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THE BIG MENTAL HOSPITAL IS OBSOLETE

STATEMENT AT PUBLIC HEARING

NEW YORK STATE SENATE COMMITTEE ON PUBLIC HEALTH (SEN. METCALF, CHMN.)

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SENATE CHAMBER, THE CAPITOL, ALBANY

by

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Senator Metcalf and members of the Committee:

"Indeed, we live in a strange world, and it has been said that the standard of civilization of a country may be judged by the number of mental hospital beds per 1,000 of the population, the United States of America being in the lead, ourselves, France and the Scandinavian countries following hard at their heels. Is there no better solution for looking after the deviants and helpless in our society than the long-term mental hospital?...The other day an Infectious Diseases Hospital closed down and was put up for sale, not for lack of staff, but for lack of patients. Perhaps those who are coming after us will regard the period through which we are now passing in psychiatry as the mental hospital era, and maybe at the Annual meeting of the Royal Medico-Psychological Association in 2056, a coach trip will be arranged to pay a visit to the last of the big custodial care long-term mental hospitals before it is finally converted into a holiday camp!"

The author of the above words is Dr. T. P. Rees, father of the Open Hospital and for more than 20 years, superintendent of the famous Warlingham Park Hospital near London. Warlingham Park is one of 29 mental hospitals which serve the southwest region of London. There are five and one-half million people in this region, but the capacity of the average mental hospital is less than 2,000 beds. After touring a number of these superb hospitals, I asked Dr. Rees how he and the other superintendents had succeeded in holding their size down.

"We just refused to allow them to build any additional wings on hospitals which had reached the size of 2,000 beds," Dr. Rees told me. "When more beds were needed, we suggested additional small hospitals in nearby communities."

In America, the resistance to the big mental hospital has been less successful. In an attack on the big mental hospital at the Ninth Mental Hospital Institute of the American Psychiatric Association last year, Dr. Harry Solomon, President of the American Psychiatric Association, talked nostalgically of the futile efforts of the medical superintendents of the 19th Century to keep their institutions small and close to the heart of the community:

"As we all know, the hospitals increased in size to 400 to 600 to 800 and finally as high a number as 15,000...I maintain that the present system is already outmoded, that its inheritance from the 1820's and 1830's and subsequent decades must be viewed with great suspicion and new ways developed to meet the challenges."

At the same Institute, Dr. Mesrop Tarumianz who, as chairman of the Central Inspection Board of the American Psychiatric Association

has studied state mental hospitals more closely than any psychiatrist in this country, called for "a master plan for a revolutionary change in the structure of the care and treatment of the mentally ill". Dr. Tarumianz proposed small hospitals of 100 to 500 bed capacity for "individual, intensive, coordinated treatment".

Testifying before this very committee in 1956, Dr. Daniel Blain, Medical Director of the American Psychiatric Association, stated that "we are now faced with the stark reality of our failure, many years ago, to shift from a policy of custodial care for the mentally ill to active programs of treatment, training and research. We are 30 years behind in translating scientific advances into action in our state hospitals."

The most impressively documented and authoritative attack on the big mental hospital came in a 1953 report issued by the Expert Committee on Mental Health of the World Health Organization.

"The committee is convinced that it is, in general, undesirable to build new psychiatric hospitals for more than 1,000 patients," the report stated . "It is well known, of course, that many hospitals exist which far exceed this size, and in a later section some suggestions are made of the manner in which the harmful effects of such institutions can be mitigated. It is essential, however, that everything should be done to discourage the building of more hospitals of this type. Indeed, the figure of 1,000 patients which the committee puts forward is, in the opinion of a majority of its members, not put forward as representing the optimum size; it is put forward as a size which should on no account be exceeded. From the point of view of therapeutic efficiency, these members of the committee hold that

a better size would be somewhere between 300 and 1,000 beds. The committee is well aware of many arguments put forward in favour of very much larger units. These arguments are frequently based on the supposed reduction in the cost per patient per day obtainable in a larger unit. It appears, however, that the widespread belief in the economy of very large hospitals is probably unfounded.

