Woodruff Center in Connecticut

An Approach to the "Unadjusted Elderly"

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AS THE NUMBER of "senile" or "unadjusted elderly" persons increases, the problem of overcrowding in State mental hospitals becomes progressively acute. Many of these aging people are not necessarily afflicted with illness or incapacity necessitating continuous medical or nursing care, nor can they accurately be termed "psychotic." But such patients are occupying beds in the mental hospitals which could be used more appropriately for people with acute mental illnesses. Too frequently in mental hospitals, these "senile" patients do not receive the type of care which might make it possible for them to resume near-normal activities in their usual environment.

Upon its completion, the new Woodruff Center at New Haven, Conn., will offer an opportunity for the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, an agency of the State of Connecticut, to develop what it believes is a reasonable approach to the problems of caring for the elderly patient. The Woodruff Center will be an institution which will approach the problems of the elderly patient in a manner comparable to the approach to the physically disabled individual, rather than viewing the elderly patient as one whose problem is essentially psychiatric.

The Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm was created by the Connecticut General Assembly in 1945 to alleviate overcrowded conditions in the State mental hospitals and to develop a broad overall rehabilitation program for the "unadjusted elderly." The assembly delegated the following powers and duties to the commission (*1*):

"The commission shall study the problems of the care and treatment of the chronically ill, aged and infirm persons in this State; shall initiate a program, with the cooperation and aid of State agencies concerned, to coordinate and develop existing resources for such care and treatment, and shall plan and . . . construct or purchase, lease or otherwise acquire . . . and staff and operate, such buildings as it deems necessary for the care of such persons . . . Said commission shall fix rates for care at such institutions and shall determine policies and adopt regulations necessary to carry out the provisions of this act."

In carrying out the duties assigned to the commission, Connecticut's rehabilitation program was designed to provide care for these four principal groups of the chronically ill and aged:

Group A. Persons who as a result of chronic illness or accident have a physical disability and require the specialized services of physi-

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cal medicine and rehabilitation as their primary need.

Group B. Persons who as a result of physical ailments of a chronic nature are expected to require definitive medical care for a prolonged period, with a reasonable expectancy of alleviation of their condition.

Group C. The so-called "seniles"—persons who as a result of age have demonstrated an inability to adjust reasonably to their usual environment and are considered cases of mild mental confusion but who do not have such mental aberrations as to be considered truly psychotic.

Group D. Persons derived from groups A, B, and C, who represent failures in terms of limitation of present medical knowledge but who continue to require at least custodial care.

Experience With the Physically Handicapped

The commission has experienced considerable success in giving "total" care to all persons in the A and B categories admitted to the existing facilities of the commission at Rocky Hill and New Britain, Conn. The principal facility now in operation, which was established in 1948, is at Rocky Hill, Conn.

At the Rocky Hill center, the program of physical medicine and rehabilitation includes the services of a complete rehabilitation "team," the basic medical and surgical staffs augmented by psychologists, psychiatrists, and medical social workers, as well as the physiatrists and physical, occupational, recreational, vocational, and educational therapists. The center is also used for training personnel for similar rehabilitation work in other locations.

Although the rehabilitation center at Rocky Hill has emphasized care to group A and group B patients, some incidental experience has been gained with group C patients—those who are classified as being the unadjusted elderly. It was on the basis of this experience, and with a view to more directly relieving the State mental hospitals, that the commission has designed the facility to be known as the Woodruff Center, which is described below.

The experience to date has indicated that in each of these groups of patients, there is need for graded physical activity, competent attention to medical needs, intellectual stimulation, and psychiatric guidance in varying degrees. The special physical and social handicaps of everyone in each of these categories require similar attention, and every one of these persons requires the kind of attention which negates his already prevalent belief that he has been rejected by society, family, and associates.

The rejection of the elderly occurs too frequently as an indirect result of urban living, with consequent lack of employment opportunities. In fact, many groups in our society view the aging person as one whose age is synonymous with physical disability. Many elderly persons therefore must depend on relatives, friends, or private and public agencies for financial support and sometimes for a certain amount of medical care. Little enough is done to make daily living for some more than a bare existence. As a result, too many aging people become discouraged, lose confidence, feel unwanted. They tend to become inactive physically and intellectually more rapidly than they might otherwise. Relatives and friends become discouraged too and impatient when an elderly person needs constant attention or supervision. When they can no longer provide the care needed, the person may be admitted to a mental hospital for lack of any other suitable facility.

The Woodruff Center

The commission is now designing its newest unit for both long-term definitive care as well as complete rehabilitation of the physically disabled and aging, to be known as the Woodruff Center. A former hospital building is being remodeled to provide the initial 135 beds which will be ready for occupancy in the fall of 1954. The construction of an additional 400-bed unit will begin a short time later.

Sixty of the initial 135 beds will be set aside for a controlled study of unadjusted elderly patients from the State mental hospitals. It is planned to draw, completely at random, 60 elderly patients from the mental hospitals—20 from each of the 3 State mental hospitals in Connecticut—at the time they seek admission to those institutions. A control group of another 60 patients, also selected at random, will be cared for routinely at the mental hospitals.

