Trends in the Care of the Mentally Ill

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RESPONSIBILITY for care and treatment of the mentally ill is moving out from the mental hospital into the community, the outpatient clinic, the general hospital, the physician's office, and the home. There seems to be no immediate danger of the public mental hospital going out of business. However, there are indications of many efforts to find out what is the place of the mental hospital in the changing treatment picture.

As evidence has unfolded to indicate that the traditional mental hospital is not the most appropriate place to treat all mental illness and that the hospital itself may be a factor in the development of chronicity, statements have been made that "The mental hospital must go." More moderate opinion has been concerned with the need of modifying the old but also with developing other and hopefully more effective means of meeting the situation. The experiences of World War II, the advent of the tranquilizing drugs, studies of social scientists in mental hospitals, an aroused public conscience, and increased governmental interest—local, State, and Federal—have all been cited as responsible catalysts in the reaction.

Grants from the National Institute of Mental Health, Public Health Service, known as mental health project grants, are specifically designed to support projects for the development of new and improved methods in the areas we are discussing. These projects are pilot projects, experiments, demonstrations, and studies. The Office of Vocational Rehabilitation is also supporting projects in rehabilitation of mentally ill persons.

Mental illness is often precipitated by a crisis in the family, on the job, or elsewhere. Appropriate treatment given in an appropriate manner and at the appropriate time will often restore equilibrium, though not necessarily cure the patient of basic personality problems which make him prone to such crises. However, it may be possible for him to continue at home and at work without interruption or with minimal disruption. Commitment and hospitalization may be unnecessary and may make the total problem worse by disrupting the social and family situation. Like idleness enforced on muscles by immobilization of a limb, hospitalization results in some atrophy or regression with consequent prolonged recovery and more chance of developing chronicity. Of course, the nature of the illness may make hospitalization, even for long periods, the treatment of choice, but it has been shown that frequently it is not necessary. It has also been shown that hospital programs can be planned so that even the long-term patient is helped to reach his maximum level of functioning.

A corollary is that if social and family ties are not to be weakened, the patient should be treated as near home as possible, even if hospitalized. Also, if the patient is to avoid chronicity and relapse, rehabilitation and aftercare are necessary.

Alternatives to Hospitalization

Many of the new methods being tried out are called alternatives to hospitalization. While they are usually looked upon as substitutes for care in a mental hospital, they are steps toward

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developing care and treatment methods which are appropriate to the illness and situation of the patient. They also represent an effort to achieve continuity of care throughout the different stages of a patient's illness. They are, for the most part, experimental and the subject of study at the present time. Very possibly in the future they may become essential elements in effective and comprehensive treatment programs. Many hospital administrators and others are convinced that construction of facilities for the care and treatment of the mentally ill must and will be modified in the light of the knowledge developing from current experimentation with these methods.

Some interesting projects are being developed to explore the ways in which early treatment can be provided in the acute phase of an emotional disturbance. Exploratory work is being done on the feasibility of establishing treatment teams available at any time to go out into the community to see patients immediately when a crisis arises which involves an emotional disorder. This is not only for the purpose of treating a patient early in his illness but is also based on the idea that the person did not become ill in a vacuum and it is necessary to see him in his own home or job situation to assess the environmental factors involved. Recommendations may be made or action taken which may involve referral to a nonpsychiatric agency, referral for treatment to a physician, an outpatient service or a hospital, or further diagnostic study by the emergency team.

A variation of this approach being explored is seeing each patient immediately as he comes to the outpatient department or the clinic, along with his family whenever possible. Here also an attempt is made to understand the problem in its psychological and social ramifications and to take action as quickly as possible. This is contrary to a familiar pattern of placing people on a waiting list for later consideration. It is hypothesized that many problems can be solved quickly and more efficaciously if attacked when acute and that a waiting list is not necessary. In many situations long-term psychotherapy is not desirable or required. Family counseling, environmental manipulation, or physical therapy may be the treatment of choice. There is evidence that conventional psychotherapy is not suitable or effective in some socioeconomic groups.

Basically, day hospitals are outpatient departments, modified to fit the mentally ill patient. Patients are in the hospital for a varying number of hours during the day and then return home. The conventional outpatient treatment of 1 hour a day, successful with many mental patients, is not enough for the psychotic patient or for many neurotic patients. Diagnosis, treatment, and rehabilitation are functions of the day hospital. Various kinds of therapeutic activities may be added. These hospitals are usually open 5 days a week. Some patients may have daily appointments and some may come only when they feel the need. Day hospitals for children may be organized as schools with treatment of emotional disorders added. Others are organized as child guidance clinics with the school added.

