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IN THIS ISSUE

Announcing

The Second Conference

of

The Department

of

Mental Hygiene

and

Hospitals

of the

Commonwealth

DATE—DECEMBER 2 AND 3—1957

PLACE—HOTEL ROANOKE,
ROANOKE, VIRGINIA

Official Opening—December 2, 10:00 A.M.

This is YOUR invitation—Make your Reservation Early!

Speakers for Conference

Dr. Vaughan

Dr. Warren T. Vaughan who was born in Boston, Massachusetts, comes to us from Harvard School of Public Health where he holds the positions of Director of the Division of Mental Hygiene, Massachusetts Department of Mental Health and Assistant Professor of Mental Health, Harvard School of Public Health.

He is a graduate of St. Christopher School, Richmond, Virginia; Harvard College 1941 and Harvard Medical School, 1943. He received his Psychiatric Training at Worcester, (Massachusetts) State Hospital, Massachuetts Memorial Hospital and Judge Baker Guidance Center, Boston, Massachusetts.

He is a diplomate, Boards in Psychiatry, 1950.

He has held such splendid positions as, Staff Psychiatrist, Human Relations Service of Wellesley, Massachusetts, 1949-1952; Consultant Psychiatrist, Phillips Exeter Academy, Exeter, New Hampshire, 1950-1952 and Consultant Psychiatrist, Public Schools of Newton, Massachusetts, 1950-1951.

He has been active in directing a community survey of psychiatric services in Massachusetts, community hospital survey in Connecticut, and is currently assisting in the nationwide study of community psychiatry conducted by the Joint Commission on Mental Illness and Health.

Dr. Vaughan, whose subject will be "New Ideas In Out-Patient Practice" will be heard on Tuesday, December 3rd at 9 a.m.

New Ideas in Community Mental Health Practice

* Warren T. Vaughan, Jr., M.D.

Dr. Vaughan

Dr. Funkhouser, members of the Assembly, I am personally honored to discuss with you this morning some of the new approaches which are being developed in community psychiatry in many centers throughout the country. Some of the material I shall present comes from studies of patterns of patient care currently being conducted by the Joint Commission on Mental Illness and Health. Some comes from the community mental health program in Massachusetts which I direct. All of what I shall discuss is influenced by the development of what we refer to as a "public health approach" to mental illness and mental health. Schools of public health have in the past 10 years incorporated the social sciences and psychology into the family of basic public health sciences and have become interested in our field as a legitimate public health concern. The American Public Health Association two years ago began a mental health section and has for two years published its papers in the *American Journal of Public Health*. Psychiatrists, psychologists, social workers and others working in the community mental health field can now join the American Public Health Association. They will find a congenial number of colleagues in the public health field all reading the same Journal and very interested in mental health. They come from many of the health fields which have mental health concerns, such as maternal and child health, public health nursing, school health, health education, environmental planning, housing, industrial health and others.

A quick look at the logistics of psychiatry and mental health will show that a broad attack on the problem, stressing the positive health concept — to build good mental health — and utilizing the human resources in each community, largely untapped at this time, is the only possible approach. The mental health problem in the country involves such a vast number of individuals that an approach which focuses on one-to-one clinical treatment cannot possibly meet the need. Economic and manpower considerations rule this out at the onset. There are also valid theoretical considerations which also suggest that our traditional approach is not sufficient. These I will discuss a little later.

The public health approach is an approach to large groups of people living in communities under many diverse social, economic and physical conditions. Hugh Leavell, Professor of Public Health Practice at the Harvard School of Public Health describes five Levels of Health and Medical Care Activities. These are as follows:

1. The promotion of health
2. The specific prevention of specific diseases
3. Early diagnosis and prompt treatment
4. Limitation of Disability
5. Rehabilitation

I want to discuss mental health programming appropriate to each of these five areas. But first I must develop our public health frame of reference, within which we can fit pieces of programs and new projects to give us a picture of an integrated community health program.

