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The Future of the Public Mental Hospital

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THE FUTURE OF THE PUBLIC MENTAL HOSPITAL

A legislative resolution beginning: "Whereas, recent press reports indicate that the Department of Public Institutions plans to phase out state mental institutions by 1975 . . ." and demanding an investigation was introduced in a Midwestern state in January 1972.

Three Social Trends

If Moses Sheppard and Dorothea Lynde Dix were available for comment, they would ask what is happening. What is happening is this: *First,* the entire health-care delivery system in the United States is in the process of change. People who are able are going to pay for their health care in advance, whether by an arrangement called "prepayment" (as in proposed health maintenance organizations) or through "insurance premiums," or by means of direct taxation. Those who cannot pay are going to have the costs subsidized by the federal government. All citizens are going to have the right to equal health care; therefore, the distinction between public and private care must end.

Second, involuntary hospitalization, as provided by traditional commitment laws, is being eliminated. Preventive detention, the confinement of a patient believed dangerous, for an indefinite period, is under legal and social attack. The doctrine of *parens patrie,* the state assuming a paternal role, paternalism, is no longer socially acceptable; and with its demise the

involuntary detention and treatment of a person dangerous to himself, or of a person who is in need of treatment but cannot or will not recognize the need, will become impossible. These changes will not only affect the way a person enters a mental hospital but also what can be done for him once he is there. The locked ward, already largely eliminated in many facilities, is unlikely to be acceptable to many truly voluntary patients. It will not be possible to give medication or treatment to patients who decline it. The physician and the superintendent will be responsible to, not responsible for, patients. Traditionally, mental illness was often equated with irresponsibility and this was seen as absolute, not relative. Hence, the superintendent of a mental hospital was held responsible if a patient left without permission ("escaped" "eloped"), lost possessions or money, or injured himself in some way. One hundred years ago, if a woman patient became pregnant, it was without further investigation of the circumstances, "another of the base results of the wretched management of the institution."[1] Obviously, to protect himself and his staff, a superintendent would have needed strict rules governing patient supervision and conduct, quite apart from any specific patient's actual treatment needs or ability to make decisions and assume responsibility. (This is analogous to some of the ways that the possibility of malpractice suits influences medical practice today.) These attitudes of 100 years ago were not greatly changed until after World War II. Certainly the superintendent of today, and of the future, has some responsibility to protect the person and

property of patients; but it is more one of eliminating hazards, providing facilities, and seeing that advice is given, than one of regulating the patient's behavior so as to prevent him from voluntarily taking any risks. (For example, traditionally, it was felt necessary to put money and jewelry in a safe or send it home; today, as well as taking the same sort of steps the operator of a hotel or college dormitory might take to discourage pilfering, the superintendent *provides* a safe and *advises* its use.)

Third, the resident population, though not the admission rate, in public mental hospitals has been steadily declining. This decline, though sometimes attributed to the introduction of tranquilizing medication in the middle 1950s, actually results from many factors. New treatment methods have helped shorten hospital stays. The increased number of psychiatrists and other mental-health professionals trained since World War II has contributed both to improved quality in public mental-hospital staffs and to the development of alternative community facilities. An expanding economy has made it possible for more patients with residual symptoms to obtain employment and rehabilitation in the community, and expanded welfare programs have made it possible to discharge other patients who are not able to be self-sustaining. Changing social attitudes allow for greater acceptance of deviant behavior and reduced social distance from former patients. Added to these factors is a change in administrative philosophy. The superintendent of today feels that it is to his credit to reduce his census and shorten stays; so he

may try to move a number of patients into nursing homes or other facilities, as well as make efforts at treatment and rehabilitation.

It is futile to deal with these three social trends by denial or negativism. One might say that proposed health-insurance legislation may not be passed, and that even if it is, psychiatric benefits are sharply limited in most current proposals; that commitment laws cannot be repealed altogether; and that there will be an irreducible minimum of patients still needing traditional state hospital care. A more sophisticated denial might be to point out that social trends are discontinuous and a halt to or reversal of current trends is possible. One may point out that health-insurance programs do not in themselves correct problems in the supply and distribution of health resources; that prepayment programs may do more to foster cut-rate care than to pay physicians to keep people well "like the doctors of ancient China."[2] Types of patients who will suffer great harm because protective, albeit paternalistic, steps cannot be taken can be listed by the dozens. Likewise, there are innumerable examples of situations in which short hospital stays or transfers to other facilities are not in the best interest of patients. To engage in such professional chauvinism, however logical and well-motivated, is an exercise in futility. Looking at the record of organized medicine's opposition to "socialized medicine," such exercises in futility appear not unlikely to occur.

