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The Present and the Future of the Psychiatric Hospital

Henry Brill

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Introduction

In January 1976, there were an estimated 332,000 beds for the mentally ill in U.S. psychiatric facilities and an additional 425,000 in nonpsychiatric facilities, chiefly nursing homes and homes for the aged and dependent. Commonly listed among the psychiatric facilities are the psychiatric units of general hospitals, community mental health centers (CMHC), the state hospitals (including state and county mental hospitals); Veterans Administration hospitals, residential treatment centers for emotionally disturbed children, children's psychiatric hospitals, and private psychiatric hospitals. All these treatment centers are different in many ways, but they share a common body of theory and practice, as well as a common treatment technology. And they have all been similarly affected by the social and economic changes of the past several decades. This situation is clearly described in a recent paper, "Psychiatry in New York City: Five Systems, All Overwhelmed." The authors might well have added a sixth system, the nursing homes (including homes for the aged and dependent) because, nationwide, these have a larger inpatient census of psychiatric cases than all

other facilities combined. All five systems face the problem of "how to deal with more patients than there are beds for, how to treat them, and how to design programs suitable for chronic patients as well as all the others who seek treatment."

That a shortage of beds is common to all the various systems of service is a matter of daily experience. It is encountered, for example, when one seeks to move a patient from a nursing home to a psychiatric hospital or from a psychiatric hospital to a nursing home. As a result, public general hospitals are often forced to keep a long-term patient in a costly acute-care bed for weeks or months, while negotiations are carried on for some type of placement. The various types of psychiatric facilities are affected by other factors as well, such as the system of multiple source funding, the requirements of continually new developments in legislative, judicial, and administrative law, and certain shifts in public attitudes toward mental patients and "former mental patients," as well as psychiatric diagnosis and treatment generally. Finally, they all face the pressures of public concern about rising costs, and, in the long run, they all compete for the same mental health funds. Thus, from one point of view the various types of psychiatric facilities may be seen to function as parts of a single system even though they are administratively heterogeneous, and the populations they serve, though they tend to be different, have a considerable overlap.

For this chapter, hospitals shall be considered as parts of a system and, for purposes of perspective, something of the history of the development of these facilities will be considered. Then the effects of advances in treatment techniques, the administrative responses to new problems and conditions, and the impact of newer fiscal and legal developments and the effect that they have had on the structure and function of the psychiatric hospitals generally will be considered. Finally, the situation with respect to several types of psychiatric hospitals will be reviewed.

Inpatient Facilities Up to 1963

Early History

Hospital treatment of the mentally ill has a long and turbulent history. The classic Greek, Roman, and Arabic medical texts describe mental illness along with other forms of sickness; and to some degree, practice was in line with theory at least in the Muslim world, as space was provided for the mentally ill in Bagdad, Cairo, and Damascus general hospitals as early as the ninth century A.D. There is a story in the *Arabian Nights* about a man who was treated in such a facility and then released to the custody of his mother, after treatment with the strong deconditioning methods of that period had led to his recovery. Far more common during those times was the practice of extruding the mentally ill from society. They were left to wander as wild men

in the woods or set adrift at sea—as in the frequently described ships of fools.

It was the Spanish, perhaps reflecting influences from the Moorish occupation, who, in the early 1400s, first opened European asylums, and it was in the Spanish colonies that the first such facilities were established in the New World. The British followed suit not long after, perhaps as a result of the strong Spanish influence in England at the time, and by Shakespeare's day Bedlam and its wandering beggars, Toms o' Bedlam, were familiar to the public.

In the eighteenth century there were asylums scattered across all of Europe. A psychiatric ward was opened at Guy's Hospital in London in the late 1720s, while in 1755 place was made for lunatics in the Pennsylvania Hospital in Philadelphia.

The early asylums were run by ignorant and often brutal keepers, and conditions there soon fell below even the primitive standards of the time. This eventually triggered a period of reform, often associated with Philippe Pinel in France and William Tuke in England although many others were involved. Though this was the period of the French Revolution, the motto "Liberty, Equality and Fraternity" did not include the mentally ill and though Pinel's moral therapy was an advance, his own writings show that this was far from the golden age that has been depicted in some recent reports. Pinel described

a very high mortality rate and some of the methods that he used would today be branded as brutal. Given the state of medical knowledge in his day, it could hardly have been otherwise: Paresis was rampant, untreatable, and unrecognized; anticonvulsants were unknown, the science of nutrition was still embryonic, and there was no effective way of controlling the twin asylum problems of psychotic behavior and epidemics. In the next 150 years other reform movements followed periodically; they centered in turn on such targets as privately run madhouses, county-run asylums, brutal care by the community, harsh commitment practices, and generally low levels of care and treatment. Legal and administrative changes followed but they never solved the underlying problems of inadequate funding, overcrowding, and understaffing. The asylums continued to grow in population until 1955 and represented a political liability as well as a fiscal burden to whatever level of government administered them—municipal, county, or state; the federal government as a matter of policy was not involved.

Compared with other branches of medicine, psychiatry was scientifically stagnant. The period after World War I saw the advent of psychoanalysis on the American scene but it was only an office practice. The prospects for improvement in the overall situation were dim, and the population of state mental hospitals continued to grow twice as fast as the general population.

