PREAMBLE

The information and suggestions contained in this report on the public psychiatric hospitals of the United States are offered for consideration, criticism and comments.

The material was compiled by the Group for Advancement of Psychiatry, which is a group of approximately 150 members of the American Psychiatric Association, organized as a series of 15 committees. The Group for the Advancement of Psychiatry exists for the purpose of working intensively on and discussing important psychiatric issues of today, in the belief that informal discussions and hard work in small groups or committees can produce new ideas and new approaches to old problems. At the meeting held in Minneapolis on June 30, July 1-2, 1947 the problems of the state hospital were considered by each committee of the Group from the point of view of that individual Committee. Later the Hospital Committee sent a questionnaire to all members of the Group asking for comments on each part of the Report thus formulated; a brief summary of the responses to the questionnaire is included under each section.

I. INTRODUCTION

A. Report of the Group for the Advancement of Psychiatry

The results of a survey made by the Committee on Hospitals of the Group for the Advancement of Psychiatry (November, 1946) showed the overcrowding in public psychiatric hospitals to be from 20% to 74%. The shortage of doctors was serious. There were major deficits in nurses. One state hospital had no nurses. The attendant shortage was less. The doctor-patient ratio in one area was 1 to 500. Retired general practitioners were used and in a few areas, unlicensed physicians. The nurse-patient ratio in one district was 1 to 1,320. The per capita cost variation ranged from 43 cents per day to $1.94. Research activities were almost nil. Psychiatric educational and training programs were infrequent. There was little contact with teaching hospitals. Individual psychotherapy was absent except in a few notable instances. Public relations programs were infrequent. Jails were widely used for temporary care of the mentally ill. This report was based on information from 25 state hospitals and 1 private mental hospital.

The report to the American Psychiatric Association of the Committee on Standards and Policies made in May, 1947 showed general confirmation of our figures. The situation regarding attendants, nurses and doctors, shown in that American Psychiatric Association report was as follows:

<table>
<thead>
<tr>
<th>Ratio to Patients</th>
<th>American Psychiatric Association Standards</th>
<th>Actual Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendants</td>
<td>1 per 6 or 8 patients</td>
<td>1 per 12 to 30</td>
</tr>
<tr>
<td>Nurses</td>
<td>1 per 4 to 40</td>
<td>1 per 176</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>1 per 30 to 200</td>
<td>1 per 250 to 500</td>
</tr>
</tbody>
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The responses of members of the Group for the Advancement of Psychiatry to our original report voiced general approval of the need for improved facilities, personnel, and budget; endorsement of the American Psychiatric Association standards for inspection, approval, and certification of state hospitals and of hospitals for training; and urged a campaign for public education with the appointment of a Public Relations Officer by the American Psychiatric Association.

There was some opposition to the advocacy of a central department of mental health, the exchange of interns between state and general hospitals, and vice versa, and the requirement of several months' internship for state licensure.

Superintendents of state hospitals (from California and Mississippi to the Eastern seaboard), to whom our reports were sent, concurred almost unanimously with our findings. Their chief complaints were budgetary and personnel deficiencies. One state hospital superintendent wrote, "It is a hopeful sign to have an active committee working on this problem."

This report is an attempt to present concrete ways and means of helping public psychiatric institutions.

B. American Psychiatric Association Committee on Standards and Policies

The American Psychiatric Association sent out an elaborate questionnaire to 496 public and private hospitals and by May, 1947 had received replies from 121. The questionnaire was so comprehensive that it irritated some superintendents. The frequency with which questionnaires are received constitutes a problem. It was surprising how much essential ma-
terial was not at the fingertips of hospital administrators and how much work was needed to obtain significant and important figures. This demonstrates the advisability of having an "Operational Report," which would be made out once a year by hospital superintendents. Such data prepared once a year on a uniform operational report would save much time in answering the many queries that come to the desk of the busy superintendent. The name of the form—"Inspection and Rating Forms," sent out by the American Psychiatric Association was unfortunate because the name aroused a critical and defensive attitude. Our suggestion is that the title be "Annual Function and Operation Report."

For actual evaluation of a hospital, questionnaires sent by mail are unsatisfactory. Personal visits and discussions are necessary. Our committee has certain suggestions for modification of the A. P. A. form.

The time devoted to treatment and the type of treatment and the time devoted to individual therapy needs to be more specific when reported. For example, one hospital reported ward rounds as therapy. Provisions for the evaluation of therapy must be more accurately delineated and recorded. A clarification of the concept of "discharge" and what is meant by it must be made. Much time and money is spent yearly on compiling discharge statistics, yet they are not comparable in reports of the various hospitals. For example, in some states a patient may have been home for three years, but not "discharged." The words "parole" and "on visit" and "furlough" have different meanings. Week-end visits are recorded as discharges by some hospitals. There has been intimate cooperation between the committees of the American Psychiatric Association and the Group for the Advancement of Psychiatry working in this area. There was some misunderstanding at first—but when the role of the Group for the Advancement of Psychiatry was interpreted, friendly and cooperative relationships resulted. The American Psychiatric Association has requested that the Committee of the Group meet with them for discussion, criticism, and suggestion, when the complete data on the hospital questionnaire has been received.

C. Discharge Statistics

There is general dissatisfaction expressed with the present method of reporting discharges from hospitals. Comparative statistics are not possible because practices vary so widely. Present statistical tables call for hospitals to tabulate discharges. Such figures often include those released against advice, those dismissed to private psychiatric hospitals, those on visit in the community 3 to 6 years, those who disappeared after an escape, and those dismissed from observa-

tion. Discharge figures have no relation to the admissions reported for that year. We have been unable to discover an entirely satisfactory basis for reporting discharges uniformly that will be practical and will serve at the same time as an index by which to evaluate therapy. We do suggest that the following statistics be compiled by all hospitals:

1. Where is the patient admitted one year ago? (At home, in the hospital, dead, unknown.)
2. How long was the stay in the hospital? (Of those who left within the year or who died.)
3. What patients were discharged after more than 12 months from the time of admission? (Maintain a card file on all discharges that occurred on patients after the first year.)

D. Conclusions and Recommendations on Standards and Policies

1. We heartily endorse the American Psychiatric Association standards of rating and certification. We recommend the vigorous support and promulgation of the established standards.
2. We recommend that the American Psychiatric Association standards be elaborated and clarified.
3. We recommend that the American Psychiatric Association grant temporary or conditional approval to those hospitals which show satisfactory evidence of improvement on the basis of annual inspection in progressing toward the American Psychiatric Association standards.
4. A distinction should be made between the approval of hospitals for the training of psychiatric or medical residents and their approval on the basis of provision of adequate care and treatment to patients.

The Hospital Committee is aware of the changing function of the public psychiatric institution. For example, there is a trend toward the use of the general hospital for new and acute patients and greater use of the state hospital for the care of the aged. The suggestion has been considered that there be separate institutions to care for the acute and chronic patients. There are pros and cons on each side. More detailed study and discussion of this problem is planned in the future.

The majority of the Group concurred in the suggestion that an operational report be made out once a year by the hospital superintendents to be called "Annual Function and Operative Report" and agreed with the conclusions and recommendations on standards and policies.

E. Recruitment of Psychiatrists for State Hospitals

The Committee sought the help of Dr. Forrest Harrison, as a consultant, because of his experience,
to prepare a statement on the recruitment of physicians for state hospitals. Of 938 physicians seeking opportunities in psychiatry, only 60 were interested in working in state hospitals. There were many more jobs available in state hospitals than applicants for them. Superintendents emphasized the considerable difficulties they were having on account of their "seriously depleted staff." We will not go into the reason for this shortage in this report. Dr. Harrison’s recommendations follow:

1. Public psychiatric hospitals must give more adequate psychiatric training to physicians. The lack of adequate supervision and training seemed more of a deterrent factor than the salary offered.

2. A new position of educational director should be created. This psychiatrist should devote his entire time to training and supervision.

3. Liaison with medical schools and teaching hospitals is recommended. Standards should then be raised and dignity given to the training.

4. More integration with general hospitals is desired.

5. Part of the time of the physician should be spent in out-patient clinic work.

6. The stipends should be increased to prove more adequate for men with families and added responsibilities.

7. Quarters for physicians need improvement, but better than this, would be an arrangement enabling them to live in the community.

8. To compete with the Veterans Administration, state hospitals must offer larger salaries, more congenial living conditions, and better training than they now do.

9. New hospitals should be located near centers of population.

10. Physicians should be given an opportunity to take refresher courses.

11. There is a real training opportunity in the intimate contact with and the prolonged study of the psychotic patient.

The Hospital Committee recommends the wider use of general practitioners and specialists in the physical and mental care of patients in the state hospital. It results in utilization of psychiatrists to best advantage, education in the better care and treatment of patients. Part-time psychiatrists, as used in some states and in the Veterans Administration, would be helpful. The more professional workers in the hospital going to and from the community, the more understanding there is between community and state hospital. An added thought, in connection with recruitment, is the appeal to the chemical and drug industries to establish training fellowships in state hospitals.

