

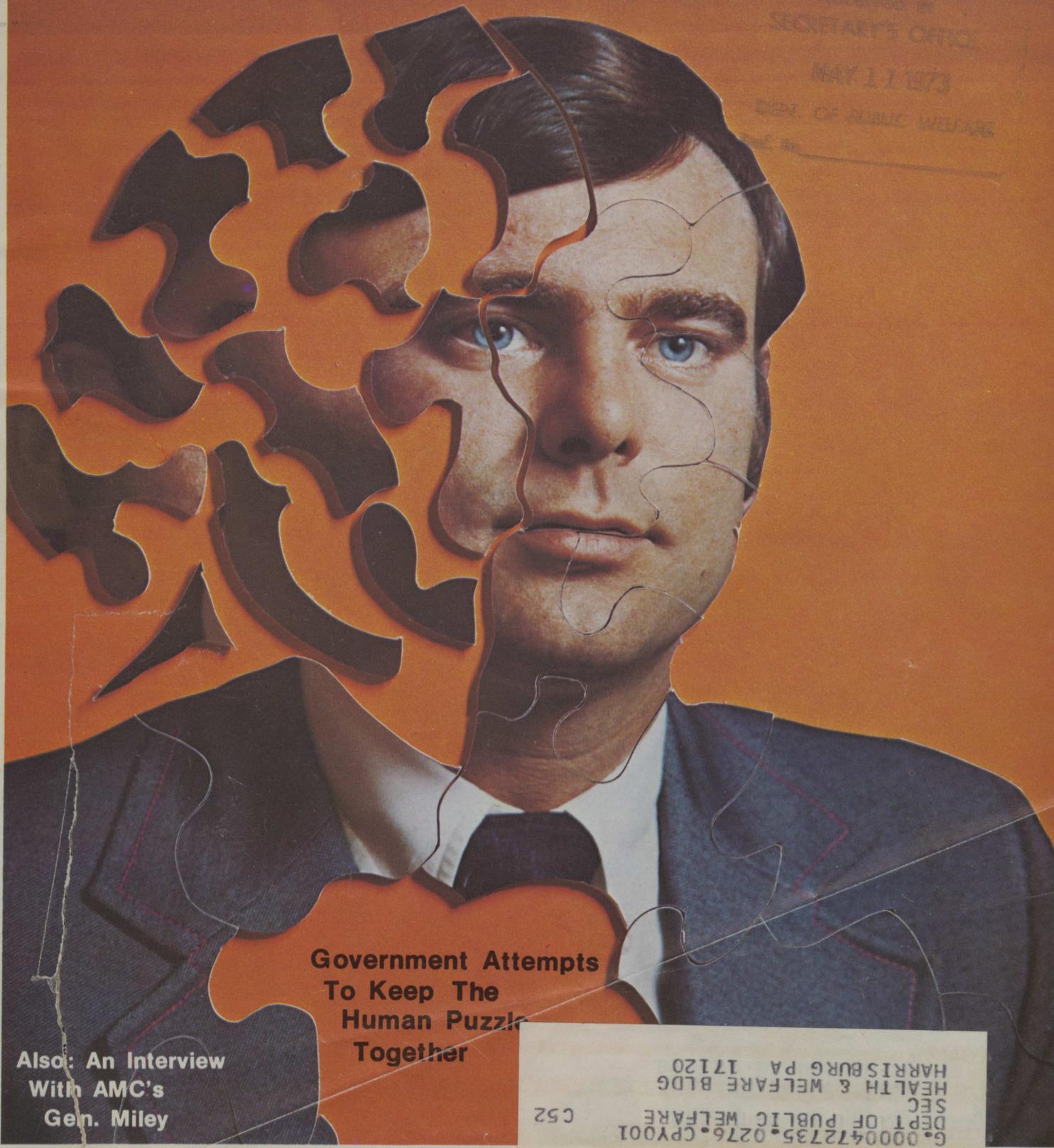
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Animal, Vegetable or Human Being?

By JOHN WILPERS
Associate Editor

Highlights:

1—Mental illness is the Nation's largest and most costly health problem. One person out of 10 will be afflicted. Costs run beyond \$20 billion a year.