Night hospitals are operated for patients who work during the day. They spend the evening and night at the hospital.

Many types of programs make use of the "halfway house." It is intended to be a transitional domicile for patients who do not require further hospitalization but are not yet ready to resume independent living. They live with other patients under some supervision in this transitional dwelling, moving gradually back into the community by reestablishing relationships through employment, social and family activities, and recreation.

This is a broad description of halfway houses. In practice they vary a great deal in organization, program, and auspices. For example, one halfway house is established specifically for the purpose of finding work for patients. Another provides not only supervision and social activities but also psychiatric treatment. Halfway houses in the community may be organized under official or voluntary auspices. Some are developed under the supervision of the mental hospital and may even be located in a ward of a mental hospital. In such cases the hospital regulations are liberalized with regard to this ward. Patients are placed more on their own responsibility with regard to movement in and out of the hospital and their activities within the hospital. Definite rehabilitation programs are organized for

them and they are encouraged to step out into the community.

Social clubs for ex-patients may be organized and supervised by professional people or they may be organized by ex-patients themselves. They attempt to provide some social life for ex-patients and in many instances offer counsel and advice as to sources of help: social, medical, and vocational. Some halfway houses are not residential facilities but in actuality are social clubs.

Followup and aftercare services for mentally ill patients discharged from hospitals are being extended. We need studies to help in planning the type of these services to develop. For example, how many and what kinds of patients want or need these services? What services may best be offered by the hospital or by the clinic? What should be provided by the official and voluntary health and welfare agencies in the community? It is generally agreed that a coordinated effort is a prime necessity. The public health nurse, the social worker, the vocational rehabilitation worker, the practitioner of medicine, and many others have a role to play just as they do in other human problems.

General Hospitals and Community Centers

Twenty years ago there were 48 general hospitals in the United States treating psychiatric patients. Now there are 500 to 600 with psychiatric units. Many others accept mentally ill persons for short-term treatment. This has been both a cause and a result of more psychiatrists moving into practice in communities. Factors in this trend have been the improvement in treatment techniques, the increased experience and confidence of psychiatrists that patients can be treated in general hospitals, and the increased understanding and leadership of hospital administrators. The length of hospitalization is usually short and no commitment is involved, so that there is less social disruption for patients and their families. Patients are often more amenable to the idea of going to a general hospital than to a mental hospital, and their attitude is frequently more favorable for treatment. Several States are experimenting with subsidizing the care and treatment of patients in the psychiatric wards of general hospitals. These wards are for patients who would ordinarily be admitted to State mental hospitals. In other places attempts are being made to admit all mentally ill persons from a specific area to a psychiatric service to determine the feasibility of such care for all mentally ill.

Many psychiatric services are so large that they really operate as mental hospitals under the administrative umbrella of a general hospital. In other general hospitals, psychiatric patients are hospitalized with general medical patients and there are no separate wards. Without discussing in detail the advantages and disadvantages of treating patients in general hospitals, we already have abundant evidence that we should continue to move ahead in developing psychiatric services in these hospitals. We need to study the possibility of integrating care and treatment of the physically and mentally ill just as we need to appreciate that there are unique aspects to each.

Community mental health centers are concieved of as places where all mental health services, including prevention, promotion of mental health, consultative services, treatment, and aftercare services can be centralized. Treatment services may include all of those already mentioned. Experimentation with these centers has occurred mostly in urban areas. It is hoped that they will provide for the coordination of mental health services so difficult to achieve.

Mental Hospitals

Today there is generally a more hopeful atmosphere in mental hospitals. Although admissions are increasing, the total number of patients in our State mental hospitals has been decreasing slowly in the last few years. We do not know the meaning of these decreases as both discharges and deaths have increased. There is increased emphasis on treatment and rehabilitation which was additionally stimulated by the advent of the tranquilizing drugs. Studies of social scientists have pointed out that the hospital organization and procedures may promote chronicity. This has resulted in renewed efforts to discharge patients as soon as possible and to design rehabilitation programs for the patients who remain longer.

A recognized first step in producing a therapeutic community is to be sure that you aren't doing anything antitherapeutic. Most authorities, here and abroad, feel that the large mental hospital can be just that. We can't tear down these hospitals tomorrow, but we don't have to make the same mistakes in building new hospitals. Also, we can make important modifications in existing hospitals. Modern treatment ideas call for dividing hospitals into small treatment units so that the personnel and the patients can develop a close relationship and understanding. These units are being established in many older hospitals. This trend must be taken into consideration in planning new construction.