There was general agreement by the Group on this section.

II. FORENSIC PSYCHIATRY COMMITTEE ON HOSPITAL PROBLEMS*

A. The Committee discussed the following points:

Certification of patients to public psychiatric hospitals.
Voluntary admission
Provision for emergency care.
Elimination of anachronistic terminology.
Legal responsibility for hospitalized psychiatric patients.

B. Certification

1. Historically the insane were identified with the criminal. At first only the "dangerously insane" were admitted to institutions. The same procedures for admission were used for both criminals and insane. Many states still adhere closely to this practice. The Committee felt that separation in the connotation of insanity from crime is desirable.

2. The Committee condemned the following practices:

a. Use of jails for detaining psychiatric patients. This practice is widely used.

b. Serving patients with a notice—equivalent to a warrant.

c. Compulsory appearance of patients at a hearing. This creates a public spectacle and a court record.

d. Trial by jury—This constitutes an accusa-
tion. (This practice is mandatory in 2 states and elective in 19.) It is illogical to ask lay people to determine whether a mental illness exists and the need for hospitalization. These matters are for medical judgment. There is a widespread belief that trial by jury is a civil right. This is true with regard to criminal cases but does not apply in the case of mental illness. Educational work will be needed to counteract the opinion that trial by jury should be included.

e. Inquiry into financial status at time of com-
mitment.

f. Linking of incompetency and commitment.

3. Varieties of Commitment Laws

Use of Jury—21 states (Mississippi and Texas mandatory)

Two physicians—6 states (Maryland, Con-

* A more complete report on Commitment Procedures. Report No. 4, was published in April, 1948.
hcticut, Pennsylvania, Rhode Island, Vermont, New Hampshire)
Standing Commissions—6 states
Nonjudicial Authority and 2 Physicians—3 states
Judge and Commission—6 states
Judge and 1 Physician—8 states
Judge and 2 Physicians—23 states
4. Essentials of a good Certification Law:
   a. Use of the concept of mental illness, instead of insanity.
   b. Certification to be made by responsible persons—professional people—the doctor who is the best judge of the need for hospital care.
   c. Certification by 2 physicians (as a double check on the necessity for in-patient care)—no court procedure.
   d. The right of the patient to demand that a hearing be given him if he objects to restraint.
5. The Committee approves the principle of a uniform commitment law but feels it is impractical at present. The Committee recommends that every state adopt certification by two physicians without court procedure. The patient, or anyone acting in his behalf, may petition for release. If the medical director of the hospital is unwilling to release him, he must notify the nearest judicial authority. A hearing must then be held to determine if the patient may be restrained. (Four states now have desirable certification laws. These are Maryland, Connecticut, Rhode Island and Vermont. Pennsylvania and New Hampshire have the same provisions but require a magistrate’s concurrence.)

C. Voluntary Admissions
1. The Committee believing that the aim is greater participation by the patient in his own treatment, encourages much wider use of voluntary admissions to public psychiatric hospitals.
   a. If the patient has sufficient motivation to realize he needs treatment he should be admitted even though incapable of signing the application. This may be done for him by a responsible relative. The aim is to eliminate all stigma and fear. (New York and Illinois and Ohio have good laws.)
   b. It is recommended that 15 days, or preferably 30 days notice of change from voluntary to involuntary status be given.
   c. All states but 6. (North Dakota and 5 Southern states) have provision for voluntary admissions, but it is not used in many states.

D. Emergency Care
1. The Committee recommends that the emergency admission to psychiatric hospitals be as simple as possible. No temporary certificate need be issued. In the absence of two certifying physicians, referrals may be made by a physician, police officer, welfare worker or relative. The receiving physicians of the psychiatric hospital or psychiatric ward of a general hospital, shall have the power to accept the patient.
2. The patient shall, in each instance, go directly to the hospital and within 72 hours must be examined by two physicians and a certificate issued if the patient is to be retained in the hospital. (No state now requires signature of a psychiatrist.)

E. Anachronistic Terminology
The Committee recommends the following substitutions for words in use: "Certification" to be used instead of "commitment."
"Mental illness" to be used instead of "lunacy, insanity, feeble-mindedness or weak-mindedness."
"Convalescent status" to be used instead of "parole or visit."
"Leave" instead of "furlough of absence" to cover temporary absences from the hospital.

F. Legal Responsibility
1. Certification of insanity should be made only when the question of responsibility in legal matters is raised.
2. This eliminates the concept of commitment and does away with the need of "observation or temporary status."
3. The Committee disapproves of the depriving of the patient of those reality contacts which he is competent to maintain. There is a tendency to deprive a patient of all privileges and to infantilize him. A man who is psychotic may have the right to enter into contracts although the burden of proof is against the sick person.
4. Maryland law says that the insane may make a will. Mere presence of insanity does not invalidate a will.

When approved, the Hospital Committee recommends this section of the report be sent to the Bar Associations. It was also recommended that it be sent to the legislative Committee of the American Bar Association as well as to state hospital superintendents. Psychiatrists on university staffs are urged to discuss it with the law departments.

There was concurrence by the majority upon this section with a comment that the responsibility of psychiatrists in psychiatric hospitals to protect the community was not sufficiently stressed.

The majority also approved of sending this section of the report to the American Bar Association, the Legislative Committee of the Bar Association, and the state hospital superintendents.
III. ROLE OF THE STATE HOSPITAL IN PREVENTIVE PSYCHIATRY

What the state hospital can contribute to preventive work in psychiatry will vary greatly among such institutions. Those hospitals which are adequately supported and ably staffed can, of course, attempt much more than those where the patient-physician ratio is 500 or more to 1.

Preventive psychiatry, in contrast to clinical treatment, consists primarily in the utilization of social, educational, and medical devices to diminish anxiety, to combat unhealthy attitudes such as prejudice and false information, and to promote in the public sound, modern concepts of personality disorders and personality adjustment.

The primary contribution that the state hospital can make is to give good treatment and adequate care to its patients. Even today many public psychiatric institutions are regarded as grim depositories for the hopeless. If the state hospital can, as a first step, do a better job in treatment and send more patients back into the community recovered or improved, much will be accomplished to dispel the dread of psychosis as an inevitable, irreversible process.

This can probably do more to mitigate the stigma, superstition and unreasonable fear of mental illness than any verbal arguments.

Staff members of the state hospital, working with relatives of the patients, can promote in them a better understanding of mental illness and the factors that contribute to it. These relatives, in turn, will disseminate some psychiatric knowledge and combat false ideas in the community.

There are conflicting opinions as to the advisability of the state hospital undertaking directly such preventive measures as talks on mental hygiene, discussions over the radio, educational moving picture demonstrations, etc. Some maintain that the incorrect but prevalent concept of state hospital patients as the hopelessly demented will impede efforts in preventive work by its personnel. Against this must be weighed the possibility that such preventive work may modify this negative attitude and help the public to look upon the state hospital as an institution actively working against mental disorder and working with some measure of success.

If the state hospital does not deal directly with the public at large, its staff should work for the establishment and support of preventive agencies elsewhere, such as independent mental hygiene clinics. The knowledge of personality disorder acquired by the personnel of the state hospital can also be usefully applied in advising agencies, such as the radio and newspapers, and by school teachers and clergymen, who directly influence the public.

It is believed that physicians, nurses, social service workers and attendants connected with state hospitals should not live in isolation within the grounds of these institutions. If the personnel live out in the community and mingle freely with other citizens, this association will tend to dissipate ideas, still not uncommon, that everyone and everything connected with the treatment of mental illness is in some degree queer and set apart.

Agreement is general that the primary task of the state hospital in the field of prevention, is identical with its immediate job, the job of giving good treatment to its patients and so demonstrating that much personality disorder can be treated successfully.

So long as personnel is limited and financial support inadequate, we believe it desirable that the state hospital devote its full resources to this primary objective. It is, however, strongly recommended, when sufficient personnel and resources become available, that staff members work in mental hygiene clinics and with other directly preventive agencies. This, it is believed, would not only contribute to the total effort in preventive psychiatry but would also stimulate the hospital personnel, offset tendencies toward defeatism and the withdrawal into dead routines, and would broaden fields of interest.

It was the opinion of the majority that at the present time mental hygiene clinics should not be housed in psychiatric hospitals due to the stigma which the laity attach to the latter. The psychiatric hospital staff should have follow-up clinics for discharged patients; however, if they have clinics for community cases they should probably be housed elsewhere than in the psychiatric hospital. There was agreement as to the role of the state hospital in preventive psychiatry.

IV. COMMITTEE ON PUBLIC EDUCATION IN RELATION TO HOSPITALS

A. Need for Public Education Program

At the Rye, New York meeting of the Group for the Advancement of Psychiatry, (November, 1946) the Hospital Committee recommended the establishment of a Public Relations Office in the American Psychiatric Association. In March, a letter was sent to the Public Education Committee stating the importance of a public education program to psychiatric hospitals, and requesting special assistance. Public relations experts considered the requests of the Hospital Committee for assistance.