"Recent studies have suggested that from a point of view of financial economy the optimum capacity for hospitals probably lies between 250 and 400 beds. Smaller establishments are expensive because of their lower average percentage of occupants and the difficulty of amortizing technical equipment which is not in full use. Above 400 beds, the cost per bed begins to increase slowly and reaches rather high figures above 800 beds. The reason is probably uncontrollable wastage, lack of responsibility on the part of too large a staff, unnecessary buying, and an industrial type of mechanization which is inevitable in very large hospitals; one must add to these the impossibility of sustained personal contact between the director and hundreds of hospital workers."

I am not unaware that there are present problems of mental hospital overcrowding. In his message to the legislature, Governor Harriman reported that the New York mental hospitals were overcrowded by about 19,000 patients. While this overcrowding continues, some new beds will have to be constructed. However, I do insist, with all the emphasis at my command, that these beds should not be tacked on to already overcrowded institutions. For example, Creedmoor Hospital out on Long Island now has 6,200 patients. According to a statement made by its superintendent at the Ninth Mental Hospital Institute, new construction under way and additional construction now in the planning stage will add about 5,000 more patients to its present load.

It will then become the fourth hospital on Long Island in the 10,000 patient range. I say this is monstrous and anti-therapeutic. Recent figures show that Creedmoor is presently unable to provide adequate staff for its current patient population; what happens when 5,000 more patients are added?

I am also critical of the rigidity and inflexibility of the New York mental hospital building program. It is not geared to an era of new treatments and new concepts. For example, the advent of the tranquilizing drugs has meant a drop of 500 patients a year over the past two years. This is actually a drop of 6,000 beds in hospital construction because the mental hospital population had been increasing at an annual rate of 2,500 patients in the immediate years preceding the advent of the drugs. So we don't need 6,000 beds that were considered <u>absolutely necessary</u> in 1954 when the new bond issue for building went into effect.

In a letter to the editor of "Better Homes and Gardens" relative to the article by Mr. Maisel, Dr. Paul Hoch, Commissioner of the Department of Mental Hygiene, points out that if the patient population continues to decrease at the rate of about 500 patients a year, it will take 43 years to eliminate present overcrowding. This is rank casuistry. First of all, it presupposes a freezing of new knowledge and new techniques in the treatment of mental illness. Secondly, it is the very kind of specious argument which kept building bed upon bed at Pilgrim State Hospital until today, with its 14,000 bed capacity, it is an ironic monument to Dr. Charles Pilgrim, who in his day fought the big mental hospital.

Then there is the hoary argument about replacing the "obsolete" bed. The Oxford English dictionary defines obsolete as: "That is

no longer practiced or used; discarded; out of date". How many times do you keep replacing this so-called obsolete bed? When do you reach the point when you abandon it as "out of date".

The World Health Organization report quoted above also critizes mental hospitals today as being built to last too long. As it points out: "Many countries will be burdened for a long time to come with large obsolete hospitals built years ago to fit a conception of the role of the mental hospital which is now completely rejected".

The report admits that even the small community hospitals which it recommends will probably be obsolete in 20 or 30 years time. It therefore proposes that mental hospitals be built with easily moveable interior construction. Using this standard, I defy anyone to move anything in the interior of some of the New York monoliths.

But what do we do with the present big mental hospitals in New York State? Until they can be abandoned, or reduced to manageable size, it is vitally necessary that the Department of Mental Hygiene pay some heed to the recommendations of the World Health Organization Expert Committee for a breaking-up of these large hospitals <u>into independent</u> services of from 400 to 700 patients, each with its own medical director and its own medical staff. Each of these units should be complete in that it includes patients of all clinical types, of both sexes and it should have its own admission and treatment facilities. This language is very clear and it does not mean the token breaking-up of a hospital into an intensive treatment unit and a scattering of additional buildings for all other patients not under active treatment.

Fundamentally, New York must develop an entirely new attitude

toward the large mental hospital. Apart from all other considerations, it must take off its blinders and realize what professional medical organizations have been telling it for a number of years -- that it cannot staff these large hospitals located in remote areas of the state. In 1956, testifying before this committee, I pointed out that New York was actually losing ground in recruiting psychiatric staff for its mental hospitals. Recently the American Psychiatric Association released a report which confirmed the testimony at the 1956 hearing. According to that report, New York is 31st among the states in the number of full-time employees per 100 patients. It is 16th in number of physicians per 100 patients, 47th in psychologists, 8th in registered nurses, 32nd in attendants and 22nd in social workers. In practically all these categories, it is far below the neighboring states of New Jersey and Connecticut.