Four Options for the Future

The future of the public mental hospital may be:

1. To resist social change and to be phased out of existence.

2. To accept social change and to plan an orderly process of termination.

3. To undertake new roles and functions.

4. To continue to serve the needs of the mentally ill in a manner concordant with contemporary social values.

The first option is the least desirable. A rapid phasing out of state (and other public) mental hospitals would leave a large number of patients without needed services. A state hospital in an isolated location, with an outmoded physical plant and a staff incapable of furnishing an effective treatment program, ought to be closed. Such hospitals are in the minority. Most offer effective, though not ideal, treatment, and amenities considerably superior to those of Juniper Hill. Alternative facilities and practitioners are not available to undertake care of patients served by these hospitals.

It is not reasonable to assume, as some have, that if patients have health insurance that will cover psychiatric illness, all who need it can obtain private treatment. The idea that the closing of public mental hospitals would cause the physicians employed by them to enter a new form of government-

financed and regulated private practice is valid in itself. However, the notion that they would take care of the same number of patients is unrealistic. The physician in the public mental hospital is not primarily occupied in direct patient care. Even if he were to spend all of his time in this activity, he could treat only a small percent of the patients now being served. It is in the public hospital that the team method, the therapeutic milieu, and the employment of nonmedical therapists working under supervision is most highly developed.

The second option, a gradual, planned termination, would allow new facilities and programs to develop. It would take several years to replace the present public mental hospitals with comprehensive community mental health centers, even if some state hospitals of appropriate size and location entered the centers program and were assigned catchment areas. Not only would many new centers have to be established, but most existing centers would need to expand their functions considerably to serve all the mental-health needs of their catchment areas. It would take even longer for new "private" facilities to be developed to meet the needs of a fully insured population or to provide full psychiatric care as components of health maintenance organizations.

The third possibility is really a modification of the second. It would preserve administrative organizations (some of which, at least, are worth preserving), prevent the sacrifice of usable buildings, and maintain jobs for

persons now employed. There have been a number of proposed functions. One has been that the state hospitals should serve as chronic disease hospitals, accepting all types of "incurable" patients, and, presumably, continuing to provide custodial care to certain mental patients. Another suggestion is for a move in the direction of the correctional system involving the rehabilitation of persons with character disorders, presumably delinquents and offenders suitable for minimum-security institutions. Still another has been for the institutions to undertake additional public health and welfare responsibilities or, at least, to house and coordinate various agencies involved in health, education, and welfare so as to become multiservice centers.

Response to Contemporary Social Values

Financing Mental-Health Care

The fourth option deserves the most detailed inspection. Accommodation to new systems of financing health care must first be considered. One might advocate making the public hospital fully eligible to receive health-insurance benefits (both for hospital costs and professional services) and/or to become a part of (or contract with) health maintenance organizations. Only if the present public hospitals compete on an equal footing with private facilities can we hope to eliminate a double standard of

care. It is unlikely that a universal compulsory national health-insurance program (or an equivalent prepayment system) will initially include benefits for chronic illness, including long-term psychiatric illness. There is no real reason why it should not. Most long-term care is in public facilities and is already being supported by the taxpayer. Excluding this from a health program only appears to make the program cheaper. Including it would eliminate the "dumping" of chronic cases, turning the public hospital into an institution for the chronic, with the difficulties in staffing and in maintaining a therapeutic orientation and optimism this would entail; and the perpetuation of a double standard. While chronic mental illness will not be covered at first, sooner or later it will; and it makes sense to advocate sooner rather than later.

Competition between what are now private and what are now public resources, with patients exercising a free choice, will provide incentives for improved service for all providers, not just the currently public.

Advocacy of the inclusion of adequate psychiatric benefits and of the participation by now public facilities in new health-care-financing-and-delivery systems may not insure appropriate legislation. However, if restrictive legislation is passed that excludes full participation by state hospitals, as such, this need not cause either their closure or their assumption of the responsibility for only chronic patients and those rejected by other

providers of care. For the present direct support of such hospitals by the state, there could be substituted an operation of hospitals by nonprofit-making corporations (with further steps to meet any specific requirements for participation); and grants or contracts could be used to continue state financing of research, training, indirect services, and direct services not otherwise covered.

