most patients at some time in the course of treatment are day patients.

From February 1962 to May 1964, 52 per cent of the psychiatric patients admitted were admitted to the day hospital. Of all adult psychiatric patients admitted, 76 per cent were in day hospital at some time in the course of their treatment.

FAMILY INVOLVEMENT

We have been impressed by the tendency to reject the mentally ill. We are also aware of the problems of the family with an emotionally ill member. As a result, we have embarked on a program aimed at the maximum involvement of our patients' families. Virtually all relatives are in some kind of group-therapy program. The form of this therapy varies from team to team. One team has a "family night" which the families are urged to attend as a social therapeutic meeting. Another team has organized a group of the adolescent children of its patients. Still another has a group composed entirely of the husbands of female patients.

ROLE EXPANSION

In order to make maximum use of the clinicians who work in the therapeutic setting, we have been experimenting with role expansion and redefinition. As suggested in *Action for Mental Health*[1], we are attempting to tap fully the treatment capabilities of the less trained clinicians, primarily the psychiatric technicians. A seven-month training program for technicians has been established. Simultaneously, each of the other traditional disciplines is looking at its potential contribution to treatment in the therapeutic community. In general, we see ourselves very much in a state of transition. On several teams the psychiatric technicians and nurses are very active in the group-therapy program. On one team a nurse collaborates in preadmission evaluations. Social workers are involved in a variety of activity therapies.

COMMUNITY INVOLVEMENT

We have paid special attention in the development of our program to the relationship of the center, its staff and patients, to our neigh-

bors of the Denver community. This presented certain difficulties because we could not have lived up to all of the expectations which had been aroused in the process of creating Fort Logan. Some of our colleagues in the community, who are oriented toward psychoanalytic psychotherapy, are hostile to the type of psychiatry practiced at Fort Logan.

Each team is assigned to a specific geographic area. This enhances the possibility of the team members establishing good working relationships with the doctors, judges, mental hygiene clinic staffs, attorneys, social agencies, teachers, clergy, and others in the community who are involved in work with the mentally ill. Team members are frequently called on to speak on mental illness and our treatment program.

Certain clinical functions are performed away from Fort Logan. All preadmission evaluations and posthospital follow-up care is done at the community clinics, which are independent community agencies.

OPEN HOSPITAL

The center, in all its divisions, operates with emphasis on psychological, social, chemical, and somatic therapies without physical restraints. All the units are open. Problems of disturbed patients' behavior occur, but are managed by means other than locked wards.

RESEARCH

From its beginning, the center has laid great stress on the importance of a research program. Until now, almost all of our research efforts have been in the direction of program evaluation. This is discussed in other papers.[2] A substantial grant from the National Institute of Mental Health has enabled us to put a great deal of the information about each patient on IBM punch cards. This gives us what we call a "data bank" which we are just learning to use.

ALCOHOLISM PROGRAM

Although only one part of the whole center's program, the alcoholism division deserves some special comments. It accounts for more than one-half of the center's admissions. It has some unique aspects as a treatment program.

It is divided into two phases. Phase I is a one-week inpatient

experience in which the patient is given a physical and psychological workup. During the same time a lecture series impresses the consequences of chronic alcoholism on the patient. He is given the option at the end of the week between discharge or treatment. If he chooses treatment, he enters Phase II, which consists of one week of day hospital, followed by outpatient group therapy three times a week. Should he need help in living arrangements, he is offered a maximum of three weeks of halfway house support.

The program is based on the assumption that the patient can be helped to maintain sobriety, but that he always will be a potential drinker. Consequently, his treatment needs are best met by offering continually available help. He can be supported through his life crises in ways that obviate the need for drinking.

HOW FORT LOGAN CHANGES THE SITUATION

We know there are patients at Pueblo State Hospital who were admitted because the community did not know how to deal with them. Patients who could have been treated in weeks have been kept for years. As a result, the state has had to build a huge custodial institution with 6,000 beds. With our kind of program this would not be necessary. (It should also be noted that, concomitant with the development at Fort Logan, there has been a renaissance at Pueblo with many new and exciting developments there. It is no longer the custodial hospital it once was.)

The small, more intensive unit using transitional forms of treatment is far more economical in terms of both money and human life. We keep people in the community, but we don't know at what cost to the patient, to the community, and to the family. We have no way at present of determining these costs. We know our budget is smaller than it would be for a custodial institution with the average 3,000 beds necessary to serve a comparable population. However, the community is paying for it monetarily, emotionally, and in many other ways. I don't think we yet have any research designed broadly enough to measure this cost.