As some of the study patients at Woodruff are discharged, they will be replaced by similar persons who have spent some time in the mental hospitals and who will also have been selected at random. By comparing the progress made by these groups of patients, the commission hopes to gain further insight into the needs of this type of person in helping him readjust to his usual environment.

The 60 patients admitted to the Woodruff Center will be interspersed with 75 patients who are not in the "unadjusted elderly" classification but whose needs are in many respects similar. All of these patients will receive physical, occupational, educational, and recreational therapy as well as the services of a medical social worker, clinical psychologist, and of similar personnel. The need for each type of service in each case will be, of course, an individual matter.

In remodeling the existing building at Woodruff Center, an effort is being made to minimize the "institutional" atmosphere. Color, unrestricted visiting hours, family-style meals, a "buddy" system, informal staff identification, a minimum amount of "routine," and the like will be tried. Patients requiring definitive medical service will be interspersed with the physically disabled and elderly so that there are both a variety for the staff and a possibility of each patient's abilities counterbalancing his neighbor's disabilities.

The addition to the remodeled hospital facilities is now on the drawing board and is being designed chiefly to house the rehabilitative elderly patient. As now planned, this unit will be connected with the service areas of the hospital—the lobby, the physical medicine and rehabilitation department, and the recreational areas. Varied color schemes and the use of a series of different patterns of furnishings are being considered rather than standard hospital beds and other hospital furniture, as well as having patients bring with them a piece or two of their own furniture.

All activities will be away from the sleeping quarters, and meals will be served away from the bedroom area. There will be opportunities for both indoor and outdoor work and recreational projects. The activities will be not only diversional or recreational, but useful responsibilities as well will be placed on patients in order to restore their self-confidence and, hopefully, to bring about more acceptable emotional responses. In cooperation with community agencies, a sheltered workshop will be available.

When the new addition is ready for occupancy, the commission will determine who should make use of it solely on the basis of potential benefit to the patient. If the commission is to be successful in developing an approach to care and treatment that will relieve not only the mental hospitals but other institutional facilities of long-term custodial cases, it must concentrate on helping those who have a good potential for rehabilitation. When patients admitted to the commission's facilities reach maximum improvement, they will be discharged to the most appropriate environment available, including, of course, home care and foster homes. Eventually, additional provision may have to be made for those persons who in spite of the best services available still require permanent care—those are the patients previously described as group D. At the moment this function is being performed by the private chronic and convalescent hospitals throughout the State, which have approximately 5,000 beds.

A Long-Range Solution

The commission hopes that the Woodruff Center will be able to point the way to a long-range solution rather than having its program destroyed in a rush to alleviate the problems of overcrowding in other institutions. There is little doubt on the part of the commission that with the right tools—in terms of specially designed facilities including the personnel necessary for an active program—rehabilitation of a good portion of the elderly is a realizable goal.

Obviously, institutions, of whatever kind, do not offer a complete solution to the problems presented by the chronically ill and aged. Their adequate care and treatment require the cooperative efforts of all individuals and agencies in any way concerned with their place in society. A facility such as that which is visualized for the Woodruff Center can accomplish little unless it is related to community activities which can follow through and return the rehabilitated

elderly to their rightful permanent place in their communities.

Recognition of the principle that local efforts must be developed has resulted in broadening the scope of the commission beyond the responsibility for operating facilities such as those at Rocky Hill and the Woodruff Center. The commission also has grant-in-aid funds at its disposal which have thus far been used mainly in assisting private, nonprofit hospitals in Connecticut to improve their standards of care for chronically ill and aged persons.

These funds are now being made available for the development of local efforts in home care programs, protective workshops, foster home programs, and the like. Care and continued therapy in such situations can give the disabled and elderly a more satisfactory opportunity for adjustment as contributing members of society.

To strengthen existing resources further, the commission has made available, in cooperation with the State health and welfare departments, a 10-week training course for operators and personnel of private chronic and convalescent hospitals, in order to aid in the development of better standards of care in those facilities.

This sharing of responsibility for an individual in need of care, using the type of facility which is appropriate to the individual case, will, it is believed, permit the facilities operated directly by the commission to remain relatively short-term rehabilitation units. It will also permit each group to contribute to an overall plan which will result in maximum benefits to the older citizens of Connecticut.

REFERENCE

(1) Connecticut General Statutes, 1949 revision, sec. 4194.

Course in Laboratory Diagnosis of Tuberculosis

A 2-week course in the laboratory diagnosis of tuberculosis will be offered November 15–26, 1954, by the Public Health Service at the Bacteriology Laboratories of the Communicable Disease Center, Chamblee, Ga. Reservations should be made well in advance.

Practical laboratory training in all phases of tuberculosis bacteriology, including preparation of culture media, microscopy, cultural procedures, diagnostic use of animals, and testing of drug sensitivity, will be offered. The course is open to all grades of employed laboratory personnel who are approved by their State health officers. Laboratory directors and senior laboratory staff members may also apply.

Application forms may be obtained from Laboratory Training Services, Communicable Disease Center, Public Health Service, P. O. Box 185, Chamblee, Ga. No tuition or laboratory fees are charged.