The increased emphasis on the therapeutic use of personnel and other treatment innovations, including the tranquilizing drugs, have made a great difference in the care of the so-called disturbed patients. Episodes of disturbed behavior occur but are treated more effectively. The old "disturbed" ward is almost gone. In hospitals of the future, security will be a minor issue as compared to what it has been in the past.

This brings us to a discussion of the open hospital. The idea of a completely open hospital began abroad and has many supporters in this country. Even though the open hospital movement has proceeded more slowly in this country than in the United Kingdom, the philosophy that patients are able to respond positively to more freedom has resulted in the unlocking of more wards throughout the country. Protagonists of the open hospital idea say that it reduces administrative problems and improves the attitudes of patients and personnel. They maintain that it is unnatural to lock patients up; that locked doors are a cause of a good deal of disturbance and chronicity in mental patients. It is evident that allowing patients more freedom makes it imperative to provide activities for them. It stimulates a reorientation of attitudes on the part of personnel and also has implications for hospital construction.

Planning of facilities must be preceded by good program planning if we are to avoid having programs determined by the kind of facilities available. The isolation of mental hospitals from physical care facilities, training sources, and community health and welfare agencies, both physically and psychologically, has impeded the development of mental health programs. This calls for mutual study and planning.

The Aged

All States are grappling with the problem of the aged mentally ill. It is alleged that there are many aged patients in mental hospitals who really should be in their own homes, in nursing homes, or homes for the aged. This is one of our unsolved problems and we need more facts to deal with it. Just how many aged patients in mental hospitals could be cared for adequately in homes for the aged?

People who have been working with the aged believe that here, more than in any other age group, coordinated planning by those responsible for physical and mental health and welfare is necessary. The idea that aged patients once admitted to a mental hospital must die there has been discredited. Many older patients have transient psychoses, such as depression, which yield to treatment, both physical and psychological. Many of them require brief periods of hospitalization and then can go back to their own homes, or to nursing homes. Much more study and collaboration are needed in planning programs for the aged.

In Conclusion

What are some of the factors which we need to think about in planning for the future? The care of the mentally ill has been traditionally State supported and provided on a mass basis in large mental hospitals. But will this be the pattern for the future? I have indicated that there are alternatives to sending all mentally ill patients to mental hospitals and that short-time treatment in general hospitals is feasible for many patients. Vocational rehabilitation has made forward strides in the rehabilitation of the mentally ill in the last few years. In many places health insurance programs have extended coverage to some area of mental illness and studies are being initiated at the present time to investigate the cost of further coverage. Some union medical care plans are underwrit-

ing both treatment in general hospitals and outpatient treatment. Resources from social security benefits are available to an increasing number of persons. Patients and their families will be more able to carry the cost of short-term care if they are helped by insurance and if treatment facilities are conveniently available to them. All of these factors must be taken into consideration in thinking about our total problem. They make clear the need for coordination in planning mental health facilities for the mentally ill.

Legal note . . . Sanitation

Sanitary district liable for property damage when clogged manhole caused sewage to back up and overflow into home. Duty of proper inspection of sewer lines. *Mulloy* v. *Sharp Park Sanitary District* (164 Cal. App. 2d 391, 330 P. 2d 441, October 1958).

Plaintiff brought an action for damages against the defendant sanitary district, alleging that the district created a private nuisance and was guilty of negligence in allowing a manhole of the sewer system operated by it to become clogged, causing the plaintiff's home to become flooded with sewage and debris. On appeal by the sanitary district, a jury verdict in favor of the plaintiff was upheld by the California District Court of Appeal.

The facts, as stated by the court, were that the district operated a sewer system consisting of a sewage collection system and a treatment plant. The system had about 500 manholes, and 1 manhole was located directly in front of the plaintiff's home, which was connected to the sewerlines.

On the day in question, when plaintiff flushed a toilet, water backed up in the toilet and bathtub, flooding the bathroom and other rooms in the house with about 4 inches of sewer water and debris, causing extensive damage.

When the defendant's employees were called, they found the manhole plugged and full of water. They dislodged a broom or mop from the sewer pipe connected to the manhole and there was evidence that there was other debris in the manhole.

The defendant's evidence indicated that all the manholes were routinely inspected about every 30 days. The manhole in question had been inspected the day before the occurrence complained of and no obstruction of the sewer was seen at that time. The inspectors, however, had not descended into the manhole but had merely lifted the cover and looked down, a process which took about 1 minute.