The Beginnings of Community Psychiatry

Until recent years, the state mental hospitals remained the major psychiatric resource. The entire system appeared to be, unchanging but new developments were underway. The first of these was the move toward the so-called psychopathic hospitals and the psychopathic units (now called psychiatric units) in general hospitals. Deutsch traced the former to the mid-1800s and stated that Pliny Earle, in an 1867 paper, first used the term "psychopathic hospital," urging separate hospitals for the "acutely insane." Early institutions of this type were often primarily receiving and observation points and performed a simple triage function for discharge or transfer to state hospitals, but gradually treatment became more important. In addition, relationships were established with medical schools, training for medical students and residents was provided, and research was undertaken. The Boston Psychopathic Hospital, the Syracuse Psychopathic, and the Colorado Psychopathic were early examples of this new type of small, locally based, academically oriented unit.

In 1902 the Mosher Memorial Unit in Albany, New York became the first modern psychiatric ward in a U.S. general hospital, and in 1933 the Rockefeller Foundation began to provide grants to create departments of psychiatry in university hospitals. Such units were set up in the Massachusetts General Hospital (1934), the University of Chicago (1935), George Washington University (1938), and Duke University (1940). A similar pattern was followed in the establishment of psychiatric institutes that were

autonomous but maintained relationships—with universities for example, the New York Psychiatric Institute, which was opened in 1929 as a part of the Columbia Medical School. One can see in these various facilities the emerging concept of community psychiatry based in small, short-term, treatment facilities located in the community they served. But it was only after 1963 that this became a dominant theme in American mental health policy.

Among those who prepared the ground for a shift from the state hospital to the community was H.S. Sullivan. Working chiefly in the 1930s and 1940s in Washington, D.C., and building on the theories of the Chicago school of social psychology, Sullivan incorporated some of the ideas of Adolph Meyer (1866-1950), a professor of psychiatry at Johns Hopkins, and added some of his own to create an academic base for a social psychiatry, also referred to as community psychiatry. This theory brought together much of what had been developing outside of the realms of both organic and dynamic psychiatry and emphasized the importance of the social environment on the etiology, prevention, and treatment of mental illness. With this orientation, the institution came to be viewed as a noxious factor and the community as a constructive and normalizing influence. Hospitalization was to be minimized and persons were to be treated in their own homes or at least in their own communities. Community psychiatry could thus be understood as applied social psychiatry.

World War II did much to shift opinion in this direction. Support was provided by the practical experience accumulated during the war and by studies, such as that of Querido in Amsterdam, that seemed to demonstrate that emergency intervention in a civilian population could all but abolish the need for the state hospital. It was a time of confidence in social engineering as a way of correcting social problems, which was, in part, a reaction against Hitler and the Nazi regime's violations of civil and human rights. It was virtually inevitable that large mental hospitals would continue to be a target for reform, even though major medical advances had begun to affect their operations. The introduction of penicillin in the 1940s was to reduce paresis, which had accounted for 10 percent of admissions, from a fatal disease to a clinical rarity; vitamin B and advances in nutrition were wiping out pellagra and the associated psychosis that had once been a major problem in some Southern states; the use of diphenylhydantoin (Dilantin) in epilepsy was reducing admissions with epileptic psychosis to mental hospitals and would soon lead to the phasing out of the now virtually forgotten special state hospitals for epilepsy, such as New York's Craig Colony, which once had over 2,400 cases. Another major advance was in the prevention and treatment of tuberculosis. In New York state hospitals in the 1930s, this disease had a mortality rate twenty times that of the general population; the first survey in 1941 found several thousand active cases among 80,000 mental patients. Today this figure has been reduced to several hundred and even that is

maintained only by a continual inflow of “skid-row” type admissions. Similarly other types of infection have been spectacularly reduced and acrocyanosis, once so common that it was frequently considered a complication of schizophrenia, has entirely disappeared with the advent of more active programs of patient rehabilitation and better nutrition.

The introduction of somatic therapies for functional psychoses also produced important changes. The sleep therapy of J. Klaesi introduced in the 1920s left doubts but the insulin shock of Manfred Sakel, in the mid- and late 1930s, showed that a somatic therapy could produce remission of recent schizophrenia; convulsive therapy in the 1940s gave good, rapid results in an amazing proportion of depressions. Brilliant individual results were now commonplace in the treatment of functional psychoses, but the effects of all advances were swallowed up in the overall picture of continued increase of mental hospital census, overcrowding, understaffing, and underfinancing, and the community facilities were still operating on only a token scale. State hospitals were still the major psychiatric resource, and in them large number of cases accumulated because they were refractory to all treatment efforts. In their backwards severe psychotic behavior was widespread and was marked by wetting, soiling, assaultiveness, chronic shouting and screaming, and destruction of clothing and furnishings. In the mid-1940s, psychosurgery appeared and was undertaken because it offered hope for amelioration of such symptoms and even remission for many intractable cases, but it

remained controversial. It was abandoned with the advent of the tranquilizers in 1954 and 1955. These drugs were to produce the first overall changes in the mental hospital situation.

