THOMAS P. DETRE
DAVID J. KUPFER

GENERAL HOSPITAL PSYCHIATRIC SERVICES

American Handbook of Psychiatry

General Hospital Psychiatric Services

Thomas P. Detre and David J. Kupfer

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Table of Contents

General Hospital Psychiatric Services

Historical Background

The Role of the General Hospital in Mental-Health Care

Treatment Model for A General Hospital Psychiatric Unit

The Point of Entry

Inpatient Service

Outpatient Services

Conclusion

Bibliography

General Hospital Psychiatric Services

Historical Background

> Considerations of a social nature quite outside the scientific or medical aspect of the subject have led to patients suffering from mental disorders being kept separate from other patients and dealt with in an exceptional manner.
>
> Some social reasons for the separation have ceased to exist. The superstitious ideas which less than a hundred years ago were associated with the occurrence of insanity have ceased to be entertained or, at least, to have any practical influence.

Thus wrote Sir John Sibbald in the first issue of the *Review of Neurology and Psychiatry* published in England in 1903. Sibbald continued.

> Let us now look for a moment at some of the reasons which make the treatment of mental disease in general hospitals desirable. Such wards have an advantage over an asylum of saving the patient from the mental shock which is often felt upon entering an institution largely devoted to the care of the incurably insane. . . . Wards for mental disease need not be distinguishable from other wards and residence in such wards does not entail the industrial and social injury which follows residence in an asylum.

Almost sixty years later in 1961, the Joint Commission on Mental Illness and Health of the United States took a nearly identical position, declaring that: (1) no community hospital can render complete medical services unless it accepts mental patients; and (2) each hospital should become a focal point of a community-oriented psychiatric program. This endorsement has given

further impetus to the development of general hospital psychiatric services, a trend which started in the 1920s and accelerated quite rapidly after World War II.

As far as we know, it was in 1755 when the first psychiatric beds were set aside for the "cure and treatment of lunatics" at the Pennsylvania Hospital in Philadelphia; but it was not until 1902 that the first autonomous inpatient unit, the famous Pavilion F, was established at the Albany Hospital. Its director, J. Mosher, claimed considerable success when he announced in 1922 that 15 percent of all psychiatric patients admitted were able to return to the community. By 1942, when the Pavilion was under the direction-of Dr. E. Cameron, 82 percent of the patients admitted and treated were said to have returned to the community.

These early experiments notwithstanding, the majority of general hospital psychiatric services prior to World War II were sub-departments of neurology or neurosurgery, and functioned primarily as diagnostic centers and triage stations. The excellent results achieved in Army hospitals, most of which had provisions for the treatment of psychiatric patients, rapidly dispelled the prevailing concern that the treatment of mentally ill patients in a general hospital was impractical or disruptive. Statistics compiled from various military hospitals in the 1940s showed that while the average stay of their psychiatric patients was approximately sixty days, patients presenting

symptoms of panic, depression, confusion, and other acute psychiatric problems required only brief hospitalization. Thus, such units functioned in a manner analogous to other units caring for acutely ill patients. Moreover, there was no evidence that the presence of psychiatric patients was in any way disturbing to the rest of the hospital. On the contrary, the hospital staff from other specialties acquired considerable sophistication in dealing with psychological problems encountered in medical practice which proved particularly beneficial in the management of the so-called psychosomatic disorders (Brill, 1947).

Public acceptance of such inpatient psychiatric services grew rapidly. By 1952, 205 of the 1600 larger hospitals in the United States had fairly adequate units with fifteen or more beds (Bennett, 1956) and less than ten years later psychiatric beds in general hospitals exceeded the number of beds in mental hospitals (Straker, 1971). The rise in the number of psychiatric inpatient units in general hospitals since that time has been even more striking: in 1964, there were 536 such units; in 1967, there were 694; and in 1970, there were 766 with the greatest increase occurring (71 percent of the total) in the voluntary hospital.