Even now, in anticipation of more widespread and government-sponsored insurance or prepayment programming, the financing and organization of public mental hospitals should be reconsidered. Many people, in some areas the majority of the employed, have insurance that covers psychiatric care. Some programs pay for hospital care in public institutions, but others do not. Fewer pay for professional services in public hospitals, and even fewer for public outpatient services. Two considerations are involved in nonpayment. First, the idea that this is not appropriate in a tax-supported facility; second, the fact that many institutions that do charge those able to pay for hospital care do not itemize professional services. Steps, including reorganization when necessary, revised cost-accounting and billing procedures, and initiation of adequate utilization and peer-review programs, should be initiated to allow full participation. Cash income can and should provide a greater portion of public hospital and clinic budgets, and a greater, and identifiable portion of the compensation of professional staff; for this is directly related to volume and quality of service. Ultimately, when all patients

have insurance or prepayment coverage, direct tax support for public mental hospitals can be limited to those activities not directly related to patient care: training, research, community education, and primary prevention. In regard to the latter, it might be suggested that these activities can be covered in a prepayment, health-maintenance, program. This is not altogether realistic. It will be possible to provide preventive programs that yield a high, short-term payoff in this way. Most preventive programs in psychiatry will not qualify.

Voluntary and Involuntary Hospitalization

Laws governing involuntary hospitalization are being re-inspected and revised by legislative bodies and are also likely to be modified by court decisions. The staffs of public mental hospitals, along with other mental-health professionals, can cooperate in this process. It is probable that in the public mental hospital of the future all, or nearly all, patients will be voluntary. Nevertheless, new laws must take into account the fact that there are dangerous patients and that there are patients who need care badly but cannot recognize their need.

The concept of dangerousness is a difficult one to evaluate. As a paradigm of the dangerous patient one might consider a person who has paranoid delusions, has bought a gun, and intends to kill his imagined persecutors. He may represent a real and immediate danger to others, but he

has not committed an overt act. One might choose as the paradigm a "sexual sociopath" who has committed repeated offenses against children or aggressive (sadistic) attacks on adults. (The voyeur or exhibitionist is more a public nuisance than a danger.) One might select as an example the person who has committed a crime and been found unable to stand trial because his mental condition makes him unable to understand the charges against him and/or participate in his own defense. Another example would be the person who has committed a serious offense and has been found not guilty by reason of insanity. These are the usual examples. What about the alcoholic who drives a car? Traditionally, he has not been regarded as a subject for commitment as dangerous, though he may be regarded as sick—legally as well as medically. Surely intoxicated drivers, many of whom have diagnosable alcohol problems, account for more deaths, serious injuries, and property damage than any of the traditional types of "dangerous" patients. There are other situations in which a mentally ill person's confusion or preoccupation may compromise the safety of others.

The public mental hospital had best be relieved of responsibility for the confinement, if not for the care, of most of the patients representing serious and immediate danger to others. Certainly such a patient does not belong on an open ward. The advisability of having a maximum-security unit on a hospital campus is questionable. It is likely to be uneconomical, and lacking perimeter security, offers more opportunity for escape than does a penal

complex, while at the same time forcing greater restriction on the activities of inmates. Moreover, it puts the hospital staff in something other than a helping role. Those who have committed overt acts (e.g., the sexual deviate offender) can be sentenced, with due process of law, and can be treated in a correctional facility. Treatment could be provided by the correctional institution, or, better, as an outreach activity of the mental hospital. In the latter case, the psychiatrist can work with and for the patient in the usual collaborative therapeutic relationship without having the responsibility for maintaining confinement or determining length of stay.

The handling of an individual, sick or otherwise, who truly intends to kill someone, whether a family member or a presidential candidate, presents a serious legal problem. It *is* a legal problem, not a medical one. Suppose such a person is sick but is not committable under new laws or under new interpretations of existing laws. In some instances, surely, the intended victim can be protected without detention of the patient; in some perhaps, the use of something in the nature of a peace bond, with appropriate legal steps if it is violated, might be effective. If this leads to incarceration in a correctional facility, treatment on an outreach basis can be provided as for other offenders.

In cases where danger is less immediate, involving the alcoholic or drug-dependent driver, for example, if treatment is not accepted on a

voluntary basis, it could be made a condition for probation. In that case, the responsibility for following through on a treatment program rests with the patient.

