Planning Mental Health Facilities

RECENT advances in methods of diagnosis, treatment, and care of the mentally ill present a complexity of problems not only to psychiatrists but to planners of medical facilities as well.

This fact was borne out in a report presented at the Washington conferences of both State Hill-Burton authorities and State mental health authorities called by Surgeon General Leroy E. Burney in January 1960. The report was an account of the activities of an ad hoc committee appointed last August by Dr. Burney. The committee's objective was to plan an attempt to overcome a long-felt need for more adequate facilities for the mentally ill.

Hill-Burton State authorities report that by far the Nation's greatest need for hospital beds continues to be in mental hospitals, on the basis of currently accepted standards. A solution to this crucial bed shortage becomes even more compelling in view of the prediction by mental health authorities that one out of every 10 persons will spend some part of his life in a mental hospital, if current patterns of admission to mental hospitals and current death rates remain constant. This means that about 17 million persons now living in the United States will be hospitalized for mental illness at one time or another, unless new techniques of treatment and cure are developed.

But the committee found that although the seriousness of the bed shortage is unquestionable, the problem will not be resolved by simply meeting the need for hospital beds. Indeed, some facility planners even question whether any additional beds are required until the Nation's entire mental illness picture is thoroughly examined and reevaluated. They believe that broad-scale decisions should await the results of a study of the nature and availability of the physical facilities needed for a comprehensive program of treatment and care. Some authorities even question the formula of 5 beds per 1,000 population, which is now used as a guide in determining the number of beds needed in mental hospitals.

The committee pointed out that in view of new treatment methods, facility requirements may take on a completely new dimension. As an example, it was noted that many senile patients might be transferred appropriately to nursing homes and the beds they now occupy could be used by the mentally ill in need of special hospital care.

The current trend of general hospitals "to become more general" by providing care for the mentally disturbed was commended by the committee. It was stated that this trend should be encouraged since a mentally ill patient when admitted to the general hospital receives therapeutic care at a time when such care is most important. Also, from the standpoint of social attitudes, many mentally disturbed patients would be less reluctant to enter a general hospital than a mental institution.

As of January 1960, Hill-Burton State agencies reported a total of 542,000 mental hospital beds throughout the Nation. This figure includes beds in mental hospitals and in psychiatric units of 10 or more beds in general or tuberculosis hospitals, but does not include beds in Veterans Administration hospitals, Public Health Service hospitals, and other Federal facilities. Of this number, some 92,000 beds, or 17 percent, were designated as unsuitable by the State agencies. On the basis of a more inclu-

Prepared by J. J. Ozog, chief of the State Plan and Plan Development Section, Division of Hospital and Medical Facilities, Public Health Service.

sive classification, mental health authorities have estimated that some 790,000 beds, approximately one-half the beds in all hospitals in this country, are now occupied by mental patients. Despite this staggering overall total, the States report that, using the present formula of 5 beds per 1,000 population, an additional 421,000 beds for mental patients are required.

State agencies have also emphasized that many of the existing facilities do not permit the use of modern techniques and improved treatment methods in mental care.

Some of the complicating factors which confront planners of mental health facilities were stated by the Surgeon General when he appointed the ad hoc committee.

"In the past," Dr. Burney said, "emphasis was placed on providing large institutions for the care of the mentally ill. Treatment now being offered includes outpatient and emergency service through hospital clinics or mental health centers, increased use of general hospitals for the treatment of psychiatric patients, 'halfway houses,' and nursing homes."

The Surgeon General explained that an adequate program stresses continuity of care and requires a wide spectrum of services, both community based and hospital oriented.

"If social and family ties are not to be weakened, the patient should be treated as near home as possible, even if hospitalization is indicated," Dr. Burney said.

The report, which was read at both conferences, included the following proposed principles for use in developing statewide plans:

• Facilities for the mentally ill, both as to location and type, should be programed and constructed in accordance with a comprehensive statewide plan which provides for a coordinated pattern of service.

• Statewide planning for mental health should represent a joint effort by State and local, public and private agencies concerned with mental health.

• In the interest of providing more effective service to more people, facilities should be designed and utilized to serve multiple needs, when this is consistent with sound treatment practice.

• Construction design should be flexible, to permit future expansion or modification to other uses, particularly in psychiatric units of general hospitals.

• Treatment should be suited to the patient's need and the patient should be referred to the facility most appropriate to his need. Greater emphasis should be placed on continuity and progressiveness of care.

• Programs for mental health should place increasing emphasis on prevention, early recognition, and early treatment of mental illness.

• Construction of new facilities should be based upon the current concepts of treatment and expected future development.

• Facilities for treatment should be located in terms of easy accessibility to the area of potential need.

