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The Mental Hospital as a Basis for Community Psychiatry

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THE MENTAL HOSPITAL AS A BASIS FOR COMMUNITY PSYCHIATRY

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THE MENTAL HOSPITAL AS A BASIS FOR COMMUNITY PSYCHIATRY

In his 1925 presidential address to the American Psychiatric Association, William A. White stated "The State Hospital as it stands today is the very foundation of psychiatry." Harry C. Solomon, in his 1958 presidential address, stated:

> The large mental hospital is antiquated, outmoded, and rapidly becoming obsolete. We can still build them but we cannot staff them; and therefore we cannot make true hospitals of them. After 114 years of effort, in this year 1958, rarely has a state hospital an adequate staff as measured against the minimum standards set by our Association . . . and these standards represent a compromise between what was thought to be adequate and what it was thought had some possibility of being realized. ... I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy. I believe therefore that our large mental hospitals should be liquidated as rapidly as can be done in an orderly and progressive fashion.

It was not, of course, the mental hospitals that had changed in the thirty-three intervening years but rather the foundations of psychiatry and indeed the broader determinants of man's relationship to man, from which the most crucial elements of the foundations of psychiatry at any period derive. The historic processes that, starting during the latter half of the nineteenth century, had rendered the large mental hospitals into underfinanced, understaffed, geographically isolated custodial warehouses have been described, and there is little doubt that a reaction to the shame of these

hospitals was a significant component in the confluence of forces that led to the explosive development of community psychiatry programs during the late 1950s. The civil rights movement, the war on poverty, the Peace Corps, the Durham rule, the campus revolts were slogans current in the United States *pari passu* with community psychiatry, each in their own arena reflecting the same worldwide revolutionary shift in the fundamental relations of man and society. Bartlett outlined the role the designation of mental hospital patients as “indigent” played in creating the “institutional amalgam of administrative, medical, legal, economic, welfare and political activities” which maintained the isolation of the mental hospital from the community it served; similar considerations may be extended to the fact that patients have been, in disproportionate numbers, black and foreign born. It is important to recognize that the changes in institutional structure and function that have made possible the current role of the mental hospital in community mental health programs derived from broader changes in the social structure rather than from revolutionary developments in pharmacotherapy; the open-door policy, day hospitals, the therapeutic community, and family therapy were all in clear development prior to the discovery of the antipsychotic properties of the phenothiazines. E. Linn’s study of St. Elizabeth’s Hospital from 1953 to 1956, for example, reveals that a higher proportion of patients admitted in the later years than in the earlier years were discharged, though the use of tranquilizers had not as yet been introduced. A parallel may be drawn to the

decline in morbidity and mortality from tuberculosis, which preceded the introduction of acid-fast specific antibiotic drugs, but reflected the introduction of improved social, hygienic, and housing conditions in the care of tuberculosis patients.

In order to participate significantly in the network of community mental health resources, mental hospitals must, to begin with, replace custodial practices with active treatment programs. The range of therapeutic approaches increasingly evident in contemporary mental hospitals is indeed extensive and includes organic therapies (pharmacotherapy and ECT), psychotherapies (individual, family, multiple family, and group), and sociotherapies (milieu therapy, occupational and recreational therapies, art therapies, therapeutic community). The impact of these treatment approaches on the career of patients has been extensively described; duration of hospitalization has been dramatically decreased, and concurrently the incidence of the noxious symptoms of hospitalism, which Gruenberg aptly called the "Social Breakdown Syndrome," has declined. L. Linn demonstrated, in a study of twelve state mental hospitals scattered around the country, that higher discharge rates were not significantly related to the age, mental status, or physical disability of patients, nor to the aesthetics of the wards or the personal facilities available to patients; they were, however, related to the frequency of patients receiving visitors and the frequency of organized patient-doctor, patient-staff, and patient-patient interactions. Consistent with

this report is the finding by Schulberg and Baker that concurrently with the general improvement in services attending the shift of the Boston State Hospital toward a greater community orientation, the number of patients not receiving any form of treatment was reduced from 37 to 18 percent. The capability to provide appropriate treatment may not in actuality exist in all psychiatric institutions, but this is no longer the sole frontier of the mental hospital; equally challenging is the formidable problem of breaking down the barriers between hospitals and communities and of establishing integrated and coordinated programs with community-based facilities, to the end of providing continuity of treatment for patients.