The Impact of Psychiatric Drug Therapy on Patients and the Public

These tranquilizers could be and were utilized on a large scale with existing resources. The immediate effect was a radical improvement in the operating conditions of all types of mental hospitals. The distressing behavior that had become the hallmark of the psychiatric hospital rapidly faded, although it still remains embedded as a stereotype in the public mind. Within a year or so of the introduction of tranquilizers, the census of the large mental hospitals here and abroad began to decrease because these new drugs reduced or abolished delusions and hallucinations and restored social capacity on a scale never before achieved. Nationally, the mental hospital population began an uninterrupted fall from a peak of 559,000 in 1955 504,000 by 1963, a total reduction of almost 10 percent. However, the annual rate of decline was only a little over 1 percent, and soon there was growing pressure to increase the pace of population decrease once the possibility of such a decrease had been established. The mechanism for such a change was already available. Outpatient maintenance was an accomplished fact, and by the early 1970s the community hospitals could provide rapid inpatient therapy. Although the service was available in the 1960s, the treatment time

was cut to fourteen to thirty days in the 1970s.

The introduction of antidepressant medication in the late 1950s further extended the therapeutic potential of such facilities. In view of this, the decrease in the length of hospital stay from six months for newly admitted state hospital cases to one and one-half months was not impressive.

Public Opinion Begins to Change

For a time after the advent of the psychiatric drugs, psychiatry, as practiced privately and in both the community and the large hospitals, enjoyed a favorable press. The open hospital had become a reality after almost two centuries of frustrated hopes. Voluntary admissions increased, the confidence of the general public rose, and interns competed for psychiatric residencies. But there were indications that this phenomenon was to be short-lived, and an antipsychiatry movement began to take shape. An early and rather bizarre manifestation developed in the Southwest, where a rumor was spread that left-leaning psychiatrists were planning to purge conservatives by hospitalizing them in a new facility, perhaps in Alaska. For the most part, however, the focus of attack was on involuntary hospitalization and on inadequate care and treatment in the large hospitals. Eventually the attack broadened to include the validity of psychiatric diagnosis; the effect of labeling patients, and the ethics, morality, and legal status of various

techniques of treatment. The somatic therapies and their adverse reactions were a special focus for criticism, but the concept of mental illness itself was questioned, as was the validity of psychiatric pronouncements in forensic matters. A large literature soon developed along these lines that was to have a major impact on the attitudes of those persons in a position to make or influence public policy.

The Joint Commission Report: Community Psychiatry Becomes Federal Policy

In 1955, the year the number of psychiatric patients in state hospitals reached its peak, Congress appointed a Joint Commission on Mental Illness and Health to redesign the U.S. mental health system. During the years of the Joint Commission's deliberations, the impact of the new drugs was already being felt. This fact was acknowledged in their history-making 1961 report, although the drugs were not given a central role in the document or its proposals and predictions for the future. The document was a carefully written plan for social engineering in the mental health field, and its findings have stood up well in the light of subsequent developments. Recommendations were for a large increase in community services of all types, including general hospital units; the entrance of the federal government into the mental health field with strong financial support; a sharp reduction of dependence on state mental hospitals; and a larger participation of professionals other than psychiatrists in treatment.

The federal response was contained in President John F. Kennedy's message to Congress on February 5,1963. He laid out a new concept of community-based services that would provide a complete spectrum of resources coordinated by community mental health centers. Institutional care and treatment was to be minimized and the large state hospital was a target of criticism. He said:

> . . . reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. ... If we launch a broad new mental health program now it will be possible within a decade or two to reduce the number of patients now under custodial care by 50% or more.

The proposal was quickly enacted into law and federal funds began to flow, at first for construction of the new community mental health centers (CMHC), then for staffing, and finally, more broadly, through such mechanisms as Medicaid and Medicare. Some aspects of the plan did not develop as rapidly as had been hoped. The CMHC phase was particularly slow in developing because support was time limited and the localities had to be prepared to pick up the cost or find other support. Also the integration of all services into a comprehensive system for each locality had to be left to local initiative, and this phase has posed special problems. By 1973, only 392 of the planned 2,000 centers were in actual operation and as late as October 1978, it was projected that only 678 centers would soon be in operation. In the meantime, the figure of 2,000 had been scaled down, and the centers

themselves had come under attack on the grounds that they had merely developed more services along traditional lines and that they were not delivering the minimal services required for such facilities.

Deinstitutionalization

While the CMHC part of the Kennedy program did not develop as rapidly as hoped, the phasing out of the state hospitals did progress rapidly. The target figure was a reduction of 50 percent in a decade or two, and the actual fall was from 504,000 in 1963, the date of his speech, to an estimated 175,000 in 1978. In part, this was the result of a radical liberalization by the hospitals themselves of discharge policies and in part it reflected administrative policies of higher levels of state government. In at least one state, deadlines had actually been set for the discharge of certain proportions of the population. Equally important was the change in the thrust of laws, rules, regulations, and judicial decisions, which made it more difficult to admit or retain involuntary patients. Another factor was the escalation of costs, in good part the direct consequence of class-action suits and threats of such suits to upgrade hospital conditions and set minimum standards. Indeed one of the proponents of this method said that he hoped to make state mental hospital care so expensive that it would have to be abandoned—a sentiment that has been echoed by others.