B. The Committee on Public Education recommended the following: that,

1. Every effort should be made to induce the American Psychiatric Association to secure a Public
Relations Officer as soon as possible and not await the selection and appointment of a medical director.* if adequate funds are not available for both positions. The need is immediate and no effective program of public relations can be developed and implemented without a paid public relations organization. However, provided funds are available, a medical director should be appointed, following which a public relations officer should be employed.

2. A national public relations program for state hospitals should receive strong emphasis and high priority.

3. It will be necessary for the Hospital Committee of the Group for the Advancement of Psychiatry to:
   State the objectives of such a program which the Hospital Committee believes are—
   a. To change the present misconception of mental disease held by the general public and by an appreciable percentage of the medical profession.
   b. Publicize the plight of the state hospital.
   c. Secure the necessary funds for personnel and adequate facilities for the proper care of the hospitalized patient, and as corollaries to the foregoing:
      (1) Spread the idea that mental disease is curable and that we want to cure more people of mental disease.
      (2) Also create a demand for better care and treatment in psychiatric hospitals.
      (3) Implement pressure of constructive public opinion in legislatures.

Supply necessary data and statistics which will be screened by the public relations office. This will be a continuing duty of the Hospital Committee.

4. Prior to the securing of a public relations officer the Public Education Committee will attempt, with its limited facilities and means, to edit when necessary and effectively disseminate such information as it receives from the various groups, including the Hospital Committee, making particular use of all professional organizations.

5. The Public Health Service and the Veterans Administration consider sending at regular intervals information of a statistical nature, when not confidential, regarding public psychiatric hospitals, to hospital superintendents and other interested individuals and organizations. Such information now in the possession of the Hospital Committee should be submitted to the Public Education Committee for appropriate dissemination.

6. Every hospital superintendent should make a continuous and strong effort to inform the community as to the needs of his patients. An informed local community may be said to be the grass roots of a public relations program. Initiative in public education must always come from local sources, and centralized effort on a national scale can consist only of coordination.

7. The Hospital Committee presents for consideration a proposal designed to fill a need that will not be met until a full-time public relations director is employed by the American Psychiatric Association.

The superintendent of a state psychiatric hospital should be offered assistance in the preparation of material he can use for public addresses, discussions or articles, as a part of his public relations program. Usually his personal schedule is so crowded that he has inadequate time for the preparation of such speeches and he is forced to refuse these opportunities for public education. It is recommended that ten members of the Group for the Advancement of Psychiatry each year prepare such material for presentation and that one informative outline be sent, each month, to the superintendents. This would serve as a suggestion of ideas and themes for their own speeches, or discussions, or newspaper articles, to be modified according to the local needs. The accompanying letter would clearly indicate that this prepared material was intended only as a source of ideas and facts which the superintendent or members of his staff could use as a frame of reference for presentation of local problems.

C. Statistics of Neuropsychiatric Disease

There is a lack of comparative statistics, especially economic, about psychiatric disorders in relation to other common medical disorders. Such statistics would be helpful in public education and as a basis for general orientation. The Hospital Committee asks that all Group for the Advancement of Psychiatry members refer sources of important statistics about these matters to Dr. Harvey Tompkins in the Veterans Administration, Washington, D.C. The Committee would particularly like to secure statistics on:
   a. The number of total cases and annual admissions to hospitals of tuberculosis, cancer, poliomyelitis.
   b. The amount spent in research on each of the above conditions and for research in mental disorders.

V. THE PUBLIC RELATIONS PROBLEM OF PSYCHIATRY

A. Aims of Public Relations
Mr. Harold M. Weeks, Vice-President of the John
Price Jones Corporation, served as consultant in public relations to the Hospital Committee. The following highlights are excerpted from his prepared remarks to the Group for the Advancement of Psychiatry:

Public relations is a course of conduct designed to move the public to take action in a desired manner. As such, it is distinct from education, publicity, and advertising. Publicity should be the process of making your course of conduct known to and appreciated by the public. Advertising, if you are in a commercial field, uses media for which you pay, to induce the public to buy your services or wares. It may also be used with publicity to implement a public relations program.

The charting of a course of conduct designed to move the public to take a desired action requires that you answer three questions:

1. What do you *want* to accomplish?
2. What are the *ideas* which should be implanted in the public mind to make it receptive to the desired action?
3. What organized effort is needed to effect this action?

First, you would like to have the public change its attitude toward mental ailments and toward psychiatrists—to regard mental illness as a medical problem just as cancer or heart disease—to trust and respect psychiatrists in the same manner that it does other doctors.

Second, you would like to move the public to make more adequate provision for the care of mental patients—to do something constructive to correct appalling conditions in our state psychiatric hospitals.

Third, you would like the public to provide more adequate means to increase, through research, the yet too limited base-line of knowledge which underlies your science; and to attract and train in this field a greater number of highly able men.

**B. Points for Action in Public Relations**

There is a "need to stimulate each individual psychiatrist in his public relations responsibility." The most important points for action are:

1. Talk a language the public can understand—and get other professional personnel to talk it.
2. Avoid bizarre statements.
3. Keep to your own field.
4. Don’t oversell your market beyond your ability to supply the demand.
5. Get your friends to fight for you.
6. Do all you can to break down the barriers which have isolated, and to a considerable extent, still do isolate, psychiatry and psychiatrists from the rest of medicine and the medical profession.

**C. Suggested Methods of Implementation:**

1. Establish a credo or statement of guiding policy concerning what you stand for and what you want to accomplish.
2. Establish an authoritative source of material and an authoritative body that is empowered to take stands promptly on any question.
3. Press your recommendation that the American Psychiatric Association take immediate steps to engage the services of a competent public relations man as director of public information.
4. Develop a clear cut program for action: reduce to specific terms immediate objectives and the funds required to do the job.
5. Raise some money to accomplish what you want to do.

The majority agreed that the American Psychiatric Association should be induced to secure a public relations officer.

The statements and recommendations made by the Committee on Public Education were subscribed to by a majority. It was suggested that too much emphasis is on a national rather than a community level.

**VI. COOPERATION BETWEEN LAY GROUPS AND PUBLIC PSYCHIATRIC HOSPITALS**

The Committee on Lay Groups expressed approval for the *use of the American Red Cross workers such as the Gray Ladies, the nurses aides, and occasionally Red Cross social workers.* The use of these Red Cross workers was considered to be a good mental hygiene measure for these volunteers themselves. It would promote good community relations. Hospital superintendents would take the public into their confidence to a greater extent if these volunteers were used. Superintendents should contact their local Red Cross chapters for their services. It was suggested that a screening or short training course should be instituted before these volunteers were used on state hospital wards. The Committee on Public Education or the public relations officer of the American Psychiatric Association should educate the public as to the need for these workers.

The Brooklyn State Hospital has developed the experiment of using these Red Cross workers. The Lay Groups Committee strongly encourages hospital superintendents to utilize these services.

Friends Services have been established and utilized in three hospital units: namely, Trenton, Rockland and the Clinton Reformatory for Delinquent Wom-
en. These workers are called psychiatric aides. The Committee heartily endorses Friends Services as another lay group which would be helpful in caring for state hospital patients.

The Committee does not yet know how much help could be obtained from Rotary International. Some initial contacts have been made. It was suggested that various unions, the Committee for Industrial Organization and the American Federation of Labor might be able to provide strong support.

The League of Women Voters, the American Association of University Women, and the Federation of Women’s Clubs might be most helpful in obtaining increased appropriations from legislators. It was agreed also that they would have great influence in any legislative action.

The Committee agreed that they should seek the help of the Junior Chamber of Commerce.

The Committee stated that all organizations named in the letter requesting help sent by the Hospital Committee will be written to enlist support.

The Committee was asked the question, “How can we use these lay groups?” The job of the Lay Groups Committee is to open channels for the Committee on Public Education.

State societies for mental hygiene are all being contacted. Eighteen or twenty of these have paid staffs so they can function properly and do some good. They have lobbyists for bond issues, appropriations, etc. Some 38 state societies exist.

The National Committee for Mental Hygiene has issued a new booklet, entitled “The State Hospital, A Guide for the Citizen.” This is designed for the intelligent citizen who is attempting to judge if his local state hospital is a good one. This booklet lists the good and bad points to look for in any state hospital. The National Mental Health Foundation also has a smaller booklet dealing with this subject.

Regarding professional groups, the Committee felt that the Group for the Advancement of Psychiatry could not make all of these contacts, but that we could stimulate the American Psychiatric Association to appoint a committee or to hire a man to make many of the approximately 100 contacts. The American Bar Association was written by this Committee. A long letter in answer returned the problem to us.

The Lay Groups Committee agreed that the U.S. Public Health Service statistics on mental disease, tuberculosis, cancer, and poliomyelitis, should be used and quoted by those of the Group for the Advancement of Psychiatry who are to give talks to lay groups. It was felt that copies of these statistics should be sent to all members of the Group for the Advancement of Psychiatry and to Hospital superintendents.