The forces impinging on the evolution of community-oriented programs in mental hospitals are extremely uncertain and undefined. The modalities of psychiatric treatment, the practices of mental hospitals, and the development of community psychiatry approaches are both independently and inter-dependently undergoing dramatic and rapid change. The unevenness of the rates of change inherent in the science and art of psychiatry is magnified by the immediate impact on each of fiscal support available from public funds at city, county, state, and federal levels for teaching, research, and service programs. The many other variables of place and circumstance—rural versus urban location of hospital and community mental health center, presence or absence of a medical school affiliation by either or both, presence of an unusually large concentration of old persons, of children, of ghetto residents,

or of addicts in the populations served by either or both—in addition to the unpredictable nature of fiscal support, psychiatric technical developments, and changes in the social matrix in which families and communities are imbedded, make it difficult to predict the nature of community programs mental hospitals are likely to develop in the future. What can here be described are the patterns that have characterized the significant number of mental hospitals that pioneered in developing community programs, in the expectation that these patterns are likely to continue to be applicable to those traditional mental hospitals that will be changing in the next decade.

Unitization

The single most revolutionary change in mental health services that has characterized community psychiatry programs is the shift from professional responsibility for patients—self-identified or brought to the hospital, clinic, or office by some interested other person—to responsibility for population groups. Preventive programs, early case-findings efforts, community education and consultation services, storefront and satellite clinic units, and the use of indigenous nonprofessionals all existed as components of traditional psychiatric services, but were all qualitatively increased and were newly combined in a coordinated pattern of work only after the acceptance of responsibility for the mental health of all residents in a defined geographic area made it no longer feasible for mental health professionals to wait in their accustomed places for accustomed (hopefully "good") patients on whom to exercise their accustomed skills. Inherently, the potential adaptations available to a mental hospital for change toward a community orientation would appear to be extremely limited by the traditional role of the hospital as the most classic institution in the medical model, and this limitation becomes virtually insuperable when the hospital is responsible for a huge geographic area. Historically, the sorting out of patients in such circumstances has rested on individual patient characteristics (acute versus chronic; male versus female; specific diagnostic entities, for example, alcoholics, geriatric patients, depressed patients who are candidates for ECT); the tragic consequences of

this sort of triage, for example, the inevitable process of creating chronicity by the sheer device of establishing “chronic” wards, are too familiar.

A strikingly different perspective is afforded a mental hospital when it divides its wards into units or services on a geographic basis (ideally, in our experience, from 100 to 250 beds to serve a population of from 100,000 to 200,00), with the unit chief responsible for patients from a defined catchment area and for effecting appropriate liaison with all mental health-related agencies and institutions serving that area. In those instances where receiving or screening centers—hospitals or clinics—serve the target community, a range of administrative forms for providing continuity of patient care and for the sharing of patient records rapidly develops. Some of the units find themselves serving areas that are relatively well supplied with clinical resources, while others serve barren areas. The advantages to the hospital of relating to community-based centers quickly become apparent, with reference to reduced admissions through both appropriate local treatment alternatives and more stable adjustments by patients to community life after discharge because of improved follow-up care. The most frequent sequence that follows is that hospital units serving “have-not” localities first establish their own community-based aftercare clinics; the clinics soon begin to intercept patients on their way to the hospital by offering outpatient short-term crisis therapy, in addition to treating discharged patients; crisis intervention in turn leads to consultation services, most frequently to schools,

police, and family agencies; the hospital units begin to use ward space more flexibly, to accommodate to the needs of the outpatient clinics for day and night hospitalization; and by this time the hospital is generally seeking to formalize the network of services established by such units as community mental health centers. The literature is liberally sprinkled with references describing such a sequence. In at least as many instances, centers are developed out of the associations between hospital units and their community-based partners. Rural hospitals, with some appropriate devices (satellite clinics, for example) to provide for the logistical problems of ensuring continuity of treatment, have undergone similar development.