A survey undertaken jointly by the American Psychiatric Association and the National Association for Mental Health in 1965 (Glasscote, 1965), revealed that approximately 85 percent of all general hospitals had inpatient

psychiatric units, and that the majority of these units had broadened the scope of services they provided. While some of these units still had seclusion rooms, over two-thirds of the units were "open" services. Relatively liberal admission policies were practiced in 85 percent of all general hospital psychiatric services in that they were admitting patients who were assaultive, suicidal, abused alcohol or other drugs, or had problems which fell into the domain of geriatric psychiatry. Despite the fact that over one-half of the hospitals reporting had no explicit limitations on the length of stay, the average duration of hospitalization was about twenty days. Only in university-based teaching hospitals was the average stay longer. Increasing confidence in the effect of these units was also reflected by third-party payers. At least one-half of the patients admitted had some kind of health insurance which covered a substantial portion of their charges.

From a statistical point of view the treatment approach to patients admitted to these inpatient services appeared quite eclectic and included chemotherapy (91 percent), individual psychotherapy (72 percent), occupational therapy (70 percent), electroshock (67 percent), recreational therapy (60 percent), and group psychotherapy (25 percent). Nonetheless, until about 1960 treatment programs essentially followed two models: patients would receive either psychoanalytically oriented treatment or a therapeutic regimen consisting primarily of the so-called biological therapies (such as drugs, electric shock and, in some instances, insulin coma) with little

else in the way of psychological care.

This particular polarization in treatment philosophies has easily identifiable historical roots. During the late 1930s the Meyerian psychobiological approach was superseded by the far more etiologically oriented psychoanalytic approach whose proponents believed that, given sufficient time and proper training, definitive treatment of psychiatric disorders was possible. This view stood in sharp contrast to the organically oriented approach whose proponents believed that symptomatic relief rather than "cure" was the only realistic aim of treatment. What both camps had in common was the conviction that the physician is the only important therapeutic agent, a conviction that was clearly reflected by the staffing patterns in nearly all hospital psychiatric units. Although many of these units had at least a part-time psychiatrist-administrator, with the exception of occupational and recreational therapy, all treatment was primarily administered by the patient’s own psychiatrist, rather than by a psychiatrist retained by the hospital.

One logical outcome of this trend was the lack of concern for aftercare facilities since in principle, at least, the doctor who took care of the patient while he was hospitalized was supposed to provide all treatments after discharge as well. Up to the mid 1960s, 36 percent of those hospitals which had inpatient psychiatric units did not have outpatient facilities. Partial

hospitalization or other types of aftercare services were made available to only a selected few; even patients who could afford psychiatric care after discharge from the hospital had difficulties getting outpatient treatment at the same facility. Nor were hospital administrators very eager to develop outpatient facilities; at the time health insurance provided little or no incentive to the establishment of ambulatory services.

With the growing recognition that the patient's needs were not met by either a strictly insight-oriented psychotherapeutic approach or a purely organic approach, the polarization which characterized the psychiatric scene during the 1940s and 1950s began to diminish in the 1960s. Moreover, as advances in psycho-pharmacological treatment made the management of even severely disturbed patients feasible, it became clear that merely hospitalizing the patient in his own community rather than in a state facility did not automatically diminish the adjustment problems he had to face upon discharge. It became no less obvious that we could not simply transplant the psychotherapeutic approach, which was being utilized with varying degrees of effectiveness in private practice, to a hospital setting. The purely organic approach also proved disappointing, for it was soon discovered that unless the clinician is prepared to deal with the patient's social and family-support structure to insure compliance even biological treatments of proven value are doomed to failure.

Gradually the emphasis shifted to an approach which aimed to clarify the patient’s relationship with his family and community, and provide him with social clues around which he could orient himself and increase his adaptive skills (Detre, 1961). By the mid-to-late 1960s, many hospitals had intricate and often well thought-out social treatment programs which were generally classified as "therapeutic communities." This development resulted in a de-emphasis of individual psychotherapy and increasing participation of staff nurses, social workers, psychologists, and other health professionals in the life of these units. With the counterculture then in full swing, it became possible or even fashionable to talk about one’s self with a greater degree of frankness than was ever possible in the past. Therapy for couples and families, and various group therapies became acceptable modes of treatment, thereby adding a new dimension to psychiatric care and actively involving the patients, their family, and the community at large.