For a moment, let us look at the application of epidemiology, the basic public health research approach, to mental health. The epidemiologist looks at populations much as the clinician studies the individual patient. His thermometer is his application of biostatistics to a population. By use of biostatistics he can develop indices of health or illness in a population through time, and he can compare the "health" of one community with that of another. He has an ecological approach, viewing illness as a resultant of many factors, some more crucial than others, which interplay as parts of mutually dependent systems. He identifies these factors as follows:

a) *Host factors.*—These include basic biophysical characteristics of the human population — constitutional, genetic, age and sex characteristics, with attendant psychological attributes. The degree of immunity, or susceptibility, of a population to noxious or pathogenic forces, can be studied and measured.

b) *Agents of disease.*—We are familiar with agents of disease as physical, biological or chemical elements which may get inside, infect or cause external damage to individ-

* Dr. Vaughan is Associate Director, Task Force on Patterns of Patient Care, Joint Commission on Mental Illness and Health, and Director, Division of Mental Hygiene, Massachusetts Department of Mental Health.

uals. These include not only micro-organisms, chemicals, drugs but also specific physical hazards peculiar to our modern world as seen in accident hazards and radiation hazards. We can also think of pathogenic ideas or attitudes as "infecting susceptible individuals". This is being done on one level in clinical studies of relationships between parental attitudes and development of childhood schizophrenia and delinquent antisocial behavior.

On another level, public concern about the noxious influence of certain materials which find their way into mass media such as TV and comic books has a certain validity in that certain populations or individuals may have little immunity to noxious influence of such attitudes or ideas when so communicated. For instance, certain individuals in certain parts of a big city or elsewhere may indeed be influenced to act out in certain antisocial manners by ideas or attitudes which the community may implicitly sanction by virtue of their presence in mass media.

However, just as the tubercle bacillus is the agent of the disease, but by no means suffices to explain the presence of the disease in a population or an individual and is as ubiquitous in its presence, so likewise are mentally unhealthy attitudes and ideas. We have to look further to find all factors which interrelate themselves in the community, the family and in the individual to result in mental health or illness. Furthermore, we can think of diseases related to "negative agents", or not enough of something which is needed. The epidemiology of nutrition and or deficiency diseases gives us a model for structuring much of our thinking about needs of growing children and how they will have them met.

c) *Environment.*—The third area to which the epidemiologist looks for etiological factors in disease is the environment itself, which sustains both the host and the agents of disease and may determine how the host and agents interrelate themselves. Some of the most notable public health advances have been in the field of environmental control: the development of modern water systems, the control of insects and other pests which harbor agents of disease. Of immediate pressing interest to the mental health field is the social environment, involving the manner in which people live in families and in neighborhood settings and with the help of various social institutions such as the schools, churches, health and social agencies which devote themselves to the primary function of child-rearing.

The mental health field today is devoting a major portion of its time and energy—in research as well as in clinical work to the field of social environment. The concept of the "therapeutic community" demonstrates that we operate with the implied assumption that there are significant relationships between the social environment and individual mental and emotional well-being.

Before we go further into the subject of the social environment, let us look at the present state of epidemiology with reference to psychiatric disorders. Looking at the multiple interplay of host, agent and environment on the etiology of disease, the epidemiologist can give us some sound and incontrovertible predictions concerning the directions which mental illness will take. For instance, he looks at host factors—the age-sex composition of our population and finds two trends: first the rapid increase in the number of elderly people in our country, and secondly, a "population explosion" in the younger age groups the result of the banner crop of new families and new babies since the War. These facts must then be taken by the planners and administrators to guide them in their program development. The Joint Commission has prepared a guide for community self surveys in which some of you may be interested.

The epidemiological approach has been used in recent years in various attempts to delineate the size of the mental health problem. This has been stimulated by the development of new facilities such as the Biometrics Branch of the National Institute of Mental Health and various research departments in schools of Public Health, and also by such pioneering groups as the Commonwealth Fund, The Grant Foundation, The Rockefeller Foundation and the Milbank Memorial Fund. The Milbank Memorial Fund has devoted many roundtables in recent years to consideration of mental health as an integral part of our overall public health field. Roth and Luton in Tennessee and Lemkau, Tietze and Cooper in Baltimore reported in the early 40's prevalences of psychiatric disorders in their respective rural and urban communities of between six and seven percent of the population. These early studies raise methodological problems which are extremely complex and which are still not solved, even though many more studies are now under way. These involve, first, problems of definition of psychiatric conditions so that we can have valid bases for comparisons between different communities and for studying trends. Our usual clinical criteria do not suffice for this purpose. Some studies such as the New Haven study of Redlich-Hollingshead and colleagues have tried to delineate the mentally ill group by taking as a criterion for study purposes the fact of being under psychiatric care. This immediately gets us into the problem of the meaning of "treated prevalence" figures. Are they a reflection of the disease processes themselves as they operate in a community, or are they a reflection of the facilities available for the care of the sick persons and the manner in which the facilities are used. Are