Although unitization of mental hospitals is the crucial and necessary cornerstone of a community orientation, it is not without its penalties. It is expensive; it requires considerably more staff members, with better training, to replicate admission processes and treatment programs for several units, and to cover the requisite liaison and outpatient positions, than to maintain a large custodial triage and storage center. The initial period after unitization is invariably a difficult one. Patients must be moved from hospital loci determined by age, sex, or duration of stay to geographic units. Staff relationships change profoundly from a vertical to a horizontal organization in which each service or unit determines the assignments of its staff members, rather than having department heads decide independently on hospital-wide programs for psychologists, social workers, nurses, activities

therapists, and nonprofessionals. With this shift, there is inevitably a blurring of professional disciplines; a chief psychologist is more likely to maintain the unique disciplinary identity of the roles of his staff than is a unit chief who will need to get his job done by extracting from each staff member whatever skills he possesses regardless of professional title. Even more vexing is the almost immediate creation of totally new roles, particularly boundary-spanning roles between the hospital unit and its own mini-community. It is not at all infrequent for mental hospital stationery to bear the inscription “Address all correspondence to the superintendent”; this obviously cannot be continued in a unitized hospital, but powerful traditions must be overcome before unit chiefs or their community liaison staff officers develop free mobility across the hospital boundary into the community. Finally, there is almost certain to develop a competitive relationship between units; while this may have a salutary effect, it may sometimes generate disruptive bitterness between competing units.

For all these risks, large mental hospitals must unitize their services as an essential first step if the hospitals are to break the shackles that have isolated them from the community they serve.

Patient Flow and Staff Sharing

In a considerable number of instances, freestanding community mental health centers have focused principal attention on patients with acute psychoses, neuroses, and personality disorders and have given low priority to the chronically mentally ill, the addicts, the alcoholics, the elderly, patients with poor impulse control or prone to assaultive behavior, and patients with medical and neurological as well as mental illness. The flow of patients between such centers and the area mental hospitals has tended to be unidirectional, with virtually no referrals from the hospital to the center.

In the competition with hospitals for patients most likely to respond to currently available treatment regimens, the mental health centers enjoy many advantages. University and teaching hospital departments of psychiatry are increasingly responsive to the pressures for developing community psychiatry programs, but except when they happen to be located in the vicinity of a mental hospital, the trainee and teaching staffs of these departments are unlikely to follow patients into the public mental hospital. The community mental health centers then, given first contact with patients, with substantial teaching obligations and generally with better financial support than mental hospitals, may tend to treat selectively the acutely ill patients, that is, precisely the patients we already are best able to treat. The state hospital, conversely, ringed by mental health centers, can then expect

only those patients who are least likely to respond to current treatment approaches to sift through the community-based screening units. Hospital staff members interested in active treatment will then tend to be attracted to the mental health centers, and this process, once begun, can develop its own momentum, so that a rapid sorting out of professional staff may be expected. It is thus likely in some instances that community mental health centers, designed in large part to reverse the tendency of large mental hospitals to promote chronicity in mentally ill patients, will become significant forces for promoting chronicity. Two contributions already published report precisely such a development.

There are a number of advantages to mental health centers in this pattern of patient flow. The flexibility of the newborn centers in selectively addressing community needs is maximized by having the mental hospitals as a captive backstop. The hospitals at the same time serve as reservoirs of professional manpower for the centers. Geographic distances between centers and hospitals, which may present serious logistical difficulties to the development of close liaison arrangements between a hospital and a community-based center, pose no problem to this pattern; indeed, the extrusion of undesired patients from community mental health centers is promoted by greater distances between the centers and the state hospitals. However, the promotion of chronicity and the building in of discontinuity between community and hospital phases of treatment are too great a price to

pay for these advantages.