The Role of the General Hospital in Mental-Health Care

In less than three decades the concept of treating psychiatric patients in the general hospital has been enthusiastically endorsed and implemented throughout the United States. As health professionals and the public began to regard it as the most desirable setting for the care of the mentally ill, the general hospital became for several reasons a community resource of unparalleled medical and psychological importance. Its primarily urban

environment made recruitment of competent personnel easier. The availability of sophisticated diagnostic facilities, together with a multidisciplinary approach to patient care and a wide range of services, were not easily matched by a psychiatric "specialty hospital." Then, too, the public image of the general hospital has always been very different from that of a mental hospital. Never the kind of "last resort" where people went only when they were very ill, the general hospital was also a place of joy where one's children and grandchildren were born. Families, already accustomed to receiving help for "physical" illnesses were less fearful of being admitted to the general hospital for psychiatric care than to other mental-health facilities. Families, friends, and employees were less reluctant to visit and maintain contact with the patient, and were more inclined to help his reentry into the community when he was discharged.

The acceptance of psychiatric services by other medical specialties has also rapidly increased. Psychiatrists became available and responsive to requests for consultations on difficult diagnostic and management problems throughout the hospital, demonstrating convincingly that psychological care is basic to the comprehensive care of all patients. As the psychiatrist became a more active participant on the hospital medical staff, administrators of small institutions, rather than erecting specialized units, began to show a willingness to experiment by admitting psychiatric patients to medical services, and found it a less costly and successful alternative (Reding, 1973;

Castelnuovo-Tedesco, 1957).

Paradoxically, along with the innovations that seemed to broaden the scope and increase the effectiveness of psychiatric services in the general hospital, there came expressions of concern about problems that were not solved or might even have been aggravated by the establishment of these units. Despite a substantial decrease in the average length of inpatient stay and a more realistic determination of treatment goals, the early hopes that the number of patients admitted to state hospitals would diminish remained unfulfilled. A thoughtful study comparing the psychiatric services of the Strong Memorial Hospital and the Rochester State Hospital found that the general and the state hospital did indeed serve different segments of the population (Gardner, 1964). Many patients suffering from chronic organic brain syndromes associated with arteriosclerosis and other disorders of the senium, as well as patients who were first treated in a university hospital but subsequently relapsed, tended to drift to the state hospitals. Soon accusations were leveled at general hospital psychiatric services charging that the only advancement they had made was to siphon away "good patients," leaving the state hospitals with increasing numbers of deteriorated patients, and lending further credence to their already dubious distinction as "warehouses of the unwanted."

That the general hospital tended to concentrate on those patients who

are most amenable to short-term intensive care, largely ignoring those whose prognosis was guarded or poor, also raised questions about the quality of training provided in these settings. Many medical educators felt that being exposed primarily to patients who tended to improve in a matter of days or weeks would cause health personnel to become less tolerant of frustrating and difficult cases; this would, in turn, result in less learning about the chronically ill who are in greatest need of effective care. Criticism was also directed at those general hospitals operating in close proximity to ghettos and other socioeconomically deprived neighborhoods as they seemed to be ignoring the mental-health needs of the poor. Although patient-flow statistics have revealed that these accusations were not without foundation, the causes were often fiscal. Many hospitals found themselves unable to absorb the cost of patients who did not have health insurance and made exceptions only when there was a concomitant need for medical and surgical services.

To complicate matters further, at this time in the 1960s, the community mental-health-center movement also became a potent health-delivery force and began to compete actively for patients. The community mental-health centers were mandated to develop certain essential services which included, besides inpatient services, partial hospitalization and extensive aftercare services. The aim of these centers was to change the locus of treatment from the state mental hospital to a new type of health facility in the hope that they could, within a decade or so, cut the census of the state mental hospital by 50

percent. Since the general hospital has been accused of losing sight of socioeconomic factors and emphasizing the medical aspects of psychiatric care, the community mental-health centers moved rapidly to establish outreach services and, making use of community workers, managed to reach a whole new group of "consumers" who previously would not have thought to avail themselves of psychiatric services. But the mental-health centers tended to be dominated by an almost exclusively psychosocial view of the etiology and pathogenesis of mental illness and concentrated primarily on social intervention; hence, they usually fell short of assuring the poor what they needed most—comprehensive health care.