The Narrowing Definition of Mental Illness

For many generations the definition of what constitutes certifiable mental illness had been broadened by pressure of the courts and society. It had come to include an increasing proportion of the indigent population. In the 1960s and 1970s this was no longer the case; the mental disorders of old age, simple alcoholism, and drug abuse were largely ruled out. The criteria for certification were otherwise narrowed. The state hospitals were no longer willing to simply provide care for persons for whom there seemed to be no other place. And all other psychiatric hospitals moved in the same direction. As will be seen in the section on Psychogeriatrics, other channels for placement began to open up during this period, especially by the operation of third-party payments such as Medicaid. But even this has not fully met the need, and there has been continued pressure for more beds in the inpatient system. A major problem that remains unsolved is finding a substitute for those public facilities that in the past served a triage function. The problem has been especially acute for those facilities serving a congested and poor metropolitan area. Old patterns of response die hard and the police, as well as social agencies and local government itself, still require that certain needs be met for homeless and/or helpless, confused, mentally incapacitated persons who cannot be left to fend for themselves. Under the circumstances, some of these community psychiatric units continue to serve reluctantly, providing a triage function that is parallel to their normal catchment area duties. They

view the present situation as a transitional one during which other local resources will develop.

In the meantime, the volume of work in the entire mental health system has grown from 500,000 patient care episodes in 1950 to 5 or 6 million in 1979. Yet the need seems to be even greater, based on estimates of the many millions who suffer from mental disabilities and disorders in the general population. It is inevitable that under such pressures choices must be made at all levels, and this leads to the much-discussed situation in which "the sickest persons" are said to get the least attention. Actually it would be more accurate to say that the less treatable and more chronically disabled and those who cannot or will not cooperate with a treatment plan are displaced in favor of cases in which better results can be achieved with the same resources. This can be seen as a sort of paraphrased Gresham's Law that might state, "The more treatable and more cooperative patients will tend to displace the less treatable and less cooperative cases insofar as facilities can choose their patients." Cost is not the only factor; professional satisfaction and legal responsibilities also play a role, because cases that are maintained with difficulty and at a precarious level of adjustment may create public relations problems for the agency and the staff member who takes on the treatment responsibility. If there is a real or perceived threat to others, there are legal considerations. (See the Tarasoff case on page 745.)

In spite of all these negative factors, from all indications we have passed the most difficult phase of deinstitutionalization. In New York state, the census of state hospitals has fallen from 93,550 in 1955 to a current 25,000 (est. 1980). About half of these are aged persons admitted many years ago, and their number shrinks each year, which accounts for the current institutionalized population decrease of 4 to 5 percent per year. In California the high point was 37,000 in 1956 and an informal 1978 inquiry gave a census of 5,000. "New chronics" are still appearing but at a far slower rate than in the past, and now that it is generally recognized that certain persons will require long-term help, community support systems are beginning to arise. At one time the problems of discharged patients in the community were explained as a result of inadequate preparation for community life prior to hospital discharge, which tended to absolve everyone but the hospital of responsibility for post-hospital service; today the emphasis is more realistic, especially since many of these cases are now seen only briefly in community hospitals that must discharge them after only a short-term residence. A small number of such cases are unwilling to accept assistance or to manage medication or funds by themselves. It remains to be seen how society will eventually deal with this problem.

Psychogeriatrics

The care and treatment of aged persons no longer able to remain in the

community because of mental disorder or disability remains a problem without satisfactory solution. The early literature on mental hospitals shows that admission for mental illness was largely limited to relatively young individuals. This appears to have continued throughout the 1800s. As late as 1914, New York state hospitals admitted only 770 cases of senile and arteriosclerotic psychosis, or 7.9 per 100,000 of the general population. But by 1955, this number had risen to 6,223, 39.00 per 10,000 (first admissions). These older persons, two-thirds of them aged seventy-five and over, had an average duration of hospital life of less than two years in the early 1950s. Thus the practice was viewed as simply sending aged persons to the state mental hospital to die. The situation was exacerbated because it came at a time when the hospital census was rising by over 2,000 per year, and it led to a scandalous overcrowding; some geriatric wards were so crowded with beds that there was no day room or living space left for those who were ambulatory.

These overcrowded geriatric wards were among the first to feel the relief of the early decreases of hospital census, but the improvement was slow. By the end of the 1960s it had become New York state policy to limit the admission of persons over sixty-five. This policy was adopted nationwide, and between 1965 and 1972 the rate of admission of persons sixty-five and over was reduced by about two-thirds. In the meantime, Medicare and Medicaid payments had become available, and the population of the homes for the aged

and dependent rose from 296,783 in 1950 to 469,717 in 1960 and 927,514 in 1970. The current (1980) census is estimated to be more than a million. In 1969, just over half of these residents were identified as having a mental disorder, although a 1977 study showed that only 3.5 percent of 801,000 admissions gave their former residence as a mental hospital, indicating that direct transfer was unusual. On the other hand, a New York state study of some 25,000 patients in adult homes showed that 29 percent had been patients in mental hospitals, which is almost three times as high as one would expect to find in a purely random selection of a group of aged persons from the general population.

These figures may be complex and even confusing, and they are not strictly comparable, but they do indicate that a very large problem of Psychogeriatrics has been moved from the several hundred large mental hospitals of the United States to some 18,000 widely scattered nursing and personal care facilities. How much has been gained for the patients from this move remains to be evaluated. There have been recent scandals in New York state, in which certain of these facilities were attacked in the press and criminal charges were brought. However, this does not permit of an overall judgment, and the resulting reluctance of new entrepreneurs to enter the field has intensified the shortage of beds, which, as has been emphasized, creates a backpressure that tends to be felt throughout the hospital system.