An alternative model is one in which the mental hospital serves as the regional hub of a wide network of community-based mental health centers, with each geographic unit of the hospital fully integrated into the network of services designed for a defined catchment area or serving itself as the principal locus of a community mental health center. The essence of this model is a regionalization of mental health services around the mental hospital, in close parallel to the catchment area subregions served by community mental health centers; in the present instance, liaison patterns involve the flow of patients between a hospital and a center, rather than between a center and the agencies and institutions in the community served by the center.

A variety of patterns of patient flow have emerged from liaison arrangements of this latter sort. Most simple is a separation of functions between hospital and center based on duration of hospitalization, in which decisions concerning admission and discharge remain the prerogative of each institution. Records are completely shared. The decision to refer a patient from a center program for admission to the hospital is made by the center staff, but an independent decision to admit the referred patient is the responsibility of the hospital. Conversely, a discharge recommendation is made by the hospital staff, but must be independently accepted and

implemented by the center staff. Differences in professional judgment as to admissibility or readiness for discharge are an expectable occurrence in such an arrangement and frequently lead to such shared efforts at resolution as joint hospital-center clinical conferences or service liaison committees. Generally, the centers assign liaison staff members to the hospital unit to which their patients are assigned to facilitate social service and after care treatment arrangements for patients being discharged from the hospital.

In a number of instances, administrative structures have been established in which patient flow is regulated entirely by a joint center-hospital staff unit, although the hospital employees remain responsible to the hospital director for specific administrative requirements. In these instances, complete continuity of care can be approximated, with patients followed into and out of the mental hospital by the staff member or team most involved with their treatment programs. Such arrangements are fraught with administrative difficulties. Unless the pay scales, fringe benefits, and union affiliations of hospital and center staff members are identical, employees doing substantially the same tasks but under different conditions of employment will be working side by side, a circumstance that could not be maintained for very long. The mixed chains of command—functionally to the center and structurally to the hospital—represent a further administrative complication: Neither the center nor the hospital director can act freely in pursuit of his own goals without concern for the other. Where there is a single

unifying authority (for example, the chairman of a medical school department of psychiatry with which both the center and hospital are affiliated or the commissioner of a state department of mental hygiene with authority over both hospital and local services), these difficulties are readily resolved. In the absence of a central authority, they represent formidable obstacles to the complete unification of decisions concerning patient flow between mental hospitals and community mental health centers.

Invariably, the other side of the coin of patient flow is staff deployment; provision for continuity of patient care must remain limited if staff assignments are rigidly maintained as either to the center or to the hospital. A number of staff-sharing procedures have been described, all of which fundamentally rest on some measure of mutual trust between hospital and center administrations and some measure of joint responsibility for patient care and treatment.

Central Specialized Treatment Services

One of the problems that plagues all attempts at the decentralization of health services is the replication versus the regionalization of expensive, infrequently utilized programs. Appropriate care and treatment of small numbers of patients within any community mental health center catchment area may require a facility beyond the means reasonably available to any single center, and yet readily supportable on a broader regional basis. In such instances, the mental hospital that serves a ring of community psychiatry programs may lend itself uniquely well to service as a special treatment center for these programs. Responsibility for patients while in these programs generally rests with the hospital, but in most instances the patients are at the same time in community-based treatment programs organized by the center, so that some liaison between hospital and center is forced on the cooperating institutions. Such specialized treatment programs include both facilities for special categories of patients, and specialized facilities for broad patient categories.

Examples of the former include facilities for treating mentally ill criminals, addicts, alcoholics, and patients requiring extensive physiotherapeutic as well as psychotherapeutic efforts. Some of the problems attending the establishment of a prison ward are discussed below; except for a large urban community, the number of mentally ill offenders is likely to be

too small to justify the cost of a separate security unit for the population of a mental health center catchment area. Again with addicts and alcoholics, while the number of outpatients from one area may be substantial, the number requiring inpatient treatment especially adapted for their care and treatment is likely to be too small for a community-based inpatient service.

