the odds are two to one!

A STUDY IN NEGLECT
what has happened in Kansas

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KANSAS STATE BOARD OF HEALTH
THIS report, prepared by Harry Levinson, Helen K. Moore, and Verlyn L. Norris, entitled "A Study in Neglect," brings out forcibly what has happened to our mental hospitals in Kansas. A careful study of this report will convince the reader that our institutions have been neglected. Many changes are necessary to bring our institutions up to required standards so they will compare favorably with similar hospitals in other states. Personnel should be increased, better working conditions, shorter hours, and more pay given all employees. Better housing for both employees and patients should be provided, and changes in our commitment law should be made. All patients should be given the most modern treatment known and practiced by leading doctors and hospitals. Last but not least, every effort should be made for the comfort of each patient and we should strive to make life a little more pleasant for the unfortunate, sick persons coming to our hospitals for help. I heartily recommend that every citizen of Kansas not only read this report, but study it carefully.

ERLAND CARLSSON, Director,
Division of Institutional Management

THE most unfortunate people in Kansas today are to be found in our State mental institutions. We must think of these people as our friends and neighbors. At one time they plowed their fields; they attended our schools; they walked the streets of our cities and small towns. Their interests, their ambitions, their hopes for the future—even their paths, as they pursued the varied activities of everyday life, may have crossed ours. Today, they suffer from a sickness, the very nature of which makes them dependent, body and soul, upon us. We have only to ponder the question, "Am I my brother's keeper?" to realize fully the responsibility assumed by the State in caring for these unfortunates. You and I have a dual responsibility in helping these people: First, to see that every effort is made to prevent, insofar as possible, the great number of tragic mental breakdowns occurring each year which lead to our institutions—and secondly, to make certain that every opportunity for recovery and kindly care is provided as long as necessary. Surely, this is one time we can be guided by the Golden Rule as we consider this important problem.

This report entitled "A Study in Neglect" is a picture of the care we provide for these unfortunate people. It can be reflected by similar studies in every state. The responsibility rests upon the shoulders of every citizen of the State, not alone upon administrative officials or elected legislative members.

We submit these problems to the consideration of the people of Kansas and to their representatives in the field of government. It is the hope of the Kansas State Board of Health that Kansas may join that progressive rank of states which is striving, in every way possible, to improve the lot of those who are suffering from mental illness.

F. C. BEELMAN, M. D., Executive Officer,
The Kansas State Board of Health
Kansas was a new state in 1866---

The great war between the states was only recently over. Veterans of the bitter campaigns, both north and south of the Mason-Dixon Line, were seeking the riches that lay in the fertile soil of the high plains. These sections of land were the reward their government offered them for their services. The discontented and displeased people of the East were moving restlessly westward. And the thousands who had had been rushed into the state in the struggle to make it free were already reaping bountiful crops that surpassed their most optimistic expectations.

Kansas could not help growing. Quickly its population rose. More than a million people settled within its borders in twenty years, and others were still coming. Only the occasional bitter years, the years of drought and depression, really stopped the immigrant flow, although it gradually tapered off to a comparative trickle. By 1936 the state's population of nearly two million had grown to thirteen times its population in 1866. And in the decade of dust, drought and depression that followed, it dropped only slightly.

In a new state, beset by growing pains and caught in the tremendous struggle between opposing economic and political forces, there was little time and even less interest in thinking about social welfare, health needs or individual problems. The period was one of individual struggles for survival, and the Devil could have the hindmost. The frequent wagon trains returning eastward clearly demonstrated that he took many. But there were those whom he could not take.

There were those who had broken down under the emotional stress and strain of the struggle for survival, those who could neither work nor go away, but had to remain.

The broken ones were a problem that could not be ignored. They could not be kept at home. Nor were there even jails for them, much less hospitals. Grudgingly, Kansas constructed at the cost of $500 a two-story, six-room asylum at Osawatomie for them and opened its doors for the first four patients in 1866. But from the beginning it was not enough.

Rapidly though the population grew, the number of those who fell by the wayside grew even more rapidly. Slowly the state stirred to meet its responsibilities—always slowly, always too late. A new asylum was opened in Topeka in 1879, another in Larned in 1913, and buildings were added to all three from time to time. As soon as new facilities were added they were almost immediately filled up, and there were many who languished in jails, or were secluded by harried families on outlying farms. In the first twenty years the patient load of the state institution for the insane jumped from 4 to 908. Then, even though it increased less sharply, it continued to grow from year to year. By 1946 there were 5,060 patients in the three state hospitals for the insane—percentage-wise a fantastic gain over 1866, and a rate of increase 100-times that of the increase in state population.