The defendant's superintendent also testified that it was good practice to conduct occasional flushings and cleansings of sewerlines, but the defendant did so only when the lines were obstructed. The line serving the plaintiff's home had not been flushed prior to the flooding.

The district contended that, as a public agency engaged in a governmental activity, it could not be held liable in the absence of a special statute. The court rejected this contention, holding that in California a governmental unit is liable for creating and maintaining a condition declared to be a nuisance by the legislature. Under the statutory definition of nuisance contained in section 3479 of the California Civil Code, as "Anything which is injurious to health, or is indecent or offensive to the senses, or an obstruction to the free use of property, so as to interfere with the comfortable enjoyment of life or property . . . ," the court held that the facts in the case unquestionably constituted a nuisance.

Disposing of the district's argument that it could not be held liable for negligence, the court held that under the decided California cases a governmental agency was liable for negligent damage to real property. The limited inspection of the manhole, the court declared, supported an inference of improper inspection of the sewer system and upheld the finding of the jury that the district was guilty of negligence.

—SIDNEY EDELMAN, *assistant chief, Public Health Division, Office of General Counsel, Department of Health, Education, and Welfare.*

Occupational Health Notes

Sporotrichosis Among Miners

Mature spores of the fungus *Sporotrichum schenckii* in mine timbers afflicted more than 3,000 miners with skin lesions and internal damage before the source was detected and controlled, reports Dr. Rebecca Brown, Transvaal Chamber of Mines, Timber Research Laboratory, Johannesburg. She was in Montreal at the Ninth International Botanical Congress.

Castor Bean Pomace

Castor bean pomace, imported from South America for use in fertilizer, has caused outbreaks of illness in workers handling the material at eastern seaports. The pomace, which is the residue after oil is extracted from the castor bean, has long been recognized as capable of producing illness since it contains a powerful toxin, ricin, and a potent allergen.

An outbreak in Baltimore in February 1959 affected 18 of 45 railroad workers. Symptoms were upper respiratory distress, asthma, nausea, vomiting, chills, and fever. The Public Health Service found that similar incidents had occurred in Norfolk, Va., Wilmington, Del., and Tampa, Fla.

Recommendations to importers included steam treating, improved packaging and handling, and the use, where necessary, of protective clothing, eye protectors, and respirators.

Insecticide Hazards

Two young market garden workers in Massachusetts died as the result of insecticide poisoning. Over several days they had spent about 12 hours applying various kinds of insecticides including parathion. On the day they died, they worked the entire day dusting turnips with a powder containing 1.5 percent parathion. They used knapsack dusters. They became ill about 5 p.m., and 2 hours later were taken to the local hospital where atropine therapy was administered. Autopsies were not performed, but the symptoms of the men were typical of organic phosphate poisoning.

The workers reportedly had been informed of the hazardous nature of the insecticide but were not required to wear respirators and protective clothing, although the equipment was available. The bags of insecticide carried warnings of toxicity but were not labeled "poison" and had no statement as to antidote or treatment.

Explosion in a Plastics Plant

Lack of proper identification on containers was the basic cause of an accident which took one life and extensively damaged a plastics plant compounding polyester resins.

Assigned to clean up the crib where materials were mixed, an inexperienced employee of the Michigan plant tried to consolidate two half-filled gallon jugs which he believed contained the same material. One jug contained DDM (methyl ethyl ketone peroxide in dimethyl phthalate); the other, cobalt naphthenate. An explosion and fire resulted.

The worker received burns over 95 percent of his body and died about a week later. Plant damage from fire was at least $100,000.

State Radiation Regulations

The Kentucky State Board of Health has adopted comprehensive radiological health regulations, and the Tennessee State Industrial Hygiene Service last summer began registration of radiation sources, in accordance with the Radiological Health Service Act.

Compensation for Radiation Exposures

Ionizing radiation exposure may result in physical injury, wage loss, and possible limitation of the employee's capacity to continue to work. All these effects, weighed for workmen's compensation, may not be evident for years after the guilty exposure. Donald Ream, consultant to the U.S. Bureau of Labor Standards, stressed particularly the time factor at the First Annual Governor's Conference on Workmen's Compensation in New Jersey, saying that a rating should permit continuing evaluation. He told of 35 workers reported by the U.S. Atomic Energy Commission as having received the "maximum" radiation dose but who might not evince outward symptoms for years.