Examples of specialized facilities for broad patient categories likely to prove too costly to be supported on a local basis include sheltered workshops, halfway houses, and nursery school programs for preschool children of mentally ill mothers. Although many, if not most, community mental health centers provide vocational rehabilitation services for their patients, the close replication of the conditions of work in a large factory is prohibitive, and the range of on-the-job vocational training supportable by any single center is limited; a regional vocational rehabilitation center operated by a large mental hospital can provide such facilities for a number of mental health centers. Similarly, individual centers frequently have a number of apartments and/or foster home placements available for patients judged capable of the degree of competence for independent living required for such residence but who cannot afford the intermediary living experience between a hospital and community apartments represented by a halfway house. At the Bronx State Hospital, a program designed to provide rehabilitative training in family life and mothering behavior for patients with preschool children found it necessary to extend the nursery school experience for the children and the

rehabilitative effects with the mothers long after the mothers had been discharged to outpatient treatment in community-based clinics.

Mention must be made of the specialized role of private mental hospitals. Klerman indicated the large numbers of patients, other than those requiring long-term institutionalization, treated in the private sector, and Ozarin, Herman, and Osterwellx described the many instances in which private hospitals have participated in the development of full or partial community mental health centers. Kubie suggested that the private hospital is uniquely suited for demonstration research seeking models for the hospital and community liaison. The increase in the number of private hospitals, and their widened geographic distribution, has made it possible for many private patients to be hospitalized near their homes and has stimulated the development of partial hospitalization and halfway houses in conjunction with these hospitals. With increasing pressure for the inclusion of reimbursement for psychiatric treatment by public and private health insurance programs, and with the growing tendency of medical schools and voluntary hospitals to extend patient care to low-income groups, it is likely that private mental hospitals will follow the route of the public hospitals in a shift toward greater integration of hospital programs with the communities served.

Conceptual Issues

It was noted above that the crisis of mental hospitals, in transition from geographically isolated custodial institutions to community-oriented treatment centers, can only be understood in the light of simultaneous crises in health care delivery systems and in medical education, and these in turn must be viewed against the background of the broader matrix of social change in which they are imbedded. We have accepted as national policy that health is a fundamental human right, rather than a privilege for those who can purchase medical services, and we have thereby altered in a radical way the basis from which we view such issues as the numbers, kinds, and distribution of doctors needed to implement the evolving health policy. We have at the same time begun to alter the doctor-patient relationship so that the patient sees himself less as the fortunate recipient of the favors of his doctor and more as a consumer who insists on holding his doctor to account as firmly as he does all purveyors of services. Under the pressure of the vast, hitherto poorly attended, mental health needs of large segments of our population, we have trained a range of nonprofessional mental health workers and have inevitably been forced by the mounting urgency of the need to redress centuries-old racial inequities to open channels for the more talented of these nonprofessional workers, overwhelmingly from minority groups, to para-professional and professional status. The demands of patient-consumers for a new measure of accountability, coupled with the

extraordinary skill and ability of many minimally trained mental health workers, have led to a major reevaluation of the role of the professional in the planning and administration of health care delivery systems and a challenge to the hitherto unquestioned primacy of the doctor, and of the medical board of the hospital, in decisions concerning the organization of health services to communities. As Zborowski eloquently noted:

> There are only two possible alternatives for coping with this array of problems: one dictated by fear and conservatism, and the other by the understanding of social processes and by progressiveness. The hospitals may move out of the ghetto to follow the migration of the white middle class and their physicians to the security of suburbia. Or they may remain in the old location. . . . Many hospitals have selected the second alternative, although that course is far more difficult than the first. Hospitals have to be ready to become part of the community. . . . They must accept responsibilities in the community, not only as the hospitals see them, but as they are defined in conjunction with the community.