Realizing that it was not enough merely to isolate its mentally sick, the state belatedly agreed its institu-
tions should not be asylums, but hospitals, and that a determined effort should be made to cure the mounting number of patients. But it was not so easy. There was ever a reluctance on the part of consecutive, uniformly dispassionate legislatures to grant funds to meet even the most urgent needs. At times the hospitals were allowed to become political footballs, staffed by incompetents, mired in the filth of political corruption and rocked by scandals. There was no money to pay decent help, to build adequate buildings. There was no money to restore people to usefulness. There was only money enough to give them meager sustenance so that they could continue to be burdens to the state, useless to themselves, and a continuing sorrow for their troubled families.

To complicate the situation, the enfeebled aged began to find their way to the state hospitals because there was no other place for them. No amount of protest by any official connected with a state hospital ever had any effect on this added burden. Taking up room needed by more acutely sick people, demanding attention that inadequate staff could not afford to divert from others, they received neither the care they deserved nor permitted such care to be given others.

In Kansas, a psychotic—a seriously mentally ill person—is almost a criminal before the law. To be treated he must go before a court and be committed to the state hospital. Sometimes he sits in jail for weeks awaiting his “trial.” Although voluntary admissions are allowed by law, there is hardly room for the volunteer, who is not encouraged to enter the hospital; as a result, only those who are very seriously sick manage to gain admission to the state hospitals.

Thus, historically, in addition to the increasing number of mental patients, there are many factors which impose undue burdens on the Kansas state hospital system, most prominent among which are:

- Inadequate finances.
- The increasing burden of senility.
- Outmoded legal regulations.

The net effect of these three shackles is to limit the work of the state hospitals so that only one person in three who enters a state hospital in Kansas leaves it restored or improved!

To be exact, 45,840 patients have entered the state hospitals since 1866. Of those, 15,730, or ¼, have died in the hospitals, while 17,599 have been improved or restored. What do these figures mean for each person who enters a state hospital? They say in no uncertain terms that he is as apt to stay in the hospital until he dies as he is to show any improvement.

--- chances are two to one that \( \text{he'll fail to get any better!} \)
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Written by

Harry Levinson
Helen K. Moore
Verlyn L. Norris
The blessings of increased longevity are mixed. For many --- aging is a rich experience --- for others it means enfeeblement and incapacity.

For the latter no suitable facilities exist, and they are foisted off on state hospitals when families and county agencies can no longer care for them. Multi-storied crowded buildings are poorly designed for their handicaps. The kind of supervision they need cannot be provided. Yet they constitute a constant burden on facilities already overtaxed. As a result, the recovery of acute mentally ill patients, which in a large measure depends on the care and attention they receive, is seriously impeded.
In 1866, three out of each 100,000 persons in Kansas were in state hospitals. In 1946, of each 100,000 Kansans 290 were in state hospitals.

THE SHARP INCREASE IN THE NEED FOR PSYCHIATRIC CARE HERE REFLECTED IS A MEASURE OF THE PROBLEM KANSAS FACES.
More and more people are being admitted to Kansas state hospitals each year.

yet

for every three people admitted --- only one is discharged as recovered or improved and another dies
The number of persons admitted to state hospitals since 1866 has significantly exceeded the number of discharges and deaths.

**Result**

--- constantly increasing hospital populations ---
what the superintendents said about

SENILE CASES

(Random excerpts from annual and biennial reports of Kansas state hospital superintendents.)

1872. state hospitals are something more than boarding houses.

1900. growing practice of converting asylums into almshouses for the aged.

1910. more and more mental derelicts domiciled to state hospitals.

1926. one-fourth of the patients are more than sixty years of age.

1928. institutions for the insane are becoming dumping grounds for the aged and infirm of counties who seek to evade the expense and responsibility of their care.

1930. a constantly increasing number of people of advanced age. forty-one percent (of hospital population) more than fifty years of age.

1934. establish another institution with a capacity of 2,000 especially designed and constructed for those who require domiciliary care only.

1944. counties evacuate poor farms.
There has been a continuous expansion of the state hospital plants. Yet Kansas has never kept pace with the spiraling demand for hospital facilities arising out of the increasing incidence of mental illness and the added responsibility of caring for the senile cases.

Since 1866 no hospital superintendent's report has been free from the protest

"inadequate facilities"
HOSPITAL FACILITIES
(Random excerpts from annual and biennial reports of Kansas state hospital superintendents.)