2—Treatment varies from that which is reminiscent of the Dark Ages to forms showing prescience of the Twenty-first Century.

3—Mental hospitals are still largely custodial while shifting orientation toward short-term, professional treatment.

WE USED TO burn "them." In moments of greater enlightenment, we protected ourselves from them by shipping them off to a backwoods fortress. Here, the gates were slammed shut, the windows barred, the doors locked and the keys thrown away. Inside, every possible effort was taken, including the use of chains, whips and cages, to guarantee that "they" would never return to plague society again.

Today, the burning is considered barbaric, as are the visible whips and chains. But the fortresses are still with us. So are the bars, the locks, the cages and worst of all, many of the fears and uncertainties that caused those fortresses to be built and the doors locked in the first place. And beyond that, 20th Century America, in all of its sophistication, now substitutes subtle social chains for the wrought iron of the past.

What possible illness exists that would make a "civilized" people draw back and repel some of its own in such a fashion, that elicits on some occasions sympathy and warmth but on others laughter, rejection that brands its victims with a social sable that there still exists a human condition, that brands its victims with a social stigma whether they seek treatment or not, that brands them even if that treatment is successful?

Such a condition is mental illness. Long a mystery to mankind, its spiritual and psychic nature does not lend itself to an easy, empirical, and practically fool-proof type of diagnosis and treatment. No X-rays are available to provide undeniable proof of a specific mental malady. Invisibility in cause, coupled with varying degrees of visibility in socially aberrant behavior, makes mental illness for the average citizen confusing at best, fearful and destructive at worst.

Factors ranging from the physiological through the genetic and the psychological to the environmental all contribute to the onset of various forms of mental illness in-

cluding schizophrenia, depression, other psychoses, neuroses, character disorders and psychosomatic ailments. Each is a special kind of hell for its victims—a world where they are often alone to suffer.

While the immediate cause-and-effect process of most physical ailments is absent, the need for professional treatment in both cases is paramount. Telling someone with an emotional problem to "snap out of it" without psychiatric help is like telling someone with appendicitis to simply forget about it. Mental illness can be cured, but only with the proper treatment.

Man's search for the "proper treatment" is a history of puzzlement, superstition, fear, violence, reason and compassion whose written record alone dates back to the dawn of antiquity. The oldest written prescription on record—an Egyptian papyrus—advises a mental patient to wear a green stone to ward off hysteria. Plato advocated in the 4th Century B.C. that the mentally ill were not responsible for their acts and therefore should not be treated as criminals but instead given humane care in the community.

A History of Suffering

But the tone for treatment for nearly 2,000 years was unknowingly verbalized by a First Century Roman scholar, Celsus, when he advised that when a patient "has said or done anything wrong, he must be chastised by hunger, chains and fetters." In that tradition, human beings were subjected to a myriad of misguided, often cruel and sadistic treatment ranging from public display, supernatural rites and "magic" potions, to lifelong imprisonment, beatings, torture and even death.

From 1408, the year of the construction of the first "insane" asylum, until the present, the most common treatment of the mentally ill has been placement in asylums or hospitals. "Hospitals" is a cruel word to use, for it implies rehabilitation and historically there has been little of that.

"Treatment," for the lucky, was restricted to being locked up.

Gradually, though, voices began to cry out for a more humane approach. Among them were Dr. Benjamin Rush, Dr. Philippe Pinel and Dorthea Dix, whose efforts brought such things as occupational therapy, psychiatry, decent quarters and humane treatment into the mental hospitals.

Today the search goes on. The mental health field is probably unique in that it is possible to receive treatment reminiscent of the Dark Ages and also prescient of the 21st Century. In the United States today there are patients, totally naked, locked up in barren, unlit, unsanitary cages, conditions which even zoo keepers would deplore, and there are other patients living normal productive lives in society, thanks to the miracle of modern chemistry.

The current U.S. mental health problem is not a small one. One person out of every 10, or well over 20 million people, will suffer from a mental or emotional problem that could benefit from professional help. On any given day, 37% of all U.S. hospital beds are occupied by mentally ill persons.