Regarding titles and outlines of lectures to give to lay groups or the public, the Committee felt these should be prepared by the Public Education Committee. Suggested titles for such talks were given by various members of the Committee as follows:

The Responsibility of the Citizen and the Community for the Care of the Mentally Ill. (Given by the Massachusetts Society for Mental Hygiene.)

An Ideal Day in an Ideal State Hospital.

The Newer Treatment for Acute Mental Illness.

The Modern Hospital as an Asset to the Community.

Disintegration of the Staff of the State Hospital during the War.

The Committee strongly felt that visits and tours of state hospitals and lectures to students and teachers and relatives would be helpful in improving relations with the lay groups. It was pointed out that the Veterans Administration is doing this.

An account of the possibilities of what lay groups can do is contained in the following excerpts from a letter from the American Red Cross.

“...The Red Cross has conducted since 1931 a rather extensive program of volunteer services in Neuropsychiatric hospitals of the Veterans Administration and in Neuropsychiatric wards of Army and Navy hospitals. Chapters have made available, upon the request of the commanding officer or manager and upon his assurance to provide necessary training and give proper supervision to volunteers, all of the corps of Volunteer Special Services to these hospitals. The Services by the Gray Ladies of the Hospital and Recreation Corps and, latterly, by members of the Arts and Skills Corps have been most widely used as an adjunct to the medical social service program. Specifically the activities of these volunteers consist of performing friendly services to patients and their visiting families; recreational activities on both an individual and group basis; elementary and advanced craft work in painting, sculpture, ceramics, leather tooling and so forth. A great variety of additional services of a personal nature are performed for the patients, and many of these volunteers act as instructors in music, language and in conducting library and other services.

“Because of the particular interest of Dr. Strecker’s committee (Advisory Board on Health Services, Division on Psychiatry, American Red Cross) in the provision of volunteer personnel to public psychiatric hospitals, especially those under non-federal jurisdiction, I am including certain information on the more limited Red Cross experience of placing volunteers in civilian psychiatric hospitals. Although our
records show that chapters have assigned volunteers
to such institutions intermittently since early in the
1930's, these experimental projects were few in num-
ber and their progress was dependent upon the initia-
tive of the chapter and its ability to carry them for-
ward without impairment of its primary respon-
sibility for supplying volunteer services to the federal
hospitals. Reports of such early projects in civilian
hospitals were received irregularly and are not as com-
plete as the later ones received since 1940. Of the
earliest ones we find that Gray Ladies performed a
number of personal services for the patients, assisted
in recreational projects, acted as hostesses for parties,
and as instructors in simple crafts. All reports in-
dicate that the hospital authorities considered the
services of the volunteers as extremely valuable and
some of the programs, such as that initiated in 1939
for State Hospital No. 2 at St. Joseph, Missouri by
the Gray Ladies have continued uninterrupted and
are still in operation.

"More recently a considerable number of chapters,
following requests from the hospitals, have expressed
an interest in providing volunteer service to institu-
tions of this kind. Some of these in which volun-
teers are now providing service are:

Arizona State Hospital, Phoenix, Arizona
Columbus State Hospital, Columbus, Ohio
Ohio State Hospital, Cleveland, Ohio
Rosewood State Training School, Baltimore, Md.
Springfield State Hospital, Sykesville, Md.
Brooklyn State Hospital, Brooklyn, N. Y.
Neuropsychiatric Section of Grasslands Hospital, West-
chester, N. Y.
Central Islip State Hospital, Central Islip, N. Y.
Pilgrim State Hospital, Brentwood, N. Y.
Boston Psychopathic Hospital, Boston, Mass.

"From reports it would appear that the programs
in the Ohio State Hospital at Cleveland and in the
Brooklyn State Hospital are the most ambitious and
provide the most extensive types of volunteer ser-
vice. The program at Ohio State Hospital began in
the early months of 1945 and at Brooklyn State
Hospital in September, 1946. Among the many and
varied services performed by volunteers in these hos-
pitals, as well as in the others, are the following:

Assist recreational instructors in planning par-
ties, such as dancing, table games, community
singing, music.

Play the piano for calisthenics; teach bridge,
ballroom dancing, etc.

Provide "skits and shows" of outside and
patient talent.

Act as hostesses for all types of group enter-
tainment.

Organize and help direct games of all types and
other recreational events.

Assist in patients' library and circulate books
and magazines on wards.

Instruct in simple and advanced crafts of various
kinds.

Read to patients and visit with them.

Shopping Service and other personal services.

"The response of hospital authorities of the insti-
tutions where the program is operating has been most
commendatory. Patient reaction has been extremely
favorable. It is a common occurrence for the patient
to express disappointment if for any reason one of
the volunteers is necessarily absent on her scheduled
day. Chapters also report that the volunteers them-
elves are greatly interested in performing needed
services of this kind and believe that it will not be
too difficult to recruit additional workers.

"The following excerpt is from the senior director
of the Central Islip State Hospital, Dr. David Cor-
coran, to the South Suffolk County Chapter, Central
Islip, New York:

'We see the Gray Lady service as a very valu-
able adjunct to the hospital program, not only
as expanding the services at present scheduled,
but also in the development of a new and unique
kind of experience for the patient. We further
welcome the corps as representative of the com-
community we serve, to whom we are most happy
to interpret our policies and program.'

"The limited experience of chapters thus far au-
thorized to engage in this activity points to the feas-
ibility of successfully conducting a program of this
kind. Much depends upon careful selection and
screening of volunteers to obtain persons of proper
attitudes, stability, and competence; obtaining the
cooperation of hospital authorities in properly
training and supervising these volunteers for service
in such institutions; finally in creating an interest in
and obtaining support from the community for such
institutions. I believe the Red Cross will pursue
cautiously the promotion of this type of volunteer
service on an expanding basis."

**SUMMARY**

Lay organizations offer one of the most fertile
fields for exploration, but this has been very much
neglected by American psychiatry.

There was almost unanimous agreement on the
recommendations in this section.
VII. REPORT OF THE COMMITTEE ON
PSYCHIATRIC SOCIAL WORK
THE PSYCHIATRIC SOCIAL WORKER
IN THE PSYCHIATRIC HOSPITAL

A. Introduction. In preparing for this report, your Committee sent questionnaires to 34 psychiatrists over the country, representing psychiatric hospitals of every kind, state, veterans', and private, requesting them to sit down with psychiatric hospital people in their area, superintendents and staff, medical and social work, and to send us the results of their discussions on present practices and desirable changes. Replies were received from 27 of the 34, reporting on the current status of social work in well over 100 psychiatric hospitals and presenting a great many fruitful and challenging ideas for the fuller utilization of social work skills in psychiatric hospital practice. As the replies came in, a series of meetings, 14 in all, were held by the Committee members and experts in the New York area, abstracting and coordinating the large mass of material. Our conclusions and recommendations, therefore, embody the thinking not only of your Committee and its staff of experts, but also of more than 300 psychiatrists and psychiatric social workers with extensive experience in psychiatric hospitals in all parts of the country.

B. The profession of psychiatric social work had its origin in the psychiatric hospital. The earliest administrative provision for the inclusion of psychiatric social work as a function of hospital service can be found in the 1910 plans of the Boston Psychopathic Hospital. The psychiatric social work program at Smith College School of Social Work was not established until 1918: the New York School of Social Work, not until 1919. While the over-all field of social work has since made enormous strides in the achievement of professional classification and status, social work in the psychiatric hospital has lagged far behind, stultified in its development by a parallel failure of psychiatric hospital psychiatry to keep pace with progress in its own field.

C. Our discussion of the place which psychiatric social work should assume in the psychiatric hospital rests upon a number of basic concepts concerning the function of the psychiatric hospital itself. In the first place, we consider that the treatment of the mentally ill is primarily a community responsibility, and that the hospital is a treatment facility of the community, rather than its dump-pile for the disposal of human wreckage. We see the goal of treatment as return to community living, with the fullest utilization of all medical resources for the personal, social, and voca-


tional rehabilitation of the patient. Finally, we regard treatment in the hospital as a total institutional process, rooted in medical responsibility, but with the psychiatrally oriented participation of every staff member, each contributing to the total process on the basis of clearly established administrative allocations of responsibility and of well-grounded and disciplined professional attitudes.

D. The social case worker deals with a wide range of social problems. To enumerate them would be to name the whole gamut of human ills, as unemployment, need for money, need for medical care, need for help in planning care of children, bad housing, need for help with a disturbed inter-personal relationship. In order to help people who at least momentarily are unable to cope with their own affairs, the social case worker must know the strains in the person's life. He must know what can be done about them and how to effect change in them. He must also understand what the person feels, how he deals with his feelings and what purpose his way of responding serves him in the light of present life pressures, past experience and future aspirations. It is only with this understanding of the person who has the problem and of its import to him in his present life situation, that environmental stresses may be effectively modified and the individual's participation engaged in the recovery of self-reliance.