(*Turn page*)

they a reflection of the socio-cultural response of a community to the sick person? The New Haven studies definitely indicate that how psychiatric patients are treated in New Haven is influenced by the social class position of the patient. This is apparently true in other parts of the country also. The studies demonstate less conclusively that major psychoses occur more frequently in the lower socio-economic groups. The Chicago studies of Farris and Dunham demonstrate definitely that state hospital patients come from certain run-down areas near the center of the city. People from these social settings are sent to state hospitals when they become mentally ill. We are much less sure of the influence of these social conditions on the etiology of the illness. New prevalence studies, "the lifetime prevalence" study of Leighton and associates in Sterling County, the Yorkville studies of the late Tom Rennie and associates, represent attempts to get away from clinical nosology and to develop criteria of mental and emotional handicap or disability to apply to populations. The rates obtained in these studies using criteria which have been carefully arrived at, controlled and validated are of an order ten times the size of the six to seven percent reported in the original Baltimore and Williamson County, Tennessee studies. We as mental health workers cannot dismiss these studies as farfetched and unrealistic. They are telling us something about the society, the social environment in which we live. They may be concretizing for us in scientific epidemiological studies the general impressions, spoken of by writers, artists and social scientists, that we are living in a rapidly changing world, with rapidly changing ways of organizing and carrying out roles and functions in family living, community and job situation. Loss of family unity, in both structure and purpose, characterizes the present situation. Emotional stress with insecurity and anxiety accompanies changes. Various catch-phrases such as "The Lonely Crowd," "The Organization Man," "The Age of Anxiety" have been used to describe phases of this social process—which is apparently paying its price in emotional and mental casualty rates.

Pasamanick and Lemkau have recently given a paper suggesting that at any one time in any community about 10 to 15 percent of the population contains individuals with psychiatric disorders serious enough to warrant professional attention. I have used a rule-of-thumb figure of 10% in my work as psychiatric consultant with public and private schools, and have suggested that though 10% need direct consultative or therapy work, another 10 to 20 percent of children or more can be profitably helped indirectly through professional consultation services to teachers, administrators, school nurses, guidance personnel and parents. In summary, prevalence studies are invaluable to mental health planners and administrators. They have limited usefulness in shedding light on the interplay of host, agent and environment in the etiology of disorders. They raise many valuable questions for further research.

Incidence studies, on the other hand, enable the epidemiologist in the field to become much more closely involved with the many factors which play a role in causation. We have very few good studies of incidence in psychiatry. Some have come out of military psychiatry, where major policy changes on replacement procedures, number of combat missions, the number of days in front line duty were made following the establishment of functional relationships between days of combat stress, group cohesiveness and neuropsychiatric breakdown rate. Other incidence studies reviewed by Bowlby, showing influence of maternal deprivation on the emotional well being of infants and children, have resulted in major changes in traditional institutional practices in hospitals, child-care agencies, obstetrics and pediatrics. The data in these studies have been collected in the field on large groups of persons, ranging from sick to well. They are in contrast to traditional clinical studies which deal primarily with retrospective data collected from patients' histories. They also have the characteristic of involving the mental health professional in interdisciplinary team research, working with colleagues in other human services fields, such as child care, education, public health. Happily, more incidence studies are under way today—studies of a prospective nature—which may serve in time to delineate more clearly the interrelations between host, agent and environmental factors and give us better rationale for our preventive programs.