At this time, we lack an organized and effective policy with respect to Psychogeriatrics, and we may have to look to the British for a pattern. They have begun to establish special general hospital units for Psychogeriatrics and are developing figures as to how many beds of this type may be needed for 100,000 of this specific population. It is of no small interest that they report a reasonable turnover of cases in such units and that the proportion of treatable cases, including depression and other problems, is considerable.

Fiscal and Administrative Issues

Action for Mental Health stated that in 1954 total appropriations for state, county, and psychopathic hospital care was $568 million; this figure had risen to $854 million by 1959; the per-diem expenditure had gone up from $3.18 to $4.06 per capita. The recommendation was that expenditures for public psychiatric services be doubled in five years and tripled in the next ten. Some fifteen years later, the cost of direct care for mental illness amounted to $14,506 billion and by 1976 it was estimated at $17 billion. This is only partly a result of inflation; staffing ratios of public mental hospitals were 27 per 100 patients in 1956, while today the figure stands at over 100 staff per 100 patients. Total expenditure is now at about 12 percent of the health budget of the United States, which amounted to $160 billion in 1976. We seem to have reached a ceiling for health expenditures, which now amount to 8.5 percent of the gross national product. Within the health budget mental health must

compete with other services, and there are indications that its competitive position may not be as strong as it was at one time.

One of the earlier inducements for deinstitutionalization was that the money saved by closing state mental hospitals wards would be more than enough to finance the brief-stay hospitals and outpatient services as well. It would require an expert in government finance to explain why this has not happened, but in retrospect, it seems overoptimistic to expect such a "plowing back" at all. In general, government fiscal policy prefers to see all savings turned back to a general fund; each new expenditure must then be judged each on its own merits. Aside from this in the present stringent fiscal climate, it seems unlikely that there will be much overall increase of mental health funds in the future, and all attempts to free funds by cutting expenditures in existing large hospitals will have to contend with class-action suits and accreditation standards that seek to raise rather than lower levels of care. In the meantime, pressure for additional funds continues from within the system, and general hospital costs are quoted as high as $300 to $400 per day in the New York area. In addition the cost of community care has proved to be far higher than was originally anticipated, and is as high or higher than in-hospital costs (in state facilities). One of the illusions of the present system of multiple source funding (federal, state, county, and third party) is the idea that somehow by shifting the cost from one agency or one level to another new money will be discovered. This technique was productive for a number of

years while new sources were coming into play, and there can be no question that this system made possible the massive and revolutionary expansion of community hospital as well as outpatient services. But for the present this phase seems to have run its course. We are now encountering a highly organized and powerful move for cost containment, which comes from the large third-party interests. It is interesting that even by 1974 the care of the mentally disabled in nursing homes accounted for 29.3 percent of direct expenditures for mental health from all sources, the state and county hospitals 22.8 percent, and the general hospitals 11.7 percent, and a major shift from one sector to another seems unlikely at this time. It remains to be seen how society will deal with the conflicting pressures generated by demand for more services and increased staffing on the one hand and demand for cost containment or even cost reduction on the other.

Internal Structure and Function

Revolutionary changes—many of them apparent only on inspection and they cannot be stated in quantitative terms—have taken place in all psychiatric hospitals. Furnishings are far better, the diet has improved, the doors are open almost everywhere, and patients come and go with the traditional freedom of the open hospital. Team organization has created a new informality between staff and patients and among staff members, since uniforms are now frowned upon for the most part. Nonmedical

administration has been accepted at all levels except for strictly medical issues and the proportion of psychiatrist administrators of CMHC fell from 53.3 percent in 1971 to 30 percent in 1976. This represents a trend in psychiatric administration generally.

The rigid sexual segregation of the past has been replaced by full integration; men and women mingle freely in the dining rooms and often in the living areas as well. Many hospitals are as fully integrated in this respect as are hotels, and only the actual sleeping rooms and the use of bathing or toilet facilities are separate. Sexual acting out does occur but it has not been a serious problem, and in at least some facilities women have access to contraceptive pills or other devices on request, just as they do in the community.

One of the most radical changes is to be found in policies with respect to admission and discharge. At one time a major complaint was that patients were admitted too readily and held too long and without adequate justification. Current complaints are in the reverse direction; that it is too difficult to gain admission, even on request, and that patients are discharged too soon. In part, this situation is due to fiscal considerations—funding is limited and cost-containment groups are vigilant. But it is also partly an expression of a general administrative pressure for deinstitutionalization. This pressure has had its major impact on the state mental hospitals, but it

has influenced policy in other psychiatric facilities as well, especially the Veterans Administration and private hospitals. Compared with the general situation before 1963, a striking improvement can be seen in overall conditions due to better financing, better staffing, and to the ability of the facilities to resist being flooded with more cases than they can handle. Yet, this is not to portray the situation everywhere as ideal, because as great as the accomplishments of the past few decades have been, the expectations of the public have been even greater. It is an unusual facility that does not receive its full measure of justifiable consumer complaints. In fact, one may ask why surveys of consumer satisfaction are not a part of the regular routine of all hospital systems.