To recapitulate, we ended up with the community mental-health-center program in addition to the already existing state psychiatric hospitals, the private specialty hospitals, and the general hospital psychiatric-care system. Although all four were competing for the acutely ill, some movement toward consolidation began as general hospital psychiatric services (and to a lesser extent, specialty hospitals) became essential components of the community mental-health centers. In fact, by 1973, in almost 40 percent of all the 353 community mental-health centers, general hospital psychiatric services provided at least one segment of their mandated services.

One deplorable consequence of this haphazardly developed program of psychiatric care has been an economically bifurcated system of care. Rather

than a selection based on the patient's needs and the availability of specialized facilities, the general hospital and specialty hospital tended to admit patients who could afford hospital care, while the community mental-health centers concentrated primarily on the poor. Furthermore, since all three preferred to care for the acutely ill, each continued to refer their chronically ill patients to the state hospital system. Neither the general hospital nor the community mental-health system were suitably organized to provide care for children. The separatist attitude prevailing in child psychiatry tended to minimize joint planning efforts in both general hospitals and community mental-health centers, and as a result very disturbed children and young adolescents continued to be sent to the state hospitals. Thus, while the overall population in these state institutions has been steadily declining for the past twenty-five years, practically all their new buildings have been devoted to the care of children. Embarrassingly little has been done to assure adequate care for patients with long-standing disabilities as well. To be sure, many patients with chronic schizophrenia, a personality disorder, or an organic brain syndrome now find their way into acute treatment facilities and have a better chance than in the past to receive an adequate evaluation. Given the scarcity of aftercare facilities and the lack of coordination between hospital and community facilities, however, these patients have been compelled to continue their pilgrimage together with many elderly patients for whom the state hospital is often the only accessible facility.

Not even the alcohol and drug-abuse programs, that have been rather lavishly funded by the federal government over the past few years, are free of problems. While these programs do provide psychiatric care, they seldom offer the quality general health care so sorely needed by this kind of patient.

As mentioned earlier, the reasons for these inadequacies were rooted in poor planning. What little systematic planning was done was based on the erroneous assumption that most of the psychiatric patients are acutely ill and need help for a limited period when, in fact, the majority of patients who are ill enough to be hospitalized tend to have a long history of marked social dysfunctioning and cannot easily reinsert themselves into the community without a vast, well-organized and well-funded network of human services.

The uncritical application of social psychiatric principles became still another source of problems. For instance, the finding that schizophrenia, particularly in its chronic form, most frequently occurs in the socioeconomically disadvantaged led to the erroneous conclusion that the single most effective treatment for this disorder is psychosocial with the result that many centers were reluctant to provide drug-maintenance therapy for their patients. Another version of this psychosocial view, which blended a bit of psychoanalytic thinking into its fabric, produced the conviction, again without proof, that "intensive" family therapy was effective in treating and maintaining schizophrenic patients in the community.

We sang the praises of therapeutic communities and liked being part of them, but despite our pleasant experiences we learned that the milieu in itself is no panacea for the treatment of severe disorders. We have been reminded by insurance commissioners that not everyone who likes to be in them needs them. We also came to realize that the Community Mental Health Center Act did not provide sufficient funds to cure the urban ills of poverty and inadequate housing, poor nutrition and general health care, and that even if such economic and social measures should come to pass and succeed in altering the "urban picture," it is still uncertain whether we would have substantially reduced the number of individuals in need of specialized care because they are mentally ill.

Finally, some of the facilities and services we have designed were fiscally unsound. The eternal dilemma of any health facility located in an urban area, be it a mental-health center or a general hospital, is the cost of operating such institutions on expensive real estate. Funds needed for extensive reeducation and occupational rehabilitation are prohibitive and often consume the budget intended for specialized services, ultimately diminishing the quality of care offered and the numbers of well-trained professionals who are responsible for health care.