E. Whether the individual's social problem originates in the external situation or within himself, in either instance it may be indicated that the social case worker renders services which meet practical reality needs. These services when rendered in relation to feelings and ways of responding may ease anxieties, relieve discouragement, give new confidence, and enable the individual to manage his affairs more competently. Along with or apart from these actual services it may be indicated that the case worker helps the person:

1. Through helping other people significant in his life.
2. To understand his situation better.
3. To become acquainted with or use available resources.
4. To clarify his indecision.
5. To discharge feelings and also to understand feelings which are obstructing constructive action or inducing destructive behavior.

F. The major areas of learning which the social case worker must experience, assimilate and integrate are:

1. Knowledge and understanding of normal human behavior.
2. Considerable knowledge and understanding of psychopathology.
3. An understanding of the interplay of family life and its import for the individual.

4. An understanding of community life and its impact on the individual and his family.

5. A comprehensive acquaintance with community resources and skill in using them in service for an individual and his family.

6. An understanding of the helping relationship and its management. This implies understanding what taking help commonly means to people and becoming acquainted with the various ways in which clients need to use the relationship. It implies also considerable self-understanding in order that the social case worker may regulate his own feelings and objectify his own emotional need in order that the persons dependent upon him for help may derive strength rather than be weakened through the relationship.

All this makes necessary, in addition to certain contents of knowledge, an orderly way of thinking which is attained through study and supervision.

G. Recommendations

1. Administrative Responsibility:
   a. The chief psychiatric social worker should be directly responsible to the clinical director of the hospital.
   b. The chief social worker should participate in policy making as related to social service functions.
   c. The social worker should begin her service and make her first contact with the patient on admission and should follow all the way through to final readjustment in the community.

Where a pre-admission service exists, the social worker can assist the psychiatrist in working out plans which may possibly avoid the necessity of admission.

When the patient is received the social worker may function in history taking and provide a dynamic and continuous social record.

2. Participation in Treatment Programs:
   a. Direct psychotherapy—under the direction of the psychiatrist and if the social worker is of special competence, to work with the patient toward the clinical goal which would “enable the patient to deal with reality problems with increasing emotional stability.”
   b. Indirect psychotherapy—to participate in on more superficial levels which may be termed manipulative or environmental.
   c. Group psychotherapy—under same limitations noted in a. above.

3. Family Care Programs:
   The social worker may participate in family care programs for adults and children. The Committee on Social Work feels that the social worker is the key person in a family care program and that she is the best fitted professional to accomplish the maximum possible in such a program. It is understood that the selection of the patient and the continuing medical and psychiatric care is the responsibility of the physician.

4. The Convalescent or Home Visit Care:
   The convalescent or home visit care of patients is an area of prime importance in the responsibility of a social service department. The Committee felt that if departments were very small their energies might best be devoted to this field.

5. In-service Training Program:
   a. The social service department should assume prime responsibility for students in social work and apprentices in social work. It is understood that they would receive assistance from the psychiatric staff.
   b. The social worker can participate in the education of residents in an effort to broaden their orientation in interpersonal relationships in several areas. It is also understood that residents will need experience in history taking.
   c. The social worker should participate in the training of non-professional personnel in the area of their own professional activities.

6. Volunteer Groups:
   Volunteer Groups are the primary responsibility of the clinical director for screening, training and assigning. The clinical director may choose to delegate this activity to the head of the department to which the volunteer is assigned.

7. Participation in a Research Program:
   a. Research into the effectiveness of social work methods.
   b. Procurement of data for other research programs being pursued in the hospital.

8. Community Activity:
   The social service department should play a definite role in the community interpretations of the department and of the over-all activity of the institution.

   The majority of the Group for the Advancement of Psychiatry membership agreed upon the recommendations in this section. Several members made special comment on the recommendation regarding psychotherapy: it is not the social worker’s primary function and special care must be taken to provide psychiatric supervision for those workers who do give it.
VIII. CLINICAL PSYCHOLOGY AS RELATED TO STATE HOSPITALS

A. It was stated that all discussion of the functions of clinical psychologists in state hospitals now, or in the foreseeable future, must be based on the realities that presently emerge.

Points relevant to clinical psychologists include the following:

1. Over 600,000 patients in state hospitals.
2. 209 state hospitals.
3. 125 psychologists employed in state hospitals.
4. 75 of these only "psychometrists."
5. Making 1 psychologist per 3600 patients.
6. At present 750 persons who could be reasonably considered "clinical psychologists" in the country:
   a. Of these 50 are working in state hospitals.
   b. 200 are working in the Veterans Administration.
   c. 300 are working in universities.
   d. 175 are employed in mental hygiene and child guidance clinics of all sorts.
   e. 75 are in private practice.
   f. 350 additional are in training.
   g. In Veterans Administration.
   (1) 550 of these in Veterans Administration.

(2) Veterans Administration considers a clinical psychologist properly trained when he has a Ph.D. and 3 years experience.

7. It is therefore concluded that there is no possibility of any extensive use of clinical psychologists in any function of the state hospital for some years, regardless of policies, salary offered, or any other consideration.

When it becomes possible, it was thought reasonable to recommend the use of 2 psychologists for each 2,000 bed state hospital, working up to a ratio (as proposed by Veterans Administration) of 1 psychologist per 300 chronic patients and 1 psychologist per 50 patients under intensive treatment.

It was recommended as particularly desirable for state hospital psychologists to set up a liaison with university psychology departments for supervision of psychological interns.

No special attention need be given to the areas of function of psychologists which are almost universally accepted, i.e., testing, research, teaching. It was accepted that psychotherapy, under psychiatric supervision, was a necessary and proper field into which the clinical psychologist should expand in the future.

As to the teaching functions of the psychologist, it was considered that this should develop not on fixed lines, but as the need or demand directed, for psychiatric residents, occupational therapy workers, nurses, etc. Best teaching techniques were considered to be of a concrete type, arising out of felt needs.

In regard to therapy, it was believed that both the chronic and acute case should be the objects of attention: that psychologists in training should have intensive work with the chronic patients primarily experimentally, to aim at determining ways of helping them. In short, it was considered time that the chronic cases be not held hopeless from a treatment point of view.

The Committee on Clinical Psychology stated its belief that the psychologist could do individual therapy especially when there are minimal facilities. The Committee is cognizant of the trend toward group therapy and of the hazardous belief that it is simple, easy, and delegatable to anyone. It actually is more complex, difficult to understand, and difficult to do, than any other form of psychotherapy. Individual or group psychotherapy must be under the supervision of an experienced psychiatrist who has the medical responsibility for the patient.

The majority of the group concurred in the recommendations made in this section.

IX. PSYCHIATRIC NURSING

A. Early in the preparation of the agenda for the meeting devoted to the state hospital, the Committee found itself face to face with a major problem—that of nursing care to patients in psychiatric hospitals. The persons most intimately in contact with the patient, and as a result one of the most important forces for good care and treatment, are the psychiatric nurses and the psychiatric aides.

A sub-committee within the state hospital group was formed to discover what could be done to improve psychiatric nursing in public psychiatric hospitals. Eighteen outstanding psychiatric nurses were asked to define the areas of concentration. Their replies stressed the following needs: to create the desire for and acceptance of psychiatric nurses in state hospitals; to define the role of the nurse, and her duties; to recognize the psychiatric nurse as a co-worker with the psychiatrist; to provide for refresher courses and staff education; to provide opportunity for professional growth; to increase number of nurses in state hospitals; to provide better training of instructors of attendants and better training of attendants.

The importance of psychiatric nursing is recognized and the Committee has had several meetings with leaders of this profession. A report covering this area will be made subsequently.
B. Comment on Attendant Training

We are aware of the inadequacy and often the entire absence of attendant training programs in state hospitals. It is strongly recommended that there be immediate development and implementation of such programs. The attendant training program now in operation in Veterans Administration hospitals deserves special commendation and we believe that state hospitals should adopt this program to their particular needs.

During the coming year, this Committee will give intensive consideration to this need and the various means of improving working conditions for the hospital attendant.

X. STATEMENT OF THE COMMITTEE ON SOCIAL ISSUES

The Committee on Social Issues is aware of the fact that racially discriminatory practices directed towards patients and personnel are prevalent in many psychiatric hospitals. This Committee has agreed that more information should be obtained before specific recommendations can be made to the Hospital Committee concerning:

1. The successful experiences in intercultural relationships in selected hospitals where racial prejudice is not practiced and
2. An increased knowledge of the social and psychological effects of racial segregation.

Our Committee is working on these phases of intercultural relationships in psychiatric hospitals and expects to integrate our findings at a later meeting.

XI. STATEMENT OF THE COMMITTEE ON PSYCHIATRY IN INDUSTRY

It has been demonstrated that psychotic patients can perform productive work in some industries without creating any animosities or becoming disturbing factors to their fellow workers. It must be taken into consideration that their supervisors were familiar with their mental condition, treated them as normal individuals and rated their behavior and productivity accordingly. This was especially true during the war years in many plants throughout the United States and suggests the need for a courageous attitude in our psychiatric hospitals in experimenting with the assigning of new patients to real tasks and responsibilities as quickly as possible after admission.