The Problem of Complexity

The complexity of mental hospital administration is by itself a major problem. The U.S. Comptroller estimates that some 135 federal programs operated by eleven major departments and agencies have an impact on the mentally disabled. A New York state source states that there are some 120 state, city, county, and voluntary agencies that regulate some aspect of hospital operation. This poses a major problem of compliance, since often voluminous and detailed regulations governing fire and safety precautions, labor relations, fiscal operations, administration of medication, record keeping, and various aspects of patient care, to mention a few, are involved in

running a mental hospital. The codes and rules governing each area usually have the force of law, and infractions carry the threat of a variety of sanctions. Perhaps the most important problem is that the whole regulatory structure has the characteristics of a house of cards; noncompliance with any one of the major components easily leads to withdrawal of approval by a series of other agencies, which may lead to loss of operating certificates for essential functions. This in turn may lead directly to loss of funding from the federal and state level.

A final problem is that all parts of the regulatory system tend to be in a continual state of change; a rule that is in effect one year may no longer be valid the next. The building codes are an excellent example. While a building is usually considered in compliance so long as it is not altered in structure or function, it may require costly alterations to bring it up to code again if a change is required for hospital purposes.

Often one cannot quarrel with the intent or even the effect of the regulations, as for example when it is required that a traditional system of psychiatric records be replaced by a client- or patient-oriented record. Yet this requires that the entire staff be reoriented, and for a time this detracts from the hours available for patient programs. The cumulative effect of regulation is that the amount of documentation required for patient records has increased as much as fivefold. Such increase in administrative overhead is

particularly serious in large state facilities, which have already voluminous records and where the scarcity of clerical personnel is chronic. Another area of administrative concern has to do with legal issues.

Legal and Forensic Problems

In spite of all efforts to the contrary, differences still persist between the operation of a psychiatric ward or hospital and that of any other type of medical facility. Many of these, based on law but administrative and medical in nature, have to do with such issues as the admission and discharge of patients, the rights of patients to refuse treatment, hospital responsibility for acts of patients during hospitalization and afterward, competence of patients with respect to specific acts, general principles of civil rights as they have been applied to psychiatric patients, and finally the personal liabilities of staff members and the liabilities of the hospital when sued for violations in connection with such issues. It may be noticed that malpractice insurance rates are lower for psychiatry than for many other specialties, but this is misleading because the term malpractice has rather narrow medical definitions and insurance coverage may not extend to actions that can be interpreted as deprivation of civil rights, false imprisonment, or failure to observe due process.

As a result, the psychiatric facility is likely to maintain close liaison with

its legal advisors to make sure that various actions are in conformity with the current climate of legal opinion. Legal guidance is thus essential in psychiatry, but its value is no more absolute than is advice of a doctor with respect to medical matters. The courts are not bound by the opinions of a lawyer, and liabilities may still be incurred even for actions that were taken in accordance with the advice of counsel, although this is far less likely than when action is taken without such advice.

One of the newer areas of the law in psychiatry has to do with constitutional guarantees of civil rights. The applicable law is Section 1 of the Civil Rights Act of 1871, a law originally passed to protect the black minority after the Civil War. It reads in part:

> Every person who, under color of any statute ... regulation ... or usage of any state ... subjects or causes to be subjected any citizen of the United States to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law. . . .

This law, whose operation has been reinforced by a Civil Rights Attorney Fees Act of 1976, has been widely used in class-action suits following the *O'Connor* v. *Donaldson* decision of 1975. This case, which was in the courts for some years, was finally settled by a cash payment from the estate of Dr. O'Connor, who had died in the interim. He was held liable for the involuntary hospitalization of patient Donaldson in a Florida state hospital because he had

continued to confine, “without more” a patient who was not dangerous to himself or others and who could survive outside of the hospital with help available to him. This decision greatly increased the pressure on hospital authorities to discharge patients and made hospital personnel far more vulnerable to personal suit than they had been in the past.

Another landmark case affects a state institution and has influenced state hospital practice across the country, but its principles would seem to apply to other psychiatric facilities. This case is best known as *Wyatt* v. *Stickney.* The first major decision was in 1972 in a district federal court. As it has continued, it has set the precedent that a court may establish standards for care and treatment and make sure that constitutional rights of patients are not violated and that it may continue to monitor the results of the implementation of its orders even to the point of superseding control of the facility by the state. Personal liabilities were not invoked in this case, and the court had extensive professional assistance in the setting of standards.

The Tarasoff case (1976) in California has also had national impact, even though the decision was local. Tarasoff, a psychologist, had warning that a clinic patient of his had homicidal intentions toward a young woman. Tarasoff did not warn the woman although he did take other action; the woman was killed by the patient and liability was found by the court. This case seems to be in conflict with another major medico-legal principle, that of

confidentiality, and the results are particularly difficult to apply because they may be understood to imply that the professional and the agency may be held liable for the behavior of an outpatient. One must thus choose between violation of confidentiality and the duty to warn. If all this applies to an outpatient, it might logically be held to be even truer of an inpatient.