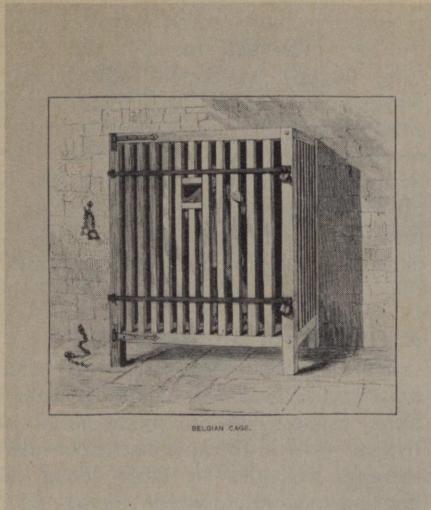
Mental illness is also America's most costly health problem, annually running in excess of \$20 billion due to such factors as absenteeism, inefficiency and turnover, accidents, alcoholism, physical ailments and treatment costs. Business authorities conservatively estimate the loss to industry at \$10 billion a year. Cost of direct treatment is nearly \$4 billion a year—65% of which is borne by governmental agencies.

Governmental efforts, on the Federal, state and county levels, to provide relief and rehabilitation to the mentally ill have been concentrated in two areas: the largely infamous mental hospitals and the fledgling community mental health centers (CMHC).

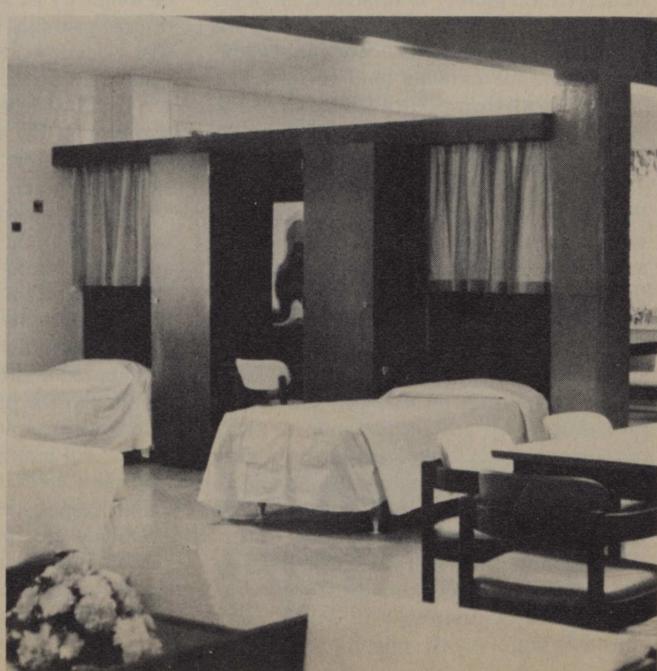
The public mental hospital: The word "stigma" pales before what has become common public folklore surrounding mental institutions. Historically located in isolated areas either far from man or surrounded by his waste and unwanted, asylums lent themselves to myth and mystery. With distance, walls, gates, bars, locks and guards between the public and the patient, understanding was difficult, tall tales and nervous jokes easy, and fear, scorn and hate inevitable.

But while some of the causes of such feelings are as tangible and contemporary as the bricks that still make up the fortress walls, they are also deteriorating, although in some cases no faster than the bricks themselves.

Years and years of the "lock" 'em up,



A Treatment Odyssey



throw away the key" philosophy has left a legacy of hundreds of massive structures—the most visible and archaic component of contemporary mental health treatment. Many are over 100 years old; many are not but appear so.

Such structures, built with one idea of "treatment" in mind, do not easily lend themselves to improvement and transition to a new mode of care. The costs of such change are high but in most states costs are a moot point when the desire is lacking. The limited upkeep that is generally provided can not even remotely be expected to cope with the ravages of time. And so, many hospitals, and the patients within them, deteriorate.

Four images are presented by today's mental institutions: the custodial or warehouse image; the prison image; the zoo image; and most recently but least common, the therapeutic community image. Numerically the majority fall within the custodial category.