XII. MANUAL FOR RESIDENTS IN PUBLIC PSYCHIATRIC HOSPITALS

The superintendent of one of the largest state hospitals in the country called attention to the great need for a manual for residents in psychiatry.

The Hospital Committee wrote to 85 state hospital superintendents and asked their opinion. With the exception of a very small number, all of whom were in the relatively well implemented eastern hospitals, there was a fervent expression of need and desire for such a manual.

As many of the existing manuals, outlines of standard practices and pamphlets, were procured as are presently used by single hospitals and hospital systems in various sections of the country. They were analyzed as to content. From this analysis and from our own formulation, it seems quite apparent that there is a basic body of useful material which can be written. It is quite apparent that there is a segment of material that is specific to each State, and to each hospital, which, as we conceive of it, can quite easily be put, in loose-leaf form, into the skeleton or framework of the basic material.

A member of our Committee has prepared the first draft of such a manual. Revision and expansion will be made on the basis of constructive suggestions received.

XIII. REPORT OF THE COMMITTEE ON RESEARCH

A. There is a great problem in the stimulation of research in isolated public psychiatric hospitals which is current and active in spite of the scarcity of personnel and in spite of the caliber of available men. The problem of research is inseparable from that of education. Research is the outgrowth of educational processes. It begins with learning new solutions for practical every day problems. It is fostered by personal contacts with psychiatrists who are teachers and investigators and who will communicate their enthusiasms to the stimulation of curiosity.

Education, beginning where interest is most intense, may gradually raise interest to higher levels that warrant the dignity of the name research.

The practical problems of personal relationships are recognized as great. The number of solutions are of varying complexity.

1. Wherever possible, the departments of psychiatry of the universities of the State or area should take the responsibility for this type of education through courses in the school for doctors working in public psychiatric institutions and by visits of the faculty to state hospitals. Each state hospital system should be surveyed and practical methods for support and teaching developed.

2. The state mental health authority, through its psychiatric consultants should reach the professional staff and offer the liaison with the Public Health Service from which financial support can be received.

3. The clinical director of public psychiatric institutions should be stimulated to foster programs of research.

4. When possible, some traveling person or persons should voluntarily visit isolated hospitals or in
response to invitation, offer educational help and search out promising talents.

5. The Research Committee of the Group for the Advancement of Psychiatry will write a letter to state hospital superintendents offering assistance possible in planning and conducting research.

6. It may be feasible at some later date, through a publication sponsored by state hospitals, to disseminate, throughout the country, knowledge concerning research problems of varying priority in the manner of a research exchange.

These methods are not mutually compatible and may apply to various areas at different times. More detail of practical methods ultimately directed toward stimulating research will be developed.

XIV. THE REPORT OF THE COMMITTEE ON THERAPY

A. Being fully cognizant of the shortage of personnel in public psychiatric hospitals, the Committee on Therapy makes the following recommendations:

1. The superintendent of the hospital should be a well trained psychiatrist. He should have the first opportunity for sabbatical leave, refresher courses, etc., as it is believed that the level of therapy within the institution will depend upon the superintendent's interests and abilities.

2. The trained psychiatrist’s time should be used as efficiently as possible by relieving him of administrative burdens associated with maintenance of buildings, farms, etc. Wherever possible, general medical men should be used for routine physical care and annual physical examinations, vaccines, etc.

3. The trained psychiatric personnel should concentrate their efforts on the care of the patients with acute mental illness or on such other patients that seem amenable to intensive therapy. The use of individual psychotherapy, group therapy, and the auxiliary treatments such as “total-push,” electric and insulin shock treatment, narcotherapy, etc., should also be concentrated upon the acutely ill patients.

4. The custodial patients should have the benefit of improved physical facilities, grounds designed for free access to outdoors by disturbed patients, recreation facilities and a dynamic occupational therapy program. This occupational therapy program should be adapted to individual needs and should be integrated with the rest of the treatment program.

5. The attendants and other ancillary personnel should have training in the hospital system in which they work. Training should be directed toward allaying fear of disturbed patients, explanation of the dynamics of the patient's behavior, and toward the goals in therapy. There should be a clear delineation of the attendant's part in the over-all therapeutic program. Voluntary workers, such as Red Cross, Junior League, and others, can be of much help, if they are properly selected and supervised.

An out-patient clinic, not in a psychiatric hospital (except for follow-up of patients discharged from that psychiatric hospital) but in another location, is an important feature in the treatment program of any public psychiatric hospital. The clinic should function to treat patients with emotional problems so that in-patient care may be avoided if possible. Follow-up examinations for the in-patient on convalescent status may also be given. The clinic functions as a valuable stimulus to the hospital staff. Physicians should be rotated through the clinic for training. The out-patient department should keep many patients out of the hospital who would otherwise be hospitalized. The psychiatrist assigned to the clinic should see the patients, formulate the dynamics of the situation, make a diagnosis, and plan the treatment program.

a. Patients must be selected who will respond within a reasonable length of time and who can attend the clinic at the time set.

b. Other patients should be given supportive care during crises, but not be received for therapy.

c. The goals of therapy must be limited. Three groups of patients are recognized, those in which the treatment will consist of:

   Management of external problems with recommended modifications in the environment.
   Superficial attempts at enabling the patient to adapt to his symptoms.

   Efforts to change the patient.

   Treatment in the first type of case is carried on by the social worker and the psychiatrist. In the second and third groups it is the physician who must treat the patient directly. The psychologist aids in the formulation of the dynamics and does remedial work (speech training, reading disorders, etc.). Out-patient department personnel should consist of a team of a social worker and a psychologist for each psychiatrist.

B. Group Therapy

While group therapy is still experimental, it offers much hope for successful therapy. It enables one psychiatrist to give dynamic therapy to 15 to 20 patients per hour. The Veterans Administration and several state hospitals are exploring extensively the possibilities of this therapy upon psychotic patients.

1. Forms of Group Therapy

   a. Superficial—patients on admission may be immediately assigned to an orientation group. In this way other patients carry much of the burden of explaining the functions of hospital, treatment, etc. The physician assigned to direct a group must
be skillful and trained in this discipline. Patients stay in groups and are assigned a specific therapeutic program.

b. Group therapy after shock treatment—An attempt is made to explain and discuss adjustment to the shock in a psychological sense. The principal orientation is toward adjustment to reality situations, both in and out of the hospital. Attempts are made to prevent regression. The optimum size of a group and the length of group treatment has not been definitely determined at this time.

(1) Some hospitals have tried a modification of the Moreno technique with seven stock situations used to dramatize conflicts. No written script is employed. Situations patients may meet at home offer good subjects for dramatic therapy. Example: How the patient will interview a prospective employer. This variation of group therapy has been well handled by trained social workers in some hospitals.

c. Group therapy in advanced chronic schizophrenia—In this form of group treatment the patients work with each others' delusions, hallucinations, aggressions, etc. After a time they begin to discuss them on a reality basis. It is important that the physician be a person with deep understanding and feeling for schizophrenic patients. Daily meetings of an hour are recommended for the group. It has been observed that many patients were improved in behavior and morale. Physicians without extensive training, but with experience and understanding of psychotic patients may do group therapy provided they have personal instruction and supervision by a psychiatrically trained person.

C. It would appear useful to have a working definition of psychotherapy. Several were suggested by members of the Group for the Advancement of Psychiatry:

1. "Consistent working with a patient according to some definite plan of treatment."

2. "A part of psychiatric treatment that implies the consciously planned, responsible activity of the therapist in relation to a patient in an effort to improve the psychological adaptation of the patient in social, economic, sexual and physical function."

3. "Psychotherapy consists of any considered and competent medical endeavor utilizing psychological techniques directed toward improvement of the emotional health (in the biological, social and economic areas,) based on the understanding of the psychodynamics involved and the needs of the individual under therapy."

D. Further Needed Studies in Therapy

The Hospital Committee asks that the Committee on Child Psychiatry and the Committee on Therapy study the use of electric shock therapy in children. No mention of its use with children was made in the recent report on that subject by the Group for the Advancement of Psychiatry. The opinion has been expressed that electric shock therapy is harmful to children; this appears to be an area of disagreement that needs clarification.

It is planned to make further study of the criteria used in evaluating the results of treatment. At the present time there is a spectacular lack of consistency in the use of the terms "discharge," "parole," "on leave," "home visit," etc., that makes comparable data difficult to obtain.

A definite classification and definition of terms is an urgent need in order that the therapeutic efficacy of various hospitals may be compared and accurate statistics compiled.

The Committee on Therapy is asked to assist in formulating a practical plan for evaluating the results of therapy for a future report.

XV. COMMITTEE ON MEDICAL EDUCATION

IN RELATION TO HOSPITALS*

A. It is the belief of the Committee on Medical Education that psychiatric education of residents in state hospitals can be successfully achieved. The amount and degree of such educational endeavor will vary between separate state hospitals. However, the excellence of patient care and the general standards of the hospital will be improved by the presence of a teaching program. All state hospitals should attempt to achieve some measure of psychiatric education for residents but in some the training will be limited by the available facilities.