The social environment, involving human relations, is the particular area for exploitation by psychiatrists and other mental health professionals. Our theoretical model for understanding the social environment which needs further development and refining in order to be of maximum use to the public health person and the clinician, has grown like Topsy. Its origin, in a practical sense, was in the child guidance clinic, where with the team approach we began to work with the family as a dynamic interacting system, rather than focusing on the child as a set of isolated stimulus-response conditioned reflexes. The team approach brought child guidance workers into contact with the child's environment, and resulted in an appreciation of the importance of the human environment in meeting the different emotional and physical needs during the various growth phases of the child. The child guidance clinic began to meet with other child care groups, with educators, court people and so forth. The clinic began to

play an integrating function: for therapeutic purposes, began to bring together the various individuals in the emotionally relevant human environment of the child, began to modify attitudes of significant others, clarify the problem, discharge tensions, bring out assets and strengths in the family and school settings. Individual psychotherapy, that is, giving the child and parent a very specialized type of human relationship, has been a peculiar contribution of the clinic, but no less important has been this integrating function of the clinic mentioned above. Our theoretical model, then involves the idea of systems of forces within individuals, and between individuals and groups of individuals, systems which have various demonstrable characteristics which can be measured (such as interaction rates) or described, (such as family attitudes, value systems, neighborhood and community subcultures). These systems can be described in various theoretical terms, such as "communication system with autoregulators and feedback mechanisms", or "steady-state systems with equilibria and pacemakers". L. K. Frank refers to them as "organized complexities".

For our public health approach, we must look at these systems as having two main characteristics:

a) that they change through time —and there is such a thing as growth as well as such a thing as an aging process.

b) that sudden changes, call them *crises*, will cause major stress within one or more of the individuals in the system which may result in temporary or more lasting incapacity.

We can readily discern many natural crises which may, then, contain the germ for later psychiatric disability; death of a key family member, birth of a sibling, illness with or without hospitalization. Also, social crises, such as moving from one location to another with loss of emotionally meaningful family and neighborhood and job ties, beginning school for a small child, getting engaged and married, separation, divorce, may be accompanied by increased emotional tension and lead to trouble. Let us look for a moment at a naturally occuring physiological and social crisis which contains the seeds for much mental ill health and also gives the mental health worker an opportunity to develop research and service in the area of prevention. I am referring to adolescence, which, as Anna Freud said recently in Worcester, has as its hall mark two emotional tasks which ordinarily do not lend themselves well to traditional clinical care: on the one hand the problem of separation and loss in the giving up of the parents of childhood, and on the other the problem of love, the development of new meaningful human relationships within the context of evolving genital sexuality.

With our public health frame of reference and our ideas of building immunity so that individuals can withstand the stress of crises, we in mental health would like to be concentrating our attention on population groups which today most infrequently visit our psychiatric clinics —the adolescents and the new families with children in the preschool years and new babies coming along.

We must also consider the daily crises in intact families which result from failure of parents handicapped by neurotic, psychotic or other disorders to play their adequate "nutritive" and educative roles in child-rearing.

I now want to go back to Dr. Leavell's five levels and have us look at each from the point of view of psychiatry and mental health.

First, let us consider health promotion. We believe that we know something about promoting the general mental health and that many pieces of advice which we may give ourselves, our friends and relatives and occasionally our patients are soundly based. Prescriptions for good healthy living are to be found in our newspapers, magazines, our popular and professional literature. We do have definitions of "mental health", but find that our concepts of mental health are greatly influenced by cultural factors peculiar to the Western World and the American scene. Mental health as an ideal, a star to hitch your wagon to may serve many, in particular professionals and upper middle class intellectuals who are trying to find an anchor to windward in an era which sees so many of those traditional institutions and practices which have served as guides for conduct and beliefs disappearing in the turbulent sea of change.

We can point to efforts at mental health promotion in the fields of mental health education and social action. Mental health education programs in public schools and in the fields of adult education, professional education and in-service training for professions have been going on for many years. Some 250,000 school children a year are exposed to the Delaware "Human Relations in the Classroom" course. Thousands of parents see the Pierre the Pelican material and other materials. Many communities have developed courses in family living. Mental Health is coming into high school home economics courses. The Mental Health Associations have taken leadership here and mental health profssionals have contributed many thousands of hours of their own time to help these programs. How to evaluate all of this?—impossible now until we have better definitions of mental health and illness and controls for before and after studies.