The Joint Commission Report has raised many crucial questions concerning the future of the state mental hospital.[1] It has even been suggested by one spokesman that the state hospital be eliminated from the scene. The Kennedy program for community mental health centers stresses the need for small, locally sponsored, comprehensive treatment

centers.[3] The most recent APA Mental Hospital Institute (1964) devoted itself to a program concerned with the future of the state mental hospital.[4]

Most thoughtful professionals reject the proposition that the state hospital be considered solely the final place of custody for the treatment failures of "intensive" treatment centers. Yet this possibility is real enough to strike fear into the hearts of many people.

The criteria for comprehensive center support under the federal legislature do not include the necessity for providing long-term care. It is possible for centers patterned after these criteria to select patients likely to respond to intensive treatment, or to treat patients for a period of time and then transfer them to another facility. It will be a unique center that treats patients for as long as they need help.

This pattern will apparently require a system of back-up, long-term treatment centers for those patients not accepted by the local centers and for those who do not respond to their treatment programs. Many, perhaps most, state hospitals will be assigned the role of accepting such patients, and limiting their services to the care of just these patients. Such an arrangement of services will firmly establish once more the dichotomy of treatment centers and custodial centers. This is a concern shared by almost all state hospital workers.

This raises the very important question of the prevention of "hard-core" or "back-ward" cases. It appears to me that the dichotomy will encourage the transfer of patients and, therefore, a build-up of such custodial cases. Thus there will be an accumulation of chronic or slowly improving patients in centers which will probably continue to be endowed with small budgets and low staff-patient ratios.

Among the many possibilities for the adaptation of the state mental hospital to the "new era" is that of serving as a community mental health center for a nearby population. Many state hospitals have already begun to do this. Fort Logan is one such state hospital.

The Fort Logan Research Department has put most of its energies and resources into a study of the center's program. The limited number of beds and the fact that treatment failures are not transferred elsewhere have forced us to *evaluate the effectiveness* of the program in terms of the *rate of the build-up of "hard-core"* patients, particularly those who continue to occupy precious bed spaces.

This problem is one which will be of concern in any broad-range mental health program. On the answer to this question depends the success or failure of the hospital to meet its goals as stated now. From the

evaluation process it is hoped that the staff will learn to what extent it is accomplishing this goal. Perhaps other studies can point out possible new ways to solve the problem of the "hard-core" cases by indicating which treatment modality is working best.

Our experience suggests that a flexible program which makes extensive use of transitional forms of treatment in conjunction with its bed spaces can not only prevent the continuous and interminable hospitalization of the chronically mentally ill, but can also alter the clinical picture of such patients. Our patients who have been seriously ill for many years, though not hospitalized for long periods, retain many of their social skills. It may be that "chronic schizophrenia" in hospitalized patients would be better described as "chronic desocialization." Such a syndrome arises from the process of hospitalization in a person who begins his institutional experience with many psychological and social disabilities.

It is our opinion that the previous pattern of psychiatric care—short-term hospitals in Denver and long-term care at Pueblo—resulted in the unnecessary admission to Pueblo of patients who could have been helped by "transititional" types of care instead of full institutionalization. We also believe that other patients who stayed in Pueblo for months and years could have been given optimal hospital care in days or weeks. Fort Logan's proximity to Denver, its flexible program and policy of continuing responsibility should prevent these errors.

In evaluating our treatment program, we have outlined three general areas of investigation: 1. our preadmission evaluation; 2. our treatment process; 3. the outcome of treatment. These will be discussed in the papers by Drs. Binner and Polak in Part II.

REFERENCES

[1] ACTION FOR MENTAL HEALTH: FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, New York, Basic Books, Inc., 1961.

[2] Binner, Paul R., Development of the Fort Logan Mental Health Services; Studies of the Fort Logan Program; Polak. Paul, Unclean Research and Social Changes; *see* pp. 313, 320, and 337 of this volume.

[3] Harris, Oren, Conference Report, Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963; House of Representatives Report No. 862, October 21, 1963.

[4] Glass, Albert J., The Future of Large Public Mental Hospitals; The Future of the Mental Hospital, Proceedings of the 16th Mental Health Institute, Dallas, Texas, Sept. 28–Oct. 1, 1964, *Mental Hospitals,* January, 1965, p. 9.