For practical purposes it is desirable to divide the training program into two groups. Some hospitals will be able to provide training only for first year residents. Other exceptional state hospitals may provide a full three year residency program with the prerequisites leading to American Board certification. In the first instance, it is expected that the first year residency hospitals will transfer their residents to other training centers for completed training.

The following standards are set up for hospitals approved for residency training:

B. First Year Residency Training

1. Requirements: It is understood that all hospitals approved for residency training will meet, as far as possible, the standards of patient care set forth by the American Psychiatric Association. By definition this


will mean that the hospital is making reasonable yearly progress toward meeting the standards of the American Psychiatric Association.

2. Personnel

a. Clinical Director. He shall be a diplomate, preferably by examination, in Psychiatry of the American Board of Psychiatry and Neurology. He shall not be overburdened by administrative duties and shall not be the assistant superintendent. His duties should be professional and not administrative.

b. Psychiatric Social Worker. The psychiatric social worker shall be a professionally competent individual who is a graduate of an approved school of psychiatric social work or of a school of medical social work offering a major in psychiatry. The worker should preferably be approved by the American Association of Psychiatric Social Workers.

c. Clinical Psychologist. The clinical psychologist should have graduate training in this specialty and should have at least a Master's degree. The clinical psychologist and psychiatric social worker will be assigned work in the hospital that is predominantly professional and under the direction of the clinical director.

d. Educational Director of Nursing. This nurse should have post-graduate training in psychiatric nursing on a level to comply in general with the suggestions of the National League of Nursing Education. The hospital should conduct under her direction, an active teaching program for nurses and attendants.

e. Occupational and Recreational Therapists. There should be competent personnel in the fields of occupational and recreational therapy and these should be persons registered in their respective disciplines if such personnel are available.

f. Consultants. There should be an adequate consulting staff in medicine, surgery, roentgenology, psychiatry, neurology, and the allied specialties. The consultants should be adequately remunerated and should be used in the teaching program. The medical and psychiatric consultants, if available, should be used for at least weekly visits and rounds and must be accompanied by the resident.

g. Pathologist. The services of a pathologist should be available. An effort should be made to secure autopsies in all fatal cases. Clinical pathological laboratories equipped for performing adequate routine tests must be available.

h. Supervisors. There should be other psychiatric staff members present who are competent and able to guide and supervise the work of the residents. There should be a ratio of at least one of such competent staff members, in addition to the clinical director, for every five residents and the ratio should preferably be smaller.

3. Library. This should contain adequate books and periodicals in accord with the approved lists and bibliographies of the Group for the Advancement of Psychiatry. A library of audio-visual aids is desirable also.

The Committee on Medical Education is preparing the following lists of basic reading:

- Minimal required reading for the American Board of Psychiatry and Neurology.
- Recommended reading for each level of psychiatric education.
- Complete bibliography of recommended selected articles and books.

4. Training Activity of the First Year Resident

a. The backbone of graduate training lies in intimate and sustained individual work with a limited number of patients. There should be an intimate relationship between the teacher and the student. Finally, the desirability of teaching the dynamic approach is stressed. There should be a minimum of four hours per day devoted by each resident to the continued study, treatment and observation of patients assigned to him. This may be in single hourly interviews but cannot be less than one-half hour per patient in cases assigned for training in psychotherapy. Based upon this the optimum case load per resident should not exceed 15 patients and on this basis he can see each patient at least every other day.

b. There should not be less than five hours per week devoted to teaching case seminars conducted by the clinical director. Administrative, diagnostic and trial visit conferences shall not be considered as teaching case seminars. These may be attended by the residents for their teaching value at the discretion of the clinical director.

c. There shall be one Journal Club per week to provide a stimulus for reading.

d. The utilization of the remaining time should be left to the clinical director, both as to content and method of teaching. In general we do not favor the use of the didactic lecture but believe that it may have some value in special situations. The clinical director should utilize this time for instruction in the various diagnostic procedures and methods of treatment and management, such as shock therapy, surgical treatments, and others, centering this teaching around the needs as they arise in the patients assigned to the resident.

e. The resident shall be required to participate
in the teaching of nurses, attendants, and others. He should be supervised in his teaching experience.

f. During the first month formal orientation seminars should be held by the:
   - Psychiatric Social Worker
   - Clinical Psychologist
   - Superintendent of Nurses
   - Occupational Therapist

In these seminars the purposes, functions, and the possibilities of these services should be discussed and illustrated. The instruction in these ancillary therapies should be continued regularly thereafter on the basis of discussion of cases assigned to the residents.

C. Training Activities of Second and Third Year Residents

In some state hospitals where facilities are available, or where affiliation with other hospitals makes facilities available, the following program is suggested. It should be noted that the second and third years are grouped together and a considerable variation can be effected in chronological order according to local needs and facilities.

1. Second Year
   a. Six months full time service in neurology.
      (1) One-half time in basic neurology including neuroanatomy, neuropathology, neurophysiology, and neuroroentgenology.
      (2) One-half time in clinical neurology. This would require a trained neurologist in charge of the instruction and adequate neurological material.
   b. Six months full time in specialized institutional psychiatry such as training school for the feeble-minded, epileptic, forensic psychiatry, penology, drug and alcoholic addiction, etc. This assignment would require an adequate schedule and supervision to be available in the hospital for assignment.

2. Third Year
   a. Six months of one-half time service and training in the psychiatric aspects of surgical and medical conditions.
   b. Six months of one-half time service in child psychiatry.
   c. Six months full time service in out-patient psychiatric service.
   d. During the three years of training the resident should be introduced to research methods.

Such a round of training can be achieved by the transfer of the resident from one state institution to another, bearing in mind the necessity for proximity to active psychiatric teaching centers. When necessary for practical administrative reasons or budgetary considerations, it will be possible to fulfill the American Board requirements by permitting the resident to work every other day in a training center and on alternate days to fulfill his obligations to the state hospital.

The program can be secured by the shifting of resident personnel from one locality to another, but it is the strong recommendation that this compromise be temporary and that the final solution include adequate administrative facilities for the detaching of a resident from his assigned state hospital to a training center for purposes of special instruction.

D. Survey of Opinion of the Group for the Advancement of Psychiatry

The Committee on Hospitals asked each member of the Group for the Advancement of Psychiatry to answer the following questions and also to make suggestions, criticisms and comments on the entire report.

1. Do you engage in any cooperative research in a state hospital or public psychiatric institution? If so, how many projects are currently under way?
   a. Fifteen had research projects under way.
   b. Are you supervising any research project in a public psychiatric hospital? Yes or No. If yes, how many projects?
      Fifteen had research projects under way.

2. Do you favor the establishment of a central department of mental health in each State?
   All of the Group were in favor of establishing a central department of mental health in each state with the following reservations:
   a. Yes, if there is a board of governors for each hospital.
   b. There should be an adequate civil service organization.
   c. There should be a tie-in with a medical school in order to assure high standards of professional work.
   d. Yes, in a large state, but in small states with only one hospital, no.
   e. The plan is generally all right but it would be better to have the mental hygiene program under the state health department.

3. Do you favor the requirement of several months service in a public psychiatric hospital as a requirement to medical licensure?
   The majority were against requiring several months interne service in a public psychiatric hospital as a requirement for medical licensure.
4. Would you favor the requirement of an exchange of interns between state and general hospitals for 2 or 3 months?

The majority decreed it impractical at this time for an exchange of interns between general hospitals and state psychiatric hospitals.

E. Facts About Nervous and Mental Disorders

The Hospital Committee agreed that essential facts and figures about the mental disease problem, its statistical and financial magnitude, with some comparisons with other illnesses, should be made available to psychiatrists. Such a formulation should give facts and figures in readily available form to meet some of the criticisms of psychiatry in public hospitals. Such facts should also give psychiatrists information for public education in these problems. It is the intention of the Hospital Committee to prepare such a fact sheet annually.

Average Census of Psychiatric Patients in Hospitals in the United States—

1946 635,769

(Four out of every 1000 persons in our population are hospitalized mental patients.)

Total Admissions to Nervous and Mental Hospitals in the United States—

1946 271,209

(Two out of every 1000 persons in our population are admitted each year to nervous and psychiatric hospitals.)

Number of Hospital Beds in the United States—

1946—General beds other than NP Beds 793,784

Nervous and mental beds 674,930

(41½% of all hospital beds in the United States are used for nervous and mental patients.)

Occupancy of Hospital Beds in United States—

1946—General Hospitals 77.4%

Nervous and Mental Hospitals 94.9%

(Only 51 out of every 1000 beds for nervous and psychiatric patients are unoccupied—an unsafe figure—considering possible emergencies, repairs, painting, refurbishing, etc.)

Number of Physicians in the United States—

December 31, 1946, Total 206,000

Psychiatrists 4,000

(4.7% of all physicians in the United States are psychiatrists.)