Treatment Model for A General Hospital Psychiatric Unit

Since a national plan for psychiatric care is still lacking, the role to be played by the general hospital psychiatric services in the care of the mentally ill remains to be defined. We now have a number of pressing questions which we will never be able to answer fully until such a national plan is put forth. What psychiatric services can the general hospital provide and for what kinds of patients? What role will it play in the early identification of cases and the rehabilitation of patients in the area it serves? How would it relate to other facilities in and outside the community? Which of its functions will it perform directly and in what others would its responsibility be primarily a coordinating one? And what kind of organization would be most consistent with its designated role?

The Point of Entry

It would seem logical to look at the general hospitals as regional centers and the gate of entry for all patients entering the mental-health delivery system. This approach would stress the overall quality of general health care and would lead to the identification of non-psychiatric problems that may be associated with, aggravated by, or even causing what appears to be psychological distress. While a screening system of this kind may appear unnecessarily cumbersome and expensive— regardless whether individuals with a longstanding psychiatric disorder are more subject to all forms of nonpsychiatric morbidity or, conversely, that a certain percentage of the

population show a generalized propensity to disease-—there is ample evidence that a significant percentage of patients with psychiatric problems come with a previously unidentified nonpsychiatric disorder that requires medical attention (Eastwood, 1972; Straker, 1971).

If indeed the general hospital is a logical point of entry for all patients in the mental-health-treatment system, it follows that one of the principal gates for entry, the emergency room of the general hospital, is not suitable for the task as it is currently structured. The utilization of emergency rooms is very high for all types of problems. This is due to the increasing "ghettoization" of the urban population and the flight of the middle and upper classes to the suburbs. This outward movement has left a medical-care vacuum for the slum poor. Yet the need to serve this urban populace cannot be met by an environment which underemphasizes the stresses of life, and the resulting reactions to it, by pretending that psychiatric emergencies are like other medical emergencies.

Among those who seek help there is a large group in which poor impulse control, antisocial behavior, promiscuous use of drugs, and personality disorders are quite common. Since this group as a whole has enormous difficulty using any set of supportive services appropriately, providing care for unscheduled admissions is a very important community need. Although storefront clinics may have their place in consumer education,

attempts to reduce the number of unscheduled admissions by setting up outreach services have not been particularly successful. Rather than constructing outreach facilities in the relative vicinity of a well-equipped hospital, it may make far more sense to operate home-care services for problem-ridden areas directly from the hospital and provide transportation to and from the facility for those who have to be evaluated in a medical setting without delay.

The majority of those who come to an emergency room for psychiatric treatment are in the midst of an immediate crisis and are seeking human contact, not active treatment in the conventional sense. The health-care delivery system's inappropriate emphasis on medical expertise and its under-emphasis upon social support and human services has prevented it from providing considerate and thoughtful attention to patients in need (Coleman, 1968). This lack of understanding of the patient's life situation is also reflected in current clinical procedures. Although the individuals who present themselves to the emergency room tend to be unreliable informants, the history is traditionally taken from the patient alone and all decisions are usually made on the basis of the data he provides.

If the psychiatric services in general hospitals were to be designated regional centers tied to satellite units with a clear mandate to make management and treatment decisions for a specific geographic area, all

scheduled and unscheduled requests for psychiatric consultations and admissions should be processed through an information-reception center (IRC), rather than through a traditional emergency room or outpatient admission unit. The purpose of the single-portal entry would be: (1) to register the patient upon entering the treatment system, collect the necessary demographic, fiscal, and clinical data, and pursue appropriate sources for additional information when necessary; (2) to have personnel available capable of assessing the patient's needs and referring the patient to the appropriate treatment facility within or outside of the system; (3) to assure that all data relevant to diagnostic and treatment decisions reaches the facility to which the patient has been referred; (4) to monitor the patient's movements throughout the various treatment systems and maintain a continuously updated central record system; (5) to coordinate all auxiliary assistance from the community, public welfare, family, physicians, visiting nurse, and other personnel, thus insuring optimal care and preventing wasteful, multiple utilization of community resources; and (6) to conduct research to identify backup facilities and initiate action where the appropriate facilities are lacking.