A number of unresolved problems attend the acceptance by a mental hospital of responsibilities in the community, one of the most immediate being the redefinition of the role of the community in determining hospital policy. It has become an accepted feature in the operation of community mental health centers that community boards enter into the formulation of center policy and philosophy. In some instances the boards have incorporated, have secured staffing grants, and have contracted with professional staffs to provide the mandated services; in other instances, boards have been serving in an advisory capacity, sometimes with carefully

restricted areas in which their advice is solicited or offered. There is as yet no consensus as to the optimal relationship between community representatives and the administrative or executive staff of a center, and community boards have barely begun to emerge in relation to the operation of mental hospitals. However, it is abundantly clear that medical boards and administrators cannot long continue to exclude the outsiders (that is, the communities they serve) from the decision-making processes of their hospitals. The impact of the active participation of community boards in establishing hospital policies and practices can be expected *to* profoundly affect every phase of hospital life, including priorities for admission of patients, hiring and firing procedures, the use of patients for teaching and research, and even the selection of treatment programs.

A second set of issues relates to the role of inpatient treatment in the network of mental health services provided by and for a population group. Community attitudes toward mental illness and psychiatric treatment are inevitably altered away from awe and fear toward a greater acceptance of hospitalization without stigma by the transition of hospitals to a community orientation and by the provision of mental health services in general hospitals and community clinics and centers. At the same time, the development of such treatment centers in the community broadens the available options to hospital admitting officers from hospital or home to a range of intermediary alternatives, and this in turn demands that a meaningful set of criteria for

hospitalization be formulated.

It is apparent that former President John F. Kennedy, in the message to Congress that heralded the shift in national policy toward support of community psychiatry programs, anticipated the demise of the large mental hospital; it seems equally apparent that facilities for inpatient care and treatment will continue to be required. Further, with reference to the use of hospitals, the consequences of the creation of community alternatives to mental hospitalization are inextricably intertwined with the development of a wide range of alternative conceptual models to the traditional medical model for understanding and helping persons seeking mental health services. At one extreme, Szasz, Liefer, and others suggested that mental illness is a myth and expressed the concern that hospitalization is merely a device designed by a social system to coerce deviants into conformity with its norms. At another extreme, Kubie, quite content with the illness model, expressed concern that the long-term benefits of community treatment and of psychoactive drugs are unproven and uncertain, and he urged that “years of observation of the delayed aftereffects of physiologic, chemical and psychological devices are essential for both the progress of our scientific knowledge and the immediate care of patients. It is extremely difficult if not impossible to carry on such a period of critical and sustained observation without hospital control and protection.”

A recent contribution to this set of issues presented in the monograph, *Crisis in Psychiatric Hospitalization*, reflected the lack of resolution that prevails; after listing three indications for hospitalization for diagnostic purposes, and five indications for hospital treatment, it offered the uncertain conclusion that “An individual’s need for hospitalization . . . involves an examination of his personal problems and an assessment of his personal and the community resources. If the totality of resources, including alternative management procedures, is inadequate, hospitalization may be clearly indicated.” A complementary contribution, suggested by Schulberg and Baker, is that an evaluation research program for outcome studies of mental hospital treatment must derive from an open-systems model and examine not only the hospital but the entire network of community mental health facilities.

Still another special set of conceptual issues confronted by the transitional hospital relates to the definition of the boundary between psychiatry and the law. The geographically isolated, long-stay custodial hospital with locked wards was functionally more similar to than different from jail, and the differentiation between madness and badness in deviant behavior was not of crucial moment. This is clearly not the case in an open ward community-oriented active treatment hospital, despite the parallel transition in penal institutions from a punitive to a rehabilitation focus; it is not unusual, among other gross differences, for the median duration of stay in a mental hospital to be less than three months.