Human Warehouses

The custodial image, evoking row after row of identical beds, inches apart with as many as 40 or 50 to a "room," has long since become a reality. Warehoused items require no privacy and lines of toilets with no doors or even dividers, make no pretense of providing it. A patient's every move and possession is public knowledge. Treatment may occur but it is rarely individualized, usually recreational and always drugged.

But the clincher is the warehoused themselves—standing, sitting, lying, perhaps walking around, but all without a purpose, all just living out another day. No different from yesterday, no different from tomorrow.

When the passage from one ward to another is interrupted by the unlocking of a "door," when the view out a window is distorted by thick, iron bars, and when the entrance to the facility is limited to a single armed-guarded interruption of a wall, the prison "image" loses its academic irrelevance. Even the patients tend to look like prisoners with their bodies draped in ill-fitting, dull-colored uniforms.

Chronologically, the Dark Ages ended almost 1,000 years ago. But today, for those who so desire, and for the patients who have no choice, it is as available, real and ugly as if it were still 900 A.D. Today, in certain isolated wards across the country, human beings are literally caged. The whole world for some mental patients is a single, unpainted concrete cubicle, unlit and totally unfurnished, its uniformity broken only by gutters designed to carry off human wastes. Naked and ignored, they stare out with empty eyes from behind an iron mesh door—a door which for them will probably open only one more time.

In the adjoining hallway, their less severely disturbed fellow inmates, also in various degrees of undress, pad from similar cells to a large empty concrete room to do

the same thing—wait. Their only distraction comes from walking in endless circles, rocking in a chair or simply falling asleep on the cold concrete floor.

A Future of Hope

Other inmates pass their days in less severe but no more humane surroundings. There are no niceties such as curtains, rugs or bedspreads. Walls and floors are made of tile and linoleum, characteristic of most hospitals, making the cleaning of filth easier than its prevention. Fire and safety hazards are many, precautions and emergency capabilities few. There is an ever-present, and sometimes overpowering stench of human waste.

The extremes, however, are disappearing. In their place, at the opposite end of the treatment spectrum, are a few select hospitals of the treatment image. The physical difference alone is immediately apparent: paint is fresh; furniture new; rugs soften the floors; bedspreads, curtains and individual armoires try to imitate home; large dormitory rooms are divided into semi-private compartments; partitions bring privacy to the bathrooms; barless windows and unlocked doors bring the outside closer; uniforms for both patients and staff are banned. A choice few even have air conditioning and cafe-style meal areas.

But physical surroundings are not the most critical factor, although they in themselves can act as an aid, instead of a hindrance, to rehabilitation. What puts light years between the zoo and the therapeutic hospital is treatment. Where there was brutality and neglect, there is now concern and active therapy. Such hospitals, whose physical facilities resemble the therapeutic, custodial or even prison image, might have any number of treatment attributes.

Such select institutions are organized into geographical units, wards whose patients are chosen on the basis of their place of residence as opposed to their diagnosis or longevity of stay. Each unit has a team of professionals—psychiatrists, psychologists, social workers, occupational therapists, registered nurses and others—who are totally responsible for that unit's patients from the moment they walk in the door to the time that they leave—and possibly even after.

The unit usually receives prior notification of a patient's arrival from his CMHC and is briefed as to his condition. The patient then meets with the unit team to delineate problems and decide on a course of action. An individualized treatment plan is formulated and one member of the team is designated the primary therapist—an individual whose one-to-one relationship with the patient guarantees that the patient will never be "lost" and has one specific individual responsible for his progress.

During treatment, every patient is reviewed at least once a week during the unit team's daily meeting. Such meetings insure not only patient review but also team communication and coordination.

The most common forms of treatment provided include various forms of group therapy, individual therapy, chemo- or drug therapy, vocational rehabilitation, occupational therapy and industrial or work therapy. Chemotherapy is common, a necessary step to eliminate violent behavior or certain distractions and allow the other therapy modes to have an effect. A therapeutic milieu also relies heavily on patients helping one another and the blurring of distinct staff roles.