At the risk of being swept up in the social phenomenon of the day referred to as "groupiness" and organization, I believe that one development which will prove to be most

(Turn page)

important in the years to come in the field of mental health promotion is the joining of the citizen with the professional in a partnership designed to bring citizen participation to the mental health movement. I am most familiar with our development in Massachusetts of community organization for mental health by the development of the voluntary partnership between the state professional service agency and the local community, with the resultant mental health center serving as a rallying point for the development of citizen understanding of mental health needs and for program developments in the areas of mental health education, consultation and clinical services. New York State and several others have developed a new system of public Mental Health Boards. Remember, our social environment model says that change is inevitable. Development of social change in directions beneficial to the mental health requires organization, citizen education, lay participation. Our mental health associations have important functions here, as well as functions related to improvement of patient care. See what has been done by aroused, well organized groups concerned with the retarded child.

In Holland during the recent flooding of the lowlands, the Dutch Mental Health Association, acting on the basis of experiences in London during the war which indicated that children were more distressed by separation from their families at the time of the evacuation than by the air raids, went to the authorities and prevailed upon them to change their plans to evacuate the children to homes in the interior, and rather to evacuate the population by family groups. This piece of action, influencing policy at the time of a social crisis, was carried out by the citizen's group. If citizens are convinced that a certain course of action is desirable, and if they become organized and know what they want and why, then action will occur. Many issues relating to family and community living are of mental relevance. It remains for them to be understood more clearly by us all so that thoughtful social action can be planned. Mental health is indeed everybody's business.

Let us turn our attention to the field of specific prevention. We look for cause of psychiatric difficulties in the areas of physical or somatic development, psychological development and in the sphere of human relations. This is a clinical slicing of the pie of multiple cause, differing slightly from the epidemiological slicing I used previously. I introduce it because in my discussion now I am beginning to focus more on the individual. Ernest Gruenberg has recently reviewed those psychiatric disorders which can be specifically prevented by application of public health techniques in the field of maternal and child health, venereal disease control, nutrition and rehabilitation. There are not many as yet, but we can list them, beginning with general paresis, pellagra, certain types of chronic brain syndromes related to trauma, infection, complications of pregnancy and delivery, toxins and so forth. Some of these involve control of the agent of disease. We know little about the control or modification of the social environment, but many of us do believe that a form of specific prevention can be developed by the development of mental health consultation services for key people who "set the tones" or determine the emotional climate of the human environment around families and growing children. We believe that a set of interview techniques differing from psychotherapy, education and supervision are applicable here, and that use of mental health consultation techniques at the times of crisis may indeed change the human environment setting for the child and family—intervening in a process which was pathogenic, thereby preventing more serious later difficulties. Direct consultation with parents concerning children is a function not unfamiliar to guidance centers and family agencies. Consultation services for school people and workers in other community settings is a newer idea. Essentially it involves a mental health consultant being available on a regular basis to the community, available on call at the time of crisis, to review and discuss problems of various sorts. Referring back to our social system model, consultation is with the key people in the social system, while therapy is with an individual who is designated as the "Patient"; consultation is focused on the international relations in the systems while treatment is founded on the intrapersonal state of the patient; the consultant and the therapist both become important to the people involved, that is, the phenomenon of transference is crucial. In consultation, change in the inter-personal relations in the social system is supposed to change the intrapersonal state of the individual (he feels better, functions better, or becomes asymptomatic) while in therapy change in the intrapersonal state of the patient is supposed to improve his functioning as a member of the social system (he gets along better at home, in school). In Massachusetts, we now have a new state position known as Mental Health Coordinator for this function and speak no longer of three-man child guidance teams, but of four-man mental health center teams. We are now developing a statistical system for describing community mental health consultation activities. We will be better able to evaluate the effectiveness of this work after this system has been in operation a few years. Lemkau refers to these activities as "secondary prevention", as distinguished from "primary prevention".