What is the answer, then, to this dilemma? Two years ago, speaking to the First Annual Conference of Community Mental Health Boards in Syracuse, I proposed that the New York Department of Mental Hygiene concentrate upon the development of small mental hospitals scattered in scores of communities throughout the state. These small mental hospitals could serve as the nuclei for a complex of mental health services in the area. After visiting a number of English mental hospitals, Dr. Robert C. Hunt, then Assistant Commissioner of the Department of Mental Hygiene and now superintendent of Hudson River State Hospital, pointed out that in these English community mental hospitals "the staffs think of themselves as operating a complete battery of mental health services in which the hospital is just one type of treatment to be used when there are special indications".

In the article referred to, Dr. Hunt noted that there are half a dozen mental hospitals in Britain which are well in advance of the best practices in this country.

In Canada, Dr. Humphrey Osmond, Superintendent of the Saskatchewan Hospital, is leading a growing movement against the big hospital. In a very thoughtful article in a recent issue of "Mental Hospitals", Dr. Osmond attacked the big mental hospitals as anti-therapeutic and frightening to patients who are already insecure. Dr. Osmond has developed the Saskatchewan plan, which will consist of a series of small regional mental hospitals serving an area of over 250,000 square miles in that province.

The psychiatric unit in the general hospital is also a key element in reducing the need for big mental hospitals. At the 1956 hearing of this committee, Dr. Paul Lemkau, then Director of the New York City Community Mental Health Board, proposed that New York State make a far greater effort to hospitalize thousands of acutely mentally ill patients in general hospitals instead of waiting until they become chronically ill and must be committed to state mental hospitals. Dr. Lemkau pointed out that the present ceiling on matching funds under the Community Mental Health Services Act does not allow sufficient funds for the development of psychiatric units in general hospitals; he proposed that these units be exempted from the present ceiling. This proposal is certainly worthy of further investigation by this committee.

In essence, what we are pleading for is a complete change in New York's attitude toward the mental hospital. In the City of Amsterdam this past summer I met a remarkable psychiatrist who, since 1930, has devoted himself to making the large mental hospital obsolete.

In that city of one million people, he has developed thirteen full-time regional psychiatric teams who handle most of the mental illness in the city. His name is Dr. Arne Querido and he argues most eloquently that too many psychiatrists hunt for diagnosable symptoms to prove the need for hospitalization; he and his co-workers look for specific strengths in the patient, his family, his neighbors and his job, which can keep him out of the hospital.

"I should like to defend the thesis that in the last analysis the cure or the adaptation of the mentally disturbed can only be accomplished in society, and that a successful stay in society is the only real test of any therapeutic endeavor," Dr. Querido remarked recently. "Of course, circumstances may compel seeking the desired change in the patient by means of a stay in the hospital, and technical considerations may require observation or treatment by an in-patient arrangement. But I think it can be said that any removal of a mentally disturbed patient from his social background implies the sidestepping of the nucleus of the problem."

This type of preventive effort cannot be accomplished cheaply. It requires highly trained manpower and expensive community resources. I therefore want to make it clear, Mr. Chairman, that I am proposing no cuts or savings in the state's expenditures for the mentally ill. On the contrary. Any money saved from the building program should go into these expanded community mental health services, and much more additional money should be appropriated for these purposes.

Psychiatric research offers one strong possibility in that it is an investment in the eventual acquisition of new treatment techniques. As a number of witnesses pointed out at the 1956 hearings of this

committee, New York is spending a disproportionately small sum on psychiatric research. New York is still spending less than $3 million a year in this area, only a fraction of the staggering $195 million annual budget of the New York Department of Mental Hygiene. As a starter, New York should immediately double the sums available for psychiatric research.

As brought out in the recent American Psychiatric Association survey of manpower, the weakest link in the New York system is the lack of trained psychiatric personnel. At the 1956 hearing, Dr. Hoch promised that "an extensive training program" would be organized. Outside of the development of some graduate training for hospital physicians conducted at the Downstate and Syracuse branches of the State University, those of us who follow the New York program rather closely have seen little evidence so far of a greatly expanded training program.