Patients who need treatment, but fail to recognize the need, represent a more difficult problem for those trying to improve laws governing involuntary hospitalization. There are two general types.

First, there are patients with acute illnesses who could probably respond to treatment (e.g., a patient with involutional melancholia who is actively suicidal; a hypomanic patient who is bankrupting himself and his family). Second, there are mentally ill people who may or may not be treatable, but who cannot meet their own needs in the community. At the extreme are those patients who literally cannot survive without medical attention. In addition, there are those who cannot maintain employment, cannot use financial assistance prudently, cannot attend to those things necessary for comfort and sanitation, and are subject to various types of abuse and exploitation in the community.

Though there are many today who advocate eliminating involuntary hospitalization altogether, others, in advocating reform of commitment laws, recognize the needs of these patients. At the same time, concern over the rights of the person who is not sick and might be the victim of a conspiracy

(to get rid of an unwanted spouse or a political dissenter, for example) has been an issue since the time of the Packard case in i860; and, more recently, there has been growing concern over the right of the person who is sick (or deviant) to decline treatment, provided at least that he is rational enough to make the decision.

To balance these factors, attempts have been made to make new commitment laws more "strict," with a greater guarantee of legal assistance and "due process" to the person who is "accused" of being mentally ill. The disadvantages of more elaborate procedures include cost, burdening an already crowded court system, time consumption that may delay needed treatment and lead to a less favorable prognosis, possible invasions of privacy as details of the patients behavior while sick must be made public, and a possible criminalization of mental illness. Alternate proposals allow for a simpler commitment procedure for most cases, but provide for increased implementation of the right of habeas corpus after admission, together with availability of "ombudsmen," inspection of treatment plans, and reevaluation of continued need for hospitalization by independent agencies.

Reform efforts are also directed toward reducing the length of involuntary hospitalization and/or instituting programs of periodic recertification.' In settings where this has been tried, it has not been completely successful, since the number of cases proposed for recertification

has reduced the process to a formality in which inadequate time is given to assess the patient's actual situation and needs.

The most likely prediction for the future is that indefinite or long-term involuntary hospitalization will be abolished altogether, but that some method of short-term certification or commitment will be available. To preserve provisions for needed short-term involuntary care, it will be necessary to apply these provisions sparingly and cautiously so that they are used only when the need and the potential benefit to the patient can be clearly established. Since the public hospital does not commit patients to itself, it cannot fully regulate the application of commitment laws. It can ask for input into the system; a requirement that prospective involuntary patients be seen by the public hospital staff, preferably as outpatients, and that the hospital be allowed to report before the action of a court or board of mental health is not unreasonable. As well as screening out some cases that do not need, or cannot benefit from, treatment, this could lead to a greater number of patients accepting voluntary care in the hospital or in alternative programs. In addition, very active public education and liaison with the legal profession can be used to discourage involuntary hospitalization and encourage voluntary referral.

The individual's own ability to recognize illness in its early stages and his willingness to seek voluntary care can be augmented by mental-health

education, public-relations programs, and, of course, changes in facilities and procedures that will make the institution more acceptable to its potential clientele.

Service to Long-term Patients

If provisions for long-term involuntary treatment and custodial care are absent from new commitment laws, new methods of serving long-term patients must be developed. Merely returning such people to the community would lead to a recurrence of the problems that led to the creation of the state mental hospitals in the first place.' Unless help is provided, where is the person too sick to take care of his own needs to go? In the nineteenth century it was to jail or the almshouse. You can't hardly find almshouses no more, but we still have jails. Today, though we sometimes jail the alcoholic or the drug-dependent person for his illness, we do not jail the chronic schizophrenic for schizophrenia; but without help he is all too likely to get into situations that lead to his being incarcerated, and not as a result of his being "dangerous."

Various things can be done. The hospital can develop adequate outreach facilities for aftercare (not merely a clinic where patients can come to get medication, psychotherapy, or counseling) unless these are actually available in the community. For many patients this care involves regular home visits and assistance, or arrangements for assistance, in coping with various

problems of everyday life. Mobilizing support systems in the family and neighborhood is part of this, but careful judgment as to how much support is needed is crucial if one is to promote eventual rehabilitation rather than indefinite dependence on others. Day-care programs in the community are needed also.

In the hospitals themselves, day care is possible for patients living in the vicinity; and voluntary participation can be encouraged, when indicated, through home visits and through developing programs that attract patients to participate.