Dr. Leavell's third level is that of early diagnosis and prompt treatment. We have little or none of this

in psychiatry, regrettably. We have too little too late. Our mental health coordinators are playing something of a casefinding role and we can show that where consultation services are established in public school systems, that the average age of children referred to the clinics becomes lowered. This suggests earlier detection and referral. One of the concerns of the Joint Commission is the problem of bringing psychiatric care to people at the time of crisis, with a minimum of delay, removing administrative, social, cultural and psychological barriers to service. There are some new programs of emergency psychiatric care worthy of brief discussion here. The service of Querido in Amsterdam, described in one of the Milbank Monographs is a case in point, where the psychiatrist on emergency service goes out into the home of the patient at the time of crisis rather than having the patient brought to the hospital by police or other methods. Querido reports remarkable results from this service, states that "one psychiatrist on this service is more effective than the personnel of a sixty bed ward". Zwerling and Coleman of the Einstein Medical School have begun a somewhat similar service at the new Bronx Municipal Hospital. They report being able to help many patients over crisis without hospitalization, where the crisis of hospitalization may further complicate the psychiatric state of the patient. This is especially true in the geriatric field. Furthermore, they state that many social agencies can continue their work with individuals and families with less anxiety if they know that a psychiatric service is available at a moment's notice.

Some of our mental health centers, in particular the Worcester Youth Guidance Center under Dr. Joseph Weinreb has been trying to develop a system of crisis consultation in the clinic, studying cases at the time of the crisis, instead of putting them on waiting lists. This has resulted in favorable outcomes in many instances, and has tided many cases over until treatment hours became available. They have set up specific blocks of time for this community service and have spent some time interpreting this approach to the community. It essentially is as follows: we will not take over the responsibility for the problem (to the agency, school or parents), but will study out the problem with you and try to be helpful to you as you continue your responsibility for the problem.

This is ducking the issue of treatment for a while, and requires that we develop in our mental health centers the public health function of follow-up, in order that we may evaluate results of consultation and institute definitive treatment programming when indicated.

The fourth group of activities involves medical care, work with patients. Hugh Leavell refers to this area as limitation of disability. I have already mentioned the need to bring treatment to people more rapidly and the need to remove barriers to treatment. In both community clinic and hospital situations our professional manpower situation is deplorable. It probably will not improve in the next five or ten years. After that, when our crop of war babies become of professional age we will have enough people in the manpower pool to see major breakthroughs. Ten years ago people talked of one three-man clinic team for 100,000 people; now we hear talk of one clinical team for 50,000 people. In Massachusetts, we are beginning to talk about one mental health professional for every 10,000 persons. We have no idea what the picture will look like in 1975. We know that public mental health programs will have to develop their own training programs and that good clinical services are intimately tied to the development of research and training programs.

There are two new ideas in patient care that I want to mention, for they tie in with the manpower problem. These are the use of group methods and the use of volunteers in direct work with patients. There is little doubt but that group techniques are just beginning to be exploited in hospital and clinic settings. This will become an increasingly important treatment modality as we gain more understanding of the relationships between group process and possible modification of neurotic configurations and sympton-formation. The use of volunteers, in particular in an individual or group activity program, described recently by Hans Hussey with college students and being developed in some centers with the help of Big Brother organizations, appears to be of real benefit to many children. These activities help children with situational maladjustments, problems of emotional immaturity, children who have not had opportunities to learn social skills, who have lost significant adult figures in their life. Children with well-internalized neuroses, such as hysteria, phobic reactions, learning disabilities, psychosomatic disorders need classical psychotherapy. These volunteer programs bring more people from the community into meaningful contact with the mental health program. They also serve as a valuable recruitment device as they interest young people in the mental health professions.

One further point about psychiatric treatment which many leaders in the field have stressed to me in the past few months as I have interviewed them for the Joint Commission, namely we must be careful not to oversell psychiatric treatment, and should stress a realistic assessment of what psychiatry can do and what it cannot do. Much of our professional work is dealing with people with lifelong mental and emotional handicaps. We must clarify for ourselves and the public what is "treatable"

(*Turn page*)

and what is not, and explain more adequately our role in working with handicapped people.