Liability for acts of an inpatient may be taking a new form, as illustrated by a recent Long Island, New York case. This case involved a patient who murdered his wife while he was on pass from a state hospital. In this instance, indictment on charges of criminal negligence was sought against two psychiatrists. The grand jury did not return an indictment but, as always in such cases, the possibility that such charges might be brought had its own impact. A broader issue raised by the preceding case is related to the general policy regarding psychiatric patients who have criminal tendencies. At one time, New York state held several thousand such persons in special security facilities but a series of cases such as *Baxstrom* v. *Herold* (1966), in *Gault* (1967), and *Jackson* v. *Indiana* (1972) were reinforced by new laws, and New York now has specialized facilities holding only a few hundred such patients. It has been widely noted that the reduction of the population of the old security facilities across the country did not produce any significant problems. Many of these patients could be released to the community. Nevertheless the pressure for “secure” beds has continued, and there has been an increase of admissions with a history of arrest in New York: in 1946 to 1948, 15 percent

of a surveyed group of men released from New York hospitals had a previous arrest; in 1968, 32 percent had been arrested at some time before hospitalization; in 1975, the figure was 40 percent. A record of arrest is an indication of antisocial tendencies, and the rising proportion of cases with such records intensifies the dilemma of responsibility for antisocial acts after hospital. On the one hand it is argued that prediction of overt acts is so unreliable that hundreds or thousands of persons would have to be incarcerated to avoid one antisocial act; on the other hand the psychiatric facility and its staff are required under severe sanctions to predict the behavior of its patients and to prevent such overt acts but without violating civil rights.

Finally, the major advances in the field of patients' rights must be noted. It is now generally recognized that patients may refuse treatment, except for emergency situations, and such refusal can be overcome only by specific due process. Patients also have a right to the treatment that their condition requires, and this must be given in situations no more restrictive than necessary. Restraint and seclusion may be applied only under rigidly controlled conditions, if at all, and informed consent must be secured for various forms of specific therapy.

The preceding is but a quick glimpse of hospital psychiatry and the law, and it is indeed "A System in Transition." Legal controls have evolved within

the social climate and with developments in treatment technology; the overall results have been strongly positive, but much more remains to be done before the system reaches a new equilibrium.

The Psychiatric Hospital Systems

As ordinarily reported, the major systems of psychiatric hospital are as follows: (1) community mental health centers; (2) psychiatric units of general hospitals; (3) private psychiatric hospitals; (4) residential treatment centers for children and psychiatric hospitals for children; (5) state and county psychiatric hospitals; (6) Veterans Administration (V.A.) hospitals. Another group, the nursing homes, have already been considered. Now the three systems that fall somewhat outside of the focus of this section, the V.A., the children's facilities, and the private hospitals, will be discussed. In January 1976 there were 35,913 psychiatric beds listed in the V.A. system. The V.A. facilities have carried on important academic and research activities in American psychiatry. The organizational and operational changes in the V.A. system have closely paralleled those in other psychiatric facilities, which have been described. Treatment centers for emotionally disturbed children numbered 331 in 1976, and they reported a population of 18,000—almost 97 percent of these patients under nongovernmental auspices. Turnover was relatively low, and there were only 12,000 additions in the year. The centers also reported 53,000 patient care episodes, of which 29,000 were inpatient.

While these figures may appear large the demand for such beds far exceeds the supply and this is even truer of the twenty state and four private psychiatric hospitals for children. This scarcity is not surprising in view of the untold numbers who are thought to suffer from various disabilities. Finally, the private psychiatric facilities are a small but important source of treatment. Their distant past was a stormy one, they have come to be regarded as a valuable resource. In 1975, there were 180 such facilities; they admitted 119,000 patients, ending the year with a census of some 11,500. It is interesting to note that there was an increase of 10 percent in the capacity of these facilities between 1968 and 1975, although the number of nonprofit private hospitals decreased somewhat in this period.

Community Mental Health Centers

As of January 1, 1976 there were 10,193 beds listed in CMHC's, and even in 1973 they were already reporting 23 percent of all U.S. patient care episodes. These facilities have been criticized for falling behind the program goals set in 1963, but in retrospect it seems that the goals were unrealistic and did not allow sufficiently for the problems inherent in just setting up some hundreds of new facilities, let alone having each of them integrate the resources already existing in its area. The aim was to have each of them supplement services that were lacking and insure that each area would have at least inpatient, outpatient, emergency care, partial hospitalization, and

consultation and education services. It is doubtful if anyone anticipated the virtual avalanche of unmet needs that would be released by Medicaid, Medicare, and other third-party payments and by the social changes of the coming years. It is also doubtful if the complexities of coordinating a wide variety of jealously autonomous local agencies were given due consideration. Nevertheless, in spite of a slow start, the CMHC program has made important contributions. For a time it seemed that this program was in danger of being abandoned at the federal level, but the situation now looks more favorable again.

Psychiatric Units in General Hospitals

Greenhill states that the general hospital has emerged as the focal point in the delivery of mental health care in the United States. There is much to support his contention. The speed with which these facilities have proliferated is impressive. While their history can be traced back for hundreds of years, an earlier official American Psychiatric Association publication states that until after 1900, Bellevue was "the only such service in the land." Even as late as 1950, there were only a small number of such units in existence. Yet by 1963 almost 500 of a total of 5,400 general hospitals had psychiatric units, and in 1971 this number had grown to 750 reported by 5,565 hospitals. By 1978 the figure had jumped to 1,600 units. In 1963 the number of inpatient beds was 18,500; it grew to 39,000 in 1975. The volume

of work carried on in these facilities increased correspondingly; 370,000 cases were treated in 1963, and by 1975 admissions alone numbered 543,000. While these figures are not fully comparable they do show a marked trend for psychiatric units in general hospitals to play a dominant role in mental health care. In 1975 they accounted for 36 percent of all patient care episodes.