The potential role of a mental hospital in providing a locked ward unit on a regional basis for patients who require such a unit is dictated by the demands of the judiciary rather than by treatment needs; it is, therefore, difficult to avoid the establishment of a custodial prison ward atmosphere. Many states provide for civil hospitalization of criminal offenders accused of misdemeanors, whose behavior in the course of their arrest and arraignment raises questions concerning their sanity or competence. If the judiciary demands the return of such patients after examination and/or treatment, a security unit is mandatory, and there is the risk of the locked ward atmosphere spreading through the hospital. On the other hand, if the patients are released by the judiciary to the hospital, as Lowenkopf and Yessne showed, they constitute a very significantly different population from the other patients: They are more frequently involved in sex offenses, in bringing alcohol or drugs to the wards, in assaultive episodes, and in more than one-third of the cases their treatment is terminated by elopement from the hospital. Referral to outpatient treatment clinics is rejected by the patients, and the clinics in turn are prone to refer these patients back to the hospital on the slightest indication. The community-oriented hospital will find the mentally ill criminal offender a serious problem, and it may be that some totally new and more suitable modality for treating these patients will emerge out of current efforts to resolve the dilemmas they create.

Perhaps the most difficult problem in the transition of a mental hospital

to a community orientation is the change demanded in the philosophy of the hospital staff. Baker and Schulberg demonstrated that mental health professionals working in mental hospitals fall in the lowest scoring category on their community mental health ideology scale. This is not surprising. The mental hospital is a highly centripetal institution: The hospital groups, the hospital milieu, the hospital activities and programs, and above all the hospital staff are the stuff of which remedy is fashioned. The patients "belong" to the staff, and the prevalent perspective among staff members holds that it is precisely "those people" in the family and community who have generated the forces that led to illness in their patients; to develop active alliances with "those people" is not congenial to the staff. Equally inimical to expectable hospital staff attitudes is the introduction of primary prevention as a major emphasis; there is a qualitative conceptual leap from the accustomed concern of staff members with secondary and tertiary prevention, involving people already identified as patients, to programs designed to forestall patienthood, a leap that staff members often find difficult and baffling. A not infrequent chart note will read, "Mary has been upset each time her mother has come to visit; I have therefore restricted the mother from visiting until further notice." For a hospital staff to develop a true dedication to community treatment requires a major change in the staff self-image, away from that of caretakers and more toward that of change agents.

Conclusions

Kraft pointed out that community psychiatry involves rather little up to this point in the way of new treatment techniques, but rather offers traditional treatment approaches in a new delivery system designed to bring more of the therapeutic effort to patients in the community. For a traditional mental hospital to serve as a base for a community psychiatry program, it must then first offer a wide range of active treatment programs aimed at the most expeditious return of the patient to his family and community. Large mental hospitals must be unitized, so that clusters of wards with a total of from 100 to 250 beds are organized to serve a population area of from to 200,000 persons. Liaison arrangements between a hospital unit and the community-based mental health facilities in the geographic area served by the unit should aim for the free flow of patients and records and for the full sharing of staff. Of particular concern where a community mental health center and a large mental hospital fail to develop such liaison arrangements is the likelihood that the center will retain for treatment only those patients likely to respond rapidly to currently available treatment modalities and will concentrate patients likely to become chronic in the hospital. A mental hospital serving as the hub of a regional network of community facilities can offer a variety of specialized services, or services for special categories of patients, likely not to be supportable economically by the resources of community mental health centers for smaller patient populations. Finally, a

number of conceptual issues are introduced by the transition of a mental hospital from a geographically isolated to a community-oriented center, among which are community participation and control, the problem of the priority in public mental health programs of providing for the need for hospitalization, the nature of the relationship between the health system and the law system for dealing with deviant behavior, and the attitudes of hospital staff members.

Mesnikoff made the observation that we are coming full circle in the history of our country regarding the treatment of mental illness—from family to county to state and now back to county and family—though at a significantly more sophisticated level and with a great deal of expertise available to support treatment in the community. Viewed in this light, the mental hospital must serve as one resource in a network of mental health services designed to support programs for the community-based treatment of the mentally ill.

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