Ratio of Physicians to Population—

1946—Total 1 to 680

Psychiatrists 1 to 35,500

Number of Psychiatrists Needed in United States—

Total 20,000 or 16,000 additional Ratio 1 to 7,100 general population Ratio 10% of all physicians needed for psychiatry

Ratio of Physicians to Patients in Psychiatric Institutions—

1943—Physicians and Hospital Superintendents (State Hospitals) 3.6 to 1000 patients

1942—Physicians and Hospital Superintendents (State Hospitals) 3.8 to 1000 patients

(Staff shortages were extreme.)

Ratio of Graduate Nurses to Patients in Psychiatric Institutions—

1943—7.0 graduate nurses to 1000 patients

1942—7.5 graduate nurses to 1000 patients

(Shortages of graduate nurses were marked.)

Standards of American Psychiatric Association—

PSYCHIATRIC HOSPITAL:

1 Superintendent
1 Psychiatrist per 200 resident patients plus
1 Psychiatrist per 100 annual admissions
1 Social worker per 100 annual admissions

MENTAL HYGIENE CLINIC:

(For non-hospitalized cases in a general population of 100,000)

1 psychiatrist
1 psychologist
2-3 psychiatric social workers

Importance of Follow-Up Care (after Hospital Care)

1945—23% of admissions were readmissions.

Annual Cost of Hospitalized Nervous and Mental Patients in the United States—

TOTAL COST:

State Hospital 1945 $165,743,122
State Hospital 1943 138,491,553
V. A. Hospital 1946 55,087,173
V. A. Hospital 1943 29,382,762

PER PATIENT COST PER YEAR:

State Hospital 1945 $386.80
State Hospital 1943 335.84
V. A. Hospital 1946 1,288.45
V. A. Hospital 1943 841.12

(Costs are increasing each year.)

Cost to Keep a Patient in an Institution (Estimated)—

State Hospital—15 year period $8,100
Veterans Hospital—15 year period 15,000

Per Patient Expenditure for Maintenance—State Hospitals for Mental Disease—1945—

Total U. S. (182 hospitals reported) $386,80
SELECTED STATES:

District of Columbia 714.67
Wisconsin 563.11
New York 512.34
Illinois 490.11
New Hampshire 479.60
Michigan 468.89

(Eight states reported less than $250 per patient cost.)

Total Annual Cost for Hospital and Institutional Care: Mental Disease, Mental Defectives and Epileptics—

1945—$300,000,000
1943—192,243,000

Residency Training in Psychiatry—

All hospitals with psychiatric residencies 159
General hospitals with psychiatric residencies 48
Total residencies in psychiatry 207

Comparative Statistics—Major Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>Total Number of Patients—1946</th>
<th>Deaths Per Year—1945</th>
<th>Death Rate*</th>
<th>Money for Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>500,000 to 600,000</td>
<td>174,46</td>
<td>134</td>
<td>(not available)</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>117,910</td>
<td>52,916</td>
<td>41.3</td>
<td>$6,500,000</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>25,191</td>
<td>1,186</td>
<td>.85</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>Nervous and Mental diseases</td>
<td>800,000 to 900,000</td>
<td>50,000**</td>
<td>69**</td>
<td>$3,000,000</td>
</tr>
</tbody>
</table>

* per 100,000
**estimated (1943 deaths totaled 51,218)
1945 U. S. Civilian Medical Bill
(health services, all types) $6 billion
Paid by patients and their families $4 1/2 billion (approx.)
Paid by government, industry and
voluntary agencies 1 1/2 billion

Average Daily Number of Disabled Persons in Labor Force
2 to 2.4 million (1945)
Estimated wage loss $3 to $4 billion annually

Average daily number of disabled persons never in labor force
or with prolonged disability 5 to 6 million (1945)

XVI. PSYCHIATRIC BIBLIOGRAPHY:

Basic Books

Because of differences of opinion and difficulty in reaching
unanimity, it seemed desirable to ask one of our members to
prepare a list of basic reading in psychiatry. This is important
not only for medical students, but for residents in psychiatry,
especially those preparing for examinations by the American
Board of Psychiatry and Neurology. The committee asked
Karl Menninger to prepare a list for this purpose. Such a list we
thought would be a great help in orienting the basic reading of
residents and physicians in public hospitals far from medical
centers, who have little opportunity for guidance in their
training. It is hoped that in a subsequent report of the Hospital
Committee a comprehensive psychiatric bibliography will be
published in collaboration with the committee on Medical Edu-
cation.

LIST OF SUGGESTED BASIC READINGS IN PSYCHIATRY
WITH WHICH EVERY QUALIFIED PSYCHIATRIST
SHOULD BE FAMILIAR

Prepared originally at the suggestion of Dr. Kenneth Appel,
chairman of the Committee on Hospitals of the Group for the
Advancement of Psychiatry by Dr. Karl Menninger, assisted by
Dr. George Devereux and numerous colleagues of the Winter
VA Hospital, Menninger Clinic and the Group for the Advance-
mement of Psychiatry. This list is subject to change and cer-
tainly additions will be made.

NEUROLOGY

or Thomas. 3rd edition, 1943.

Brain, W. Russell.—Diseases of the Nervous System. New
or York, Oxford University Press, 1933.

Brock, Samuel.—Basis of Clinical Neurology. Baltimore,
or Williams & Wilkins. 2nd Edition, 1945.

Spurling, R. Glen.—Practical Neurological Diagnosis. Spring-
field, Ill., Charles C. Thomas. 3rd edition, 1944.

PSYCHOLOGY

Hunt, G. McV.—Personality and the Behavior Disorders.
(editor) 2 volumes. New York, Roland Press, or
1944.

Murphy, Gardner.—Personality. New York, Harper & Bros., or
1947.

Murray, H. A. et al.—Explorations in Personality. New York,
or Oxford University Press, 1938.

Allport, G. W.—Personality: A Psychological Interpretation.

PSYCHOLOGICAL TESTING

Rapaport, David et al.—Diagnostic Psychological Testing.

PSYCHOPATHOLOGY

Tomkins, Silvan S.—Contemporary Psychopathology. Cam-
bridge, Mass., Harvard University Press, or
1943.

Maslow, A. H. and Mittelmann, B.—Principles of Abnormal

Menninger, Karl—The Human Mind. New York, Alfred A.

HISTORY OF PSYCHIATRY

Deutsch, Albert—The Mentally Ill in America. New York,
or Doubleday, Doran & Co., 1937.

Zilboorg, Gregory—A History of Medical Psychology. New

PSYCHIATRIC EXAMINATION

Appel, K. E. and Strecke, E. A.—Practical Examination of Personality
or Behavior Disorders in Adults and Children.

Noyes, A. P.—Modern Clinical Psychiatry. Philadelphia,
or W. B. Saunders, 2nd revised edition, 1939.

PSYCHIATRIC SYNDROMES

Henderson, D. K. and A Textbook of Psychiatry. New York,
or Gillespie, R. D.—Oxford University Press, 1927.

Strecke, E. A.—Fundamentals of Psychiatry. Philadelphia,
or Lippincott, 3rd edition, 1945.

Kraepelin, Emil—Dementia Praecox and Paraphrenia. Edin-
burgh, E. & S. Livingstone, 1919.

Jung, C. G.—The Psychology of Dementia Praecox. New York,
or Nervous & Mental Disease Publishing Co.,
or 1936.

Janet, Pierre—The Major Symptoms of Hysteria. New

Jellinek, E. M.—Alcohol Addiction and Chronic Alcoholism.
New Haven, Yale University Press, 1942.

PSYCHIATRIC ADMINISTRATION

Norton Co., 1936.

PSYCHOTHERAPY

Levine, Maurice—Psychotherapy in Medical Practice. New

Wolberg, L. R.—Hypoanalysis. New York, Grune and or
Stratton, 1945.

Gill, M.

MILITARY PSYCHIATRY

Grinker, Roy R. and Spiegel, J. P.—War Neuroses. Philadelphia, Blakis-
oron, 1945.

Menninger, W. M.—Psychiatry in a Troubled World. New

CHILD PSYCHIATRY


or Freud, Anna—Psychoanalysis for Teachers and Parents. New


PSYCHIATRIC NURSING


SOCIAL PATHOLOGY AND CRIMINOLOGY


PSYCHIATRIC SOCIAL WORK


INDUSTRIAL PSYCHIATRY


RELIGION AND PSYCHIATRY


ANTHROPOLOGY AND PSYCHIATRY


MALINOWSKI, B.—The Sexual Life of Savages in Northwestern Melanesia. 2 volumes. New York, Hor- ace Liveright, 1929.


PSYCHOANALYTIC THEORY, ELEMENTARY


PSYCHOANALYTIC THEORY, ADVANCED

FREUD, SIGMUND—The Basic Writings of Sigmund Freud, or New York, Modern Library, 1938.


PSYCHOANALYTIC THEORY, APPLIED


PSYCHIATRIC MEDICINE [PSYCHOSOMATIC MEDICINE]


MENTAL HYGIENE MOVEMENT


SUPPLEMENTARY LIST OF STRONGLY ENDORSED BOOKS


MEAD, MARGARET—From the South Seas. New York, Mor- row, 1939. (This includes Coming of Age in Samoa, Growing Up in New Guinea and Sex and Temperament in Three Societies.)