This takes us to our final area of concern, rehabilitation. In the children's field we are involved with the very confusing field of mental retardation, where we can find many factors of host, agent and environment at work. We know that most children of the educable variety who are institutionalized are hospitalized not so much because of their mental retardation but because of the inadequacies in their social environment, in particular their family situations. Can these situations be recognized years earlier and worked with within the framework of rehabilitation? We are struck by the concept of the multiproblem family and the St. Paul study which shows that 50% of the community's health and social service dollars are going to care for a hard core 6% of such families. We have one experimental program at Boston University, under Dr. Eleanor Pavenstedt which attempts to identify such families and begin work with them at the time of a crisis, namely, the birth of another child. The casework in this program is active, with the worker going from the health agency into the home, performing many surrogate functions, following up on broken appointments, even chauffeuring the family members to important appointments. A homemaking service is in the program too. The program is predicated upon the notion that these families are made up of deprived people full of hostile tensions, ambivalent feelings and who are suspicious of agency people. The work with them has to be carried on in a very active fashion for many months for results to be seen. Preliminary evaluation indicates that many families in precarious states of disintegration have been helped to develop new strengths and healthier states of integration and effectiveness.

Community programs addressed to the rehabilitation of discharged hospitalized patients may be able to materially influence the readmission rates to mental hospitals. The evidence is coming in that this indeed is the case. Here in a brief consideration of rehabilitation we have come the full circle, for here, just as in the general work of promotion and prevention, we again need the full participation and support of the community in order for our work to be effective.

To summarize, our mental health activities, growing out of clinical psychiatry and child guidance work can now be extended not only to participation of the family to the benefit of the patient, but the participation of the community to the benefit of all the families and individuals that make up the community. A public health approach can give us the theoretical frame of reference needed for developing programs of research, training, clinical services, and community services.

A sound careful development of community participation in our mental health endeavors will result in a well ploughed and fertilized field for the work of the mental health professional of fifteen and twenty years hence.

Address

(*Continued from page* 4)

I am privileged to be with you today, and I want you to know that my cordial goods wishes will go with you always in your work, which constitutes one of the state's most important undertakings in taking care of and restoring to health our mentally ill.

The Future

(*Continued from page* 7)

economics of hospital operation.

From the management profession —of all places—now comes the expression that men do not work only for money. They work because of a personal identity with the group, because they want an opportunity to grow and because they want to be treated fairly and equally with others in the group. Urwick[3] calls these identity, opportunity and equity. Sometimes we speak of these as fringe benefits but I suspect if we gave more attention to these aspects of work, we would retain better staffs for longer periods in our mental hospitals.

The present unfortunate separation of mental health functions between the State Commissioner of Mental Health and the State Department of Public Health will be a thing of the past. These two departments will have been merged or will have developed complete cooperation in their overlapping functions with a clear division of the work load.

The "two-headed monster" type of management seen in some present mental hospitals—where a psychiatrist is made responsible for the treatment program and a business executive responsible for hospital business and fiscal affairs—will be happily discarded as something which should never have been tried in the first place. It seems to me it was long ago that we heard the words and believed that no man can serve two masters. The mental hospital superintendent will, of course, have highly trained administrative assistants just as he will have highly trained medical, sociological and engineering assistants. But the operation of a mental hospital—where each act and deed of every employee becomes an integral part of the therapeutic community—must of necessity by guided by medical hands and medical philosophy. Let there be no mistaking this fact!

Now in conclusion, I would remind you that our efforts to predict the future of the public mental hospital must of necessity be inaccurate

(*Continued on page* 19)

(*Continued from page* 14)

and faulty. Such efforts are necessary, however. Your decision to open this question to discussion is indicative of your interest and initiative. May I urge on you that you give practical heed to what we are discussing here today? Nineteen hundred seventy-five is not very far away. If it seems too distant, let us consider the year 1965. Are we already getting our treatment objectives in mind for that year? If not, we had better begin. Even the mental health needs of 1965 will most surely not be met unless we begin now to estimate those needs and to establish plans and procedures to get the job done. This is not an easy assignment. It will be a slow and laborious process full of pitfalls, disappointments and heartaches. But to you, my listeners, has been given the responsibility of the development of the present and future mental hospitals of the Old Dominion. You can not avoid it. You will not shirk it. You are dedicated to this purpose. May success attend you in your efforts to that end.