It is important that the clinical assessment completed in the IRC provide the information necessary to determine the actual treatment plan and/or disposition. In addition, the IRC should be appropriately staffed to provide consultation to the nonpsychiatric divisions in the general hospital as well as

to staff, and coordinate home-service teams capable of providing assistance or consultations whenever the patient or the family is unable or unwilling to come to the hospital. The degree to which consultation services should be extended to include consultation and education activities for schools and social agencies depends upon the community’s interest and willingness to provide the necessary budget, and also upon the availability of manpower.

In accordance with its multiple mandate, the manning of the IRC must be multidisciplinary in composition and include at least a part-time psychiatrist, a physician’s associate or a nurse practitioner trained in physical exanimations and other diagnostic procedures, a social worker with experience in family therapy and crisis intervention techniques, and a community worker who is preferably a cultural and ethnic representative of the neighborhood.

One of the important decisions that an IRC makes is whether or not the patient needs inpatient care and, if so, whether the setting of the general hospital is a suitable facility. Again, assuming that the general hospital is a regional center with its satellite units, a list of indications for a relatively brief hospitalization (defined as ranging from two to three days to two to three months) might include *suicidal ideation* or activity; an abrupt and significant *deterioration in social judgment* (as for instance, overt sexual behavior in public, spending sprees during hypomanic or manic episodes); *organic brain*

syndrome requiring neurological and neuropsychological studies; the *initiation of pharmacotherapeutic measures* requiring continuous observation either because of the type of medication administered or because of complicating nonpsychiatric conditions; the *withdrawal* from drugs a patient is abusing if such a program is too hazardous to be implemented outside of the hospital setting; and *decompensation* of a patient with a long-standing psychiatric illness requiring active resocialization in addition to pharmacological measures. In addition to deciding admissions to the inpatient unit, the IRC would also be expected to maintain contact with the patient throughout hospitalization, plan his discharge, and arrange for the delivery of aftercare services.

Inpatient Service

The general hospital functions best as a regional center if only those patients requiring prolonged or indefinite residential care are referred to the state hospitals or other specialty hospitals. Thus, the IRC should refer the patient to the general hospital's psychiatric inpatient service if the accepted plan of treatment is consistent with the optimal short-term care mandate of the unit. The treatment plan should be interdisciplinary and reflect the staff's judgment regarding: (1) diagnosis(es) on admission; (2) additional diagnostic procedures indicated; (3) psychological and social target symptoms requiring modification; (4) treatment of current nonpsychiatric problems, if any; and

(5) recommendations for drug treatment, electroshock treatment, or psychotherapeutic modalities including occupational and recreational treatments. Included also should be an assessment of the social, familial, and other environmental support available to the patient and his estimated length of stay in days. If the inpatient staff, after additional observation, finds it necessary to modify the treatment plan the IRC team should be notified.

Although the staffing pattern obviously depends upon the size of the inpatient unit, it is best to have a separate team (or teams) to deal with very brief hospitalization and to allocate approximately one-third of the available beds for patients who are likely to require less than one week of hospitalization. Very brief hospitalization can be particularly effective following suicide attempts, unauthorized discontinuation of maintenance drug treatment in a previously compensated patient, and also for the rapid assessment of patients who are likely to be referred to another facility for more extensive rehabilitation or even permanent care (e.g., senile, deteriorating organic brain syndromes).

The teams responsible for brief hospitalization should also assume responsibility for those patients requiring partial (day, night, or weekend) hospitalization. At any one time, probably 20 percent of the total number of psychiatric patients requiring admission live in a sufficiently supportive environment to benefit from partial hospitalization services. The partial

hospitalization unit can serve: (1) as a transitional treatment center for those moving from inpatient services to full community life; (2) as a resocialization facility for impaired patients whose families are able to take care of them some of the time; and (3) as a treatment program for those who have not responded to previous psychiatric outpatient treatment.

Utilizing the same physical facility for "crisis intervention," short-term and partial hospitalization makes it financially feasible to maintain a high staff-patient ratio and also assures a high rate of occupancy, thereby contributing to the facility's economic viability.