Domiciliary care is desirable for some patients. It does not need to be custodial. It can provide comfortable living arrangements, recreational activities, and sheltered workshops; but, in addition, there can be ongoing efforts at rehabilitation and resocialization, continued treatment when needed, and periodic reevaluation of treatability, treatment needs, and potential for rehabilitation. The hospital itself can convert custodial services to domiciliary, extended care facilities that can serve some patients better than nursing homes, foster homes, or transitional living arrangements such as halfway houses in the community.

Continuity of Care

Along with changes in financing of patient care and the elimination of

involuntary hospitalization, the decline in resident population permits a redirection of programming for better patient service.

The traditional emphasis on inpatient care neglects the fact that home care, outpatient treatment, or partial hospitalization often may be preferable, and that even those patients requiring inpatient service require it only at certain stages of illness. A total treatment program for the patient needing hospitalization often requires adequate pre-care and aftercare. Many public mental hospitals now offer a full spectrum of patient services; the public mental hospital of the future must do likewise. Services must include telephone consultations arid home visits, twenty-four-hour emergency and walk-in services, outpatient treatment programs, partial hospitalization, hospitalization for active treatment, domiciliary care, aftercare, and rehabilitation programs both at the facility and in the community.

With a full spectrum of services, continuity of care can be achieved. Adequate patient service cannot be fragmented. Continuity requires extension into the communities served by the hospital. Satellite clinics for crisis service, outpatient treatment, pre-care, and aftercare must be conveniently located in the inner city, in suburbs, and in rural areas. Unit systems, relating inpatient units to satellite clinics and areas served, maintain continuity.

Where some phases of care are available through private practitioners, private institutions, and public agencies outside a state mental-health system, contractual arrangements and/or adequate liaison services may maintain continuity of care. Continuity, however, is not achieved by giving the patient being discharged from a hospital, for example, the address of a clinic and mailing out a case summary. Experience shows that only a small percent of patients follow through with arrangements of that sort. A definite appointment helps. Meeting the person who will be in charge of the next stage of care helps. Finally, active follow-up of patients who do not complete treatment may be essential to prevent relapses.

As well as maintaining continuity of care, unit systems maintain continuity of responsibility. Cases are not "lost" and difficult cases are not disposed of by transfer to some other service. Continuity, however, does not require keeping the same therapist. Indeed, a change of therapist is often beneficial when progress fails to occur, or is slow, or when the stage of illness, or recovery, calls for different professional skills.

Flexibility of Hospital Environment

Lower resident populations allow more individual attention and the organization of patient living arrangements into smaller units so that there can be more flexibility and less regimentation. In the past, among the least

desirable features of public mental hospitals was the fact that many patients spent prolonged periods without activity, or only slightly better, were forced into a lock-step program where everyone was doing the same thing at the same time.

Regimentation, interruption of normal human activities, rules, and restriction, which made up an institutional environment, may have been necessary, may have contributed to efficiency, and may have served to protect some patients. However, many features of hospital life in the past, and some that persist today, were and are antitherapeutic. They created confusion in the already confused, reduced self-esteem and feelings of identity, and for the long-term patient who adjusted to institutional life, created problems in readjustment to normal living. They created a negative attitude toward hospitalization that interfered in participation in treatment programs. This milieu also discouraged voluntary admission and readmission.

A hospital is not a home. A cottage plan, small units, or small group programming and living in larger units does not make it a home. Group living can be normal living, however, and one can have the amenities, conveniences, freedoms, and, equally important, responsibilities of normal living insofar as illness permits.

A comfortable open ward; a flexible schedule of daily activities; contact

with the world at large through newspapers and television; having one's own clothing, possessions, and spending money; having visitors at any time; being free to go out; and having opportunities for recreation and, if able, work, is *not* treatment. It is an environment that facilitates treatment. Relative freedom from restrictions of normal activity does not mean "turning the hospital over to the patients," nor does it mean inattention to patients. An open hospital requires *more* attention to patients. Patients must be protected from the consequences of their own symptomatic behavior (and, on occasion, from that of other patients and visitors). Protection without overprotection, and guidance without domination, require more time and more professional skill.