At the 1956 hearing, Dr. Blain commended the graduate training program of the New York Department but called for "a much more comprehensive plan" involving three key elements:

1. A doubling or tripling of the state psychiatric residency program over the next six years. There has been very little change in the psychiatric residency program since Dr. Blain testified.

2. The development of an administrative scheme whereby the medical schools are given key responsibility for the administration of the training programs in the state hospitals. This works beautifully in England, where each of the 14 medical schools is assigned a

group of mental hospitals for whose training and other services it is responsible. New York State has not yet moved in this direction.

3. Subsidies to the ten medical schools of New York State for an expansion of faculty, staff and consultants to handle this training job. I see no evidence that this proposal is being acted on in any way.

The education of the general practitioner in psychiatric skills is moving very slowly, if at all, in New York State. At the 1956 hearing Dr. Richard P. Bellaire, President of the New York Academy of General Practice, presented a whole series of recommendations to enlist the general practitioner in the handling of mental illness. He urged the increased use of the general practitioner in both the state mental hospital and the community clinic, and he proposed that the Department of Mental Hygiene set up standard procedures for the follow-up of discharged patients, particularly those on maintenance doses of the tranquilizing drugs. Dr. Bellaire testified that the New York State Academy of General Practice had formed a Committee on Mental Health under the chairmanship of Dr. Carl Alden of Adams, and he pointed out that this Committee was "eager" to tackle the problem. This was a most important proposal and I wonder why immediate steps were not undertaken to sit down with the general practitioners of the state and develop a joint attack on mental illness?

In its testimony at the 1956 hearing, the National Committee Against Mental Illness proposed a minimum starting sum of $1,500,000

for the employment and training of general practitioners in the New York system. There is no evidence that this proposal has been taken very seriously.

In discussing community mental health services, we must not forget the role of the community in keeping patients from returning to the state mental hospital. In Mr. Maisel's article, the point was made that few states have developed a standard policy of distributing maintenance dosages of the tranquilizing drugs to discharged patients who cannot afford them. This is a most serious indictment, for it seems pointless to treat and bring some of these patients up to a point of reasonable adjustment, only to see the whole expensive effort fail because of financial inability to continue on the drugs.

As far as I have been able to ascertain, New York State has not yet developed any plan for the financing of maintenance drugs to discharged patients. If anyone doubts the need for such a policy, I respectfully commend to him the enormous volume of letters I received from all parts of the country after I had mailed out the Maisel article.

The problem is being attacked in a number of ways. In several states, fees are being paid by the Department of Mental Health to general practitioners willing to take over drug administration to discharged patients. Governor George Leader of Pennsylvania writes me that, in several of that state's institutions, the family doctor is brought into the hospital and a cooperative arrangement worked out with him at the point when the patient is ready to be released.

Governor Goodwin Knight of California writes that "in the 1957-58 fiscal year budget we initiated three aftercare clinics in three of our state hospitals to furnish the aftercare to which you refer.

This program will be expanded to include all hospitals as tax moneys become available for this purpose."

In Oklahoma, the local mental health associations have taken the responsibility of providing drugs for discharged mental patients.

I am appealing here, not for a perfectly devised maintenance drug plan here in New York, but for an end to the apparent indifference to any plan suggested. I would like to see the same kind of open-mindedness which characterized a recent letter on the Oregon mental hospital system which I received from Governor Robert D. Holmes:

"I would like to see the program dispense with more buildings and beds, and increase the professional staff and drug supplies, but this attitude is not as generally acceptable as I wish it were," Governor Holmes wrote. "...I agree that in the end it is very poor economy for the state not to finance an expanded treatment program for patients able to be released from our mental institutions, but not completely cured, or who need maintenance drug dosages."

Space does not permit a discussion of many of the additional community resources which must be used. If these are not used, then New York will one day face a mental hospital building need which will break its financial back.

In sum, Mr. Chairman, I am not proposing a reduction, but rather an <u>increase</u> in appropriations for the New York Department of Mental Hygiene. However, I am proposing a basic change in orientation -- a gradual transfer of the responsibility for psychiatric services from the big mental hospital to the community general hospital, the family physician and other community resources. This is a program which will take a number of years to implement, but it is the only enlightened one for the citizens of New York.