• Facilities should be used for the purpose for which programed and staffed, and at the highest levels of efficiency.

• Higher priority should be given to a mental health facility which is a part of or closely affiliated to a general hospital or health center, and to a new facility rather than to a proposal for remodeling an existing facility.

• Increased emphasis should be placed on rehabilitation of the mentally ill and preparation for complete return to home and society at the earliest feasible time.

• Long-term custodial care in mental institutions should be prescribed only as indicated following application of intensive treatment techniques.

• Provision of care and treatment to the senile aged, mentally retarded, and emotionally disturbed should be considered as a part of the State and local mental health program.

The report was read by Dr. Bernard Bucove, director of health, Washington State Department of Health, at the meeting of hospital and medical facilities survey and construction (Hill-Burton) authorities on January 5, and by Dr. Harold L. McPheeters, commissioner of the Kentucky State Department of Mental Health, Louisville, at the mental health authorities' meeting on January 6.

In addition to Bucove and McPheeters, other committee members are:

Dr. John J. Bourne, executive director, New York State Joint Hospital Survey and Planning Commission, Albany; Dr. Dale C. Cam-

eron, director, division of medical services, Minnesota State Department of Public Welfare, St. Paul; Dr. R. L. Cleere, director, Colorado State Department of Public Health, Denver.

Dr. Terrell O. Carver, administrator, Idaho Department of Health, Boise; Dr. Hiram W. Davis, commissioner, Virginia State Department of Mental Hygiene and Hospitals, Richmond; Herbert G. Fritz, chief, division of hospitals, Maryland State Department of Health, Baltimore; Dr. Stewart T. Ginsberg, commissioner, division of mental health, Indiana State Department of Health, Indianapolis.

Dr. Jack C. Haldeman, chief, Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C.; Dr. Robert T. Hewitt, chief, Hospital Consultant Services, Community Services Branch, National Institute of Mental Health, Bethesda, Md.; and Mrs. Louise Waagen Masters, director, division of hospital facilities, New Mexico Department of Public Health, Santa Fe.

Fewer Resident Patients of Public Mental Hospitals

The number of resident patients in public mental hospitals in the United States decreased during 1959, for the fourth consecutive year, according to statistics from the National Institute of Mental Health, Public Health Service.

At the end of the 1959 calendar year, there were 542,721 patients in 277 hospitals, 2,142 fewer patients than at the end of 1958. This decrease of 0.4 percent compares with a decrease of 0.7 percent during 1958, 0.5 percent during 1957, and 1.3 percent during 1956.

While the decline each year has been slight, it reverses a decided upward trend that had prevailed through this century. Between the years 1903 and 1951, the public mental hospital population quadrupled from 133,000 to 518,000. During the same period, the general population only doubled. The upward trend continued until 1956. Since then there has been a steady slight decline in the number of patients at the end of each year, even though the number of admissions during the year has continued to rise. Total admissions increased by 4.3 percent, 4.8 percent, 7.7 percent, and 6.5 percent in 1956, 1957, 1958, and 1959, respectively.

During 1959, there were 167,607 discharges as compared with 156,352 in 1958, an increase of 11,255 or 7.2 percent. In the three previous years, the number of discharges had increased by 11.8 percent in 1956, 8.9 percent in 1957, and 7.7 percent in 1958. The percentage change in the number of deaths as compared with the previous years was 8.6 percent in 1956, −2.9 percent in 1957, 9.5 percent in 1958, and −3.2 percent in 1959.

Commenting on the findings, Dr. Robert H. Felix, Director of the National Institute of Mental Health, pointed out that many factors are involved in these figures. It is unsafe to draw specific conclusions from them, he said, but they undoubtedly reflect a prevailing improvement in the care and treatment of the mentally ill both in and out of mental hospitals. He attributed this improvement, in part, to a basic change in the philosophy governing hospital administration and treatment in the past few years, and also in the public attitude toward mental illness. No longer is the hospital viewed as a custodial institution, he said. Its function is seen as rehabilitating the patient so that he can return to community living. Communities are assuming more responsibility and are providing preventive and rehabilitative services that help keep people out of mental hospitals.

Dr. Felix also credited new and improved treatment methods, including the wide use of psychoactive drugs, to the increased use of psychiatric beds in general hospitals, and to outpatient psychiatric clinics and other community facilities such as nursing homes, halfway houses, and sheltered workshops. He noted that 20 years ago, there were only 48 general hospitals treating psychiatric patients. Today there are some 500 with psychiatric units and many others that accept mentally ill persons for short-term treatment. Altogether, 1,000 or more general hospitals accept mentally ill patients. There are about 1,400 outpatient clinics offering psychiatric service within communities.