Individual Treatment Programs

There are sound professional reasons for more formal treatment planning, quality control of treatment through review processes, improved records, and program evaluation. Moreover, developing methods of financing health care will make these things mandatory. Each patient should have a written treatment program with clearly stated goals, methods, and measures of progress. Writing up a treatment plan used to be an exercise for students and house staff; the experienced clinician did not need to write out his plan. It may be open to question whether this is clinically necessary now, but there is no question that it is rapidly becoming economically necessary. At the least, it

does no harm; at best, it clarifies the clinician's own thinking, improves communication to staff, and insures that no patients are kept without a treatment plan. Review processes will have to answer, to the satisfaction of third-party payers, the questions: Was the admission necessary? Were other methods of care adequately explored? Were diagnostic studies completed rapidly and treatment instituted without unnecessary delay? Was the treatment plan appropriate in terms of both potential effectiveness and cost? Was the length of stay reasonable for the illness? If not, why is a longer stay justified?

One now finds a great deal of emphasis, generally appropriate, on keeping patients out of hospitals. This may be expected to increase to some extent if the insurance model is used in financing care, and to an even greater extent if the prepayment model is used. It must be borne in mind that while unnecessary admissions add to cost, clog treatment facilities, and interfere unduly with the life situation of patients; failure to admit patients who need hospital care can have disastrous consequences.

There are obvious advantages to patient and payer to make hospital stays as short as possible. However, premature discharge is to no one's advantage. Additional studies are necessary, and some are being undertaken now with NIMH support, to determine optimum lengths of stay for various conditions. Because of the number of variables involved, a number of studies

will be needed before conclusive data is available. Even when an optimum is determined, one must recognize individual differences and needs. In any event, the eagerness of a clinical director, or a utilization committee, to keep stays short should not lead to "revolving door" admissions and readmissions (e.g., repeated drying-out of alcoholics is not definitive treatment) nor to the dumping of patients into inadequate community facilities (as is particularly apparent in the inappropriate referral of some geriatric patients to nursing homes).

Better records will be essential for adequate case review. However, it is to be hoped that the record-keeping and review procedures involved will not be so time consuming as to interfere with adequate patient care.

Despite some criticisms of "labeling," descriptive diagnosis will probably continue to be used, because, its limitations notwithstanding, it does have some communication value and usefulness in treatment planning and research. However, problem-oriented recording is likely to prove more useful than current record systems. Checklists and graphs will replace narrative progress records to a large extent.

Objective progress charting is necessary to measure the results of treatment programs. One can go into most state or federal hospitals, and many private and community facilities, and find patients who have been on

medication for months or years with no evidence of benefit other than perhaps the patient's subjective report or the clinician's general impression. If a medication or other treatment is instituted, one must know what it is expected to do, what is a reasonable trial period to see if it accomplishes this, and how change can be measured. When this is known, an objective progress chart is possible. The expense, and possible undesirable consequences, of a treatment that is not working can be eliminated and a better treatment plan devised.

Conclusion

The state mental institutions referred to in the opening paragraph will not be phased out, in that state or any other, by 1975. Too many people need their services and alternative facilities are not available. They may be phased out in time, but the creation of a whole new system to replace them is unnecessary and uneconomical.

Instead, they will probably become an integral part of a total health-care system. Organizationally, they will probably function eventually as nonprofit corporations rather than state agencies (unless the steps beyond Medicredit, universal health-insurance and/or health-maintenance organizations lead to a national health service, in which case they will be federal facilities).

Direct patient service ultimately will be provided on a prepayment basis

(from the hospitals' point of view—a system based on the total population served, not those in treatment), or on a fee-for-service basis through government and/or private insurance carriers. Appropriated funds, or grants, will still be needed for research, training, and preventive programs. The distinction between the now public and private facilities will be largely eliminated, and, with it, dual standards of care will be a thing of the past.

The public mental hospital of the future will offer a full spectrum of mental-health care and will have outreach facilities in the communities it serves. Nearly all its patients will be voluntary. It will treat acute cases and will offer domiciliary care, rather than custodial care, to the chronically disabled. New systems of treatment planning, case review (combining features of utilization and peer review), and record keeping will be utilized.

Changes in modern society are taking place at an accelerated rate. For the state mental-health department that has not already prepared for the future role of its facilities, the time is now.

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Notes

1 A quotation from the January 10, 1872 *Omaha Daily Herald* concerning the Insane Asylum at Lincoln. (Reprinted in the *Omaha World Herald,* January 10, 1972.)

2 From President Nixon's message to the Congress of the United States, February 18, 1971.