A Treatment Smorgasbord

More specific treatment modes include music, art and recreational therapy, educational classes, behavior modification activities, physical therapy, electroconvulsive therapy, activities in daily living and homemaking, remotivation therapy, anti-depression therapy, self-government meetings, field trips, reality orientation and readjustment therapy. Sometimes a patient's family is also involved.

Alcoholic treatment units are housed in separate, homelike structures complete with private and semi-private rooms, self-government and rigorous, emotional group therapy sessions often throbbing with the fervor and commitment of a revival.

Then, after an average stay of 4 to 8 weeks, the patient is sent back to his community. This potentially painful, awkward change is eased by the hospital's division of transitional services that aids in job placement, family counseling, appointment-making with a CMHC, location in a halfway house or nursing home, the provision of outpatient services, transportation, and general follow-up, all designed to make sure that the former patient never becomes a patient again.

No one hospital has all of the above traits, but their growing acceptance and the burgeoning use of the CMHCs and psychiatric wards of general hospitals has brought about a radical change. In 1955, when the resident population in public mental hospitals stood at its peak of 559,000, the then-current growth rate would have resulted in almost one million residents by 1973. Instead, today's population has plummeted to approximately 275,000, with end-of-century predictions running around 50,000.

The dogged determination of many hospital administrators to clean house—preventing those who do not belong in mental hospitals from being admitted and eliminating that type already in the hospital—and an equally dogged, though less successful effort of "treat and return"—have been major factors in the population decline.

But at the same time admissions have increased dramatically—112% since 1956. In 1971 alone there were 407,640 admissions. The apparent discrepancy is explained by the fact that while the unqualified are being weeded out, those that need help are coming in increasing numbers, receiving treatment and going home. It is es-

timated that almost 90% of current admissions leave the hospital within a year.

That, however, though itself not the ideal, is the best side of mental health treatment. Most of the 275,000 resident patients exist in the world of limited treatment, custody and neglect.

Many such facilities utilize the "cottage" system—a series of large, dormitory-like buildings and "cottages" in name only. Not only are there no daily meetings or patient reviews, there are no units and no teams. If a patient isn't released from the admissions ward, he runs the very real risk of making an endless odyssey through the back wards of the hospital.

"Treatment" limps along on the crutches of the psychoactive drugs often used for the convenience of the staff and as a substitute for nonexistent programs.

Industrial therapy, frequently a euphemism for slave or cheap labor, serves the purposes of lowering the hospital payroll, maintaining its daily operations, occupying the patient's time and, in some cases, providing valuable work experience. Many patients are not paid, others receive a pittance and few get the minimum wage. Occupational therapy varies in effectiveness from a creative workshop where the mind is activated and observed, to a production line assembly of potholders, ashtrays and sentimental ceramics whose aging molds have dulled the minds of many a patient.

Contemporary Limbo

Periodic group and individual therapy is available in the admission cottage but might just as well not have been invented for the inmates of the stagnant backwards.

Generally skeletal and strictly custodial staffs, and a subsequent and increasing dependence on drugs, provide the basic materials for a classic scenario of a mental ward: glassy-eyed patients asleep or slouching in chairs; a TV, the hospital's cheapest therapist, blaring away with distorted sound and picture; and a white-clad staff, protected in a nursing station, drinking coffee and trading gossip. Children and adults alike, some mentally retarded and inappropriately committed, are ignored, the improvement of their minds and maladies left strictly to chance.

Release of "escape" can be as speedy as the drugs and the treatment will allow, or as slow as death. Even with a department of transitional services, hospitals labor under their age-old function of social dumping ground. The placement of patients, many of whom have become institutionalized, and possess no skills, money, family, home or friends, into communities with no desire for them or resources to handle them is difficult and too often impossible.

A major contributor to the problem is staffing. Quality professionals are kept away by meager salaries and unattractive localities. In 1970, publicly employed certified staff psychiatrists started at \$15,000 and peaked at \$33,000 while their private counterparts could easily gross \$50,000.