As had been hoped, these facilities have indeed provided brief treatment in a community setting and on a large scale. The factor of cost is an important one in their operations, and it has been noted that the median length of stay in 1975 was related to methods of payment. The overall figure was twelve days, and 84 percent of the patients were discharged within twenty-eight days, which may be related to the thirty-day limit for payment by such third parties as Blue Cross. It was also noted that median time to discharge was 6.6 days for personal payment cases and 3.3 days for no-charge cases.

These facilities have been caught in the upward spiral of hospital costs generally, and charges of $300 to $400 per day are not unusual in the New York area. Staffing ratios are high, and it is estimated that two to three personnel are required for each bed and additional staffing is needed for those facilities which maintain a twenty-four-hour walk-in service. The general hospital units now usually try to provide overall service to a limited geographic area, but their triage function still has not been eliminated. In spite

of the creation of restricted catchment areas, many patients from outside of the district are still brought to certain hospitals that once served as triage centers for large populations.

Another lingering problem for these units is posed by psychogeriatric cases. These may be admitted to medical or surgical services and then find their way to psychiatry where they may occupy a costly bed for weeks or months while alternative placement is sought. The general hospital unit may also be troubled by overall hospital staff shortages and by competing demands for emergency staffing in other parts of the facility. This may make it difficult to keep a stable staff on psychiatric wards at night or on weekends. Yet with all of these problems, persons who require hospitalization clearly prefer the psychiatric wards of the general hospital and regularly select one in their own immediate area.

State and County Mental Hospitals

These facilities were an initial target of the 1963 plan to reorganize U.S. mental health services, and they have played an important part in the changes that have taken place since then. These events have already been reviewed earlier in this paper and elsewhere. Some of the major changes that have occurred will be recapitulated. The census of these facilities has fallen from a high of 559,000 in 1955 to an estimated 175,000 or less in 1980.

Overcrowding is now a forgotten problem, and buildings or even entire hospitals are being closed. Medicaid and other third-party payments have put large sums of money into the system. Accreditation standards such as those of the Joint Commission on Accreditation of Hospitals must be met; failure to do so can and has led to loss of federal funds for some of the better known facilities in this class. In addition, class-action suits and threats of such suits have maintained a continued pressure for upgrading. Overall staff ratios, which in some facilities were once at the level of fifteen to twenty employees per one hundred patients, have now reached a level nationwide of about one hundred staff to one hundred patients. In 1975 they listed a full-time equivalent staff of 211,899 when their average census was 193,436. Their budget, which had been $568 million in 1954, was $2,641,295,000 in 1974-1975. With all of these improvements, however, the per-diem allowance per patient is still only 25 percent or less than that in a general hospital unit and far below the private hospital allowance. As their population continues to fall by 4 or 5 percent per year and rumors of closing circulate, morale is damaged and problems in recruiting capable staff, especially at the psychiatrist level, continue to increase.

It has been repeatedly pointed out that these hospitals could be a valuable resource, at least for the care and treatment of those who are not able to respond quickly to other approaches, and it is often said that many persons would seem to be more comfortable and even safer in state and

county hospitals than they are in the slum accommodations where so many of them now are congregated. Yet there are lingering fears about creating the old system anew, and thus other solutions—such as the creation of community support systems—are being sought, and the pressures for continued deinstitutionalization continue. This author knows of no organized opposition to this aim, only demands for a more adequate alternative. In fact deinstitutionalization has already been largely accomplished; the bulk of the present state mental hospital population is composed of a highly transient short-term group plus a very large group of aged persons whose high death rate accounts for the current population decrease. There is no indication that the "new chronics" will be allowed to accumulate again in these hospitals nor that these facilities will again be opened to the heterogeneous population of mentally incapacitated. The fact that these facilities still survive at a third of their previous capacity seems to indicate that they serve an essential though reduced function. It remains to be seen whether they can or will be totally replaced.

The Future

The future of the community-based psychiatric hospital as the focal point of treatment of major psychiatric disorder seems assured; the advances in treatment technology, which are now in prospect as a result of new discoveries in the basic sciences, are more likely than not to require the

technological support that only such facilities can provide. It seems probable, however, that they will have to take a more active role in the treatment of drug abuse and its complications now that this condition has become so prominent in our society. The treatment of alcoholism may also have to be expanded, and there are great unmet needs in acute Psychogeriatrics and in child psychiatry.

The possible future of the state mental hospital and the community support systems that now are being developed has already been discussed. Turning to the overall scene, it would seem that the future of psychiatric hospital service will be determined, as it has been in the past, by the interaction of a variety of forces, including the economic and social climate, the real cost and availability of personnel (including the professions), and the pace of scientific and technological advances. It is in this last that the major hope may lie, since there are indications that we have reached a ceiling in mental health expenditures. Only by such advances can we hope to do what is so strongly demanded, to accomplish more with less cost.

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