Ultimately, the only aim of hospitalization is to alleviate the reasons for which hospitalization was necessary. All other treatment goals should be pursued after the patient is discharged. Accordingly, and in view of its multiple mandate, maximum use should be made of peer group, leaderless group, family group, and community meetings in order to recreate a microcosm of the outside world and provide the patient with opportunities to practice those skills on which his autonomy in the outside world will depend. Although acutely ill patients generally do not require resocialization, multidimensional groups still perform a useful function by discouraging regressive tendencies and by making it possible to evaluate accurately both the patient's adaptive repertoire and his readiness to reenter the community outside the hospital. Families, whenever possible, should be considered

important allies in carrying out the treatment plan; their collaboration may assure that the patient utilize outpatient and aftercare facilities to the fullest extent. This is particularly important for patients whose hospitalization is very brief, or for those who are likely to benefit from partial hospitalization. Without a close collaborative relationship with the family, most efforts at "crisis intervention" or partial hospitalization are likely to fail.

In addition to group therapeutic modalities, behavior modification techniques may be utilized to deal with specific difficulties associated with socialization, such as impairment of impulse control, self-care and other isolated problems of independent living.

Outpatient Services

Ambulatory services should be organized into two relatively autonomous, though overlapping divisions. One division should provide for the administration of various sociotherapies, including the different kinds of individual psychotherapy, group, and family therapies. While most patients obtain sufficient support from the various forms of group and family therapies, time-limited individual psychotherapy and behavior modification techniques, it is estimated that approximately 10 percent may need rather extensive long-term individual psychotherapy.

The second division should be devoted to patients who can by and large

be treated within the medical model and should concern itself with the evaluation, treatment, and follow-up of inpatients whose psychiatric disorders have responded to medication or whose condition may require drug-maintenance treatment. In addition to brief supportive psychotherapeutic contacts, major emphasis in this second division should be placed upon educating the patient and his family with regard to signs and symptoms of impending relapse in order to prevent rehospitalization.

Obviously, indications for the psychotherapeutic and medication-maintenance programs of treatment overlap at times, but administrative experience has reinforced the importance of separating the psychotherapies section from the section emphasizing psychotropic medication. While most psychotherapy clinics can operate on a regularly scheduled basis, the division of medication maintenance needs to operate clinics several times a week at hours which are convenient for working patients and will also need to be readily available for emergency consultations.

The third component of an outpatient clinic, a social-service unit to coordinate rehabilitation efforts, plays an especially important role in the aftercare of the chronically ill patient. Our failure in the past to provide adequate aftercare programs for the large numbers of chronically ill patients returning to the community had nearly disastrous effects upon the entire mental-health establishment in that it eroded public confidence in our efforts.

What was once growing support for the care of the mentally ill in the community has been partially obliterated by the socially undesirable behavior of these "carelessly discharged" patients, now often living in transitional facilities and "halfway" houses, where inadequately trained personnel in insufficient numbers have been vainly attempting to oversee their haphazard reentry into society. At this moment, without training in even the simplest resocialization techniques, patients discharged into the metropolitan areas soon reenter acute treatment centers, starting a vicious cycle of patient movement. Thus, the need for well-developed and thought-out aftercare programs is all too obvious.

Such an aftercare program must stress allegiance to an institution, rather than to a particular individual such as the patient’s physician or social-service counselor. This is necessary because the teams taking care of patients rapidly change their composition, especially the ones located in community general hospitals or university-based teaching hospitals. These hospital settings are particularly conducive to the organization of self-care groups which are capable, with adequate patient supervision, of assuring some degree of socialization without exorbitant costs (Anderson, 1975).

Conclusion

Practically all of our large-scale plans in mental-health-care delivery

have been implemented posthaste, but few of them have been subjected to proper scrutiny. To be sure, the principles underlying short hospitalization, brief treatment and community orientation are laudatory but it is still uncertain whether these programs are truly effective.

The ineffectiveness of aftercare programs has resulted in the emergence of a new type of patient ghetto which has cast a long shadow over all of our services (Bennett, 1973). Society served notice on us that the desire of mental-health professionals to get rid of undesirable patients has come to an end. Our major concern today is focused on delivery of better psychiatric care to the chronically ill but while this is a task of highest priority, it is, as yet, also an unproven skill of modern psychiatry.

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