The average ratio of professional, treatment-type personnel to patients ranges from three to 33 per 100, but these are mostly therapists and counselors. The psychiatrist ratio peaks at nine per 100 and bottoms out at one per 1,000. But even if dollars were available and salaries competitive, the supply of professionals doesn't even begin to equal the need.

Over half of the total staff time is provided by nursing and attendant personnel, of which nine-tenths is strictly custodial. Thirty-six percent is provided by non-professional staff and 12% by professionals.

But actual treatment is not restricted to professionals. The subtle and not-so-subtle effects of 24-hour contact with untrained, uneducated, underpaid and largely unmotivated aides and attendants can be stifling if not cruel and destructive. Such is not the case across the board, but barely subsistence salaries tend to draw only barely qualified people.

Many innovative administrators and professionals have seen their ideas subjected to tactics ranging from "ignore, delay and forget" to actual mutiny. In many cases the attendant custodial staff has no more than an eighth-grade education, is "salaried" within a few hundred dollars of the poverty level, received no training and upon death or retirement will hand the job down to their offspring. Psychiatrists and administrators may come and go, but the custodial staff is as permanent and as threatened by change as the buildings themselves.

In the end it all comes down to money and desire. Almost without exception, the people saddled with administering the mental hospitals and providing treatment therein are extremely dedicated and doing their best to win a modern complex war with sticks and stones.

In 1970, maintenance expenditures for in-patient services of state and county mental hospitals were nearly \$1.9 billion—an impressive figure until translated into the national average daily maintenance expenditure per patient of \$14.89. Can miraculous or even satisfactory results be expected when a hospital is allowed a mere \$15 a day per patient to provide salaries for administrators, psychiatrists, occupational therapists, social workers, nurses, attendants, secretaries and maintenance men, as well as for the costs of therapeutic programs, medicine, general health care, food, clothing, treatment supplies, equipment, ordinary repairs and overhead?

It must be noted that from 1966 to 1970, the national average expenditure per patient did increase by 93%, and 15 states increased their expenditure by 100 to 200%. But such action could be repeated tomorrow and some patients would still be left in the Dark Ages. In 1970, Veterans Administration psychiatric hospitals spent over \$30 and private psychiatric hospitals over \$48 per patient per day. Not even one state matched the private figure and only

three equalled or exceeded the VA figure. Over half the states could triple their expenditure and still not equal the private figure.

But arbitrary figures are meaningless until translated into actual services or lack thereof. The resulting and often appalling discrepancies have given rise to a number of questions concerning equal protection under the law and an individual's right to treatment.

The most significant case, and one with potentially national repercussions, is an Alabama lawsuit—Wyatt v. Stickney. For the first time in history, persons involuntarily confined in institutions for the mentally ill or retarded were held to have a constitutional right to adequate treatment and rehabilitation. But the court did not stop at that.

The judge also stipulated a specific, detailed set of standards and procedures for implementation. The order includes standards on patient labor, physical and psychological environment, nutrition, patient evaluation, treatment plans, staffing patterns and transitional care.

The case is currently under appeal in conjunction with a similar Georgia case whose results were diametrically opposed. Suits of similar nature and threats of suits are being used to pressure legislators and administrators, who like to avoid legal action and publicity, to bring about the long overdue changes without court action. Litigation, however, due to the intransigence of many state legislatures appears to be the tactic for future reform.

In the final analysis, the finger of blame can never be pointed in the direction of the untrained attendants, the overworked staff, or the politically sensitive legislators. It must always point back at society in general. The quality of mental health treatment and the money allocated by the legislatures only reflects the degree of importance which society attaches to the care of the less fortunate. In some states that concern is genuine and deep; in others it could be mistaken for apathy or outright cruelty.

Past reforms have slowly brought mental health treatment out of the superstitious and violent world of the Dark Ages towards the civilized professional level of treatment designed to achieve the ultimate goal—a cure. But there are still many who have been left behind and in the hot and cold rush towards the future, these individuals and their virtual prisons must not be forgotten but changed and included in the modern mental health treatment spectrum.



(Next month: One Hope for the Future: the Community Mental Health Centers and Their Struggle for Survival)