1867... building entirely inadequate...
1872... capacity crowded to utmost limits... not more than half the applications have been admitted for want of room. 103 insane are known to receive no aid from the institution, with forty counties not reporting... two-thirds of the state's insane are therefore confined to jails, county poor farms and families...
1874... accommodate one for every five known cases...
1875... overcrowded condition... lack of much-needed facilities... hundreds of chronic insane in the state for whom no provision has been made...
1876... 127 (rejected) to languish in jails, poorhouses and private families... ordered that chronic cases must be discharged as fast as necessary to make room... calculation and argument to show the necessity for increased accommodations would be a work of supererogation. It exists now—today! Humanity cries aloud in their behalf.
1900... 121 rejected for want of room... This is a smaller number than has been rejected for want of room during any biennial period throughout the past decade. The state is (now) reimbursing counties for 328 rejected... 349 insane are known outside the state hospital... The state has never completely fulfilled its obligation to the insane. It has ever been a cry for more room.
1910... more room soon... cannot give best care... impossible to classify...
1912... overcrowded... will be compelled to refuse patients for want of room...
1916... problem of more room for patients seems ever present...
1920... handicapped by lack of adequate facilities... congested condition...
1922... overcrowded... construction two to ten years behind the times...
1924... forced to refuse admission to some, overcrowded, put some quiet patients on county farms.
1926... overcrowded conditions...
1928... overcrowding partially responsible for high mortality... wards crowded as never before... in excess of rated capacity... forced to quarter patients in basements unfit for human habitation... From the very beginning facilities did not keep up with the demands for admission...
1930... overcrowded state of wards has interfered with medical work...
1932... gratifying to note that our percentage of paroles and restorations has materially increased since the facilities for modern care and treatment of this type of case (acute) has been provided...
1934... early expansion of facilities... establish another institution with a capacity of 2,000... overcrowding still exists... more serious than before... crying need for more room...
1936... overcrowded... impossible to admit all who applied... forced to resort to lamentable practice of sending some of our chronic insane people to county homes to make room for others... innumerable fire hazards... antiquated buildings, constantly increasing population, imperative that the state adopt a definite plan for the future.
1938... serious overcrowding... long waiting list... number held in county jails... transfer of chronic patients to almshouses...
1940... quite badly overcrowded... a major problem... buildings 38 to 70 years old for 1,376 out of 1,670 patients, none were fireproof originally...
HOSPITALS ARE MORE THAN BUILDINGS

A sufficient number of highly trained medical personnel is necessary to help sick people get well. Kansas has never had enough. According to the minimum standard set up by the American Psychiatric Association:

- There should be one doctor for every 150 patients.
- Kansas state hospitals are authorized one doctor for every 316 patients.
- Kansas state hospitals actually have one doctor for every 656 patients.

This means that Kansas state hospitals must be authorized more than two times the number of doctors they are now allowed in order to meet MINIMUM acceptable standards. It means that Kansas state hospitals must employ four times as many doctors as they now have if they are to meet MINIMUM acceptable standards.
IN PSYCHIATRIC TREATMENT

... the influence exerted on the patient by the people who care for him is the most important medicine he can receive. The hospital attendant is more continuously in contact with the patient than is any other member of the hospital staff. The number of attendants and the degree of their skill is therefore crucial for the recovery of the patient.

Minimum Standards require one attendant for every eight patients for hospitals which operate on a basis of two working shifts each day.

- Kansas state hospitals are authorized one attendant for every fourteen patients.
- Kansas state hospitals actually have one attendant for every sixteen patients.

This means that Kansas state hospitals must be authorized seventy percent more attendants than they are now allowed in order to meet the Minimum acceptable standards. It means that these hospitals must employ twice as many attendants as they now have if they are to meet the Minimum acceptable standards.

Even if these increases are made, Kansas state hospital attendants must continue to work 10½ to 13 hours a day or 68 to 75 hours a week. Obviously, a far greater increase in the number of attendants would be necessary to meet the generally accepted standard of a 40 hour week.

KANSAS AGAIN --- FALLS SHORT
An important part of any hospital staff are the professional workers closely allied with the medical personnel—nurses, dentists, pharmacists, etc.,—and consulting medical specialists.

- Two state hospitals have no dentist.
- Three state hospitals have no pharmacist.
- Three state hospitals have no psychologist.
- Three state hospitals have no social workers.
- **THERE ARE ONLY TWO REGISTERED NURSES FOR THREE HOSPITALS . . . . . . HOUSING MORE THAN 5,000 SICK PEOPLE!!**
- In the small communities in which two of the hospitals are located, few specialists are available who could serve as consultants to the state hospitals. Even fewer have been appointed.
Staff and Personnel

(Random excerpts from annual and biennial reports of Kansas state hospital superintendents.)

1899.... Kansas pays lowest salaries . . . even 50 percent more would be below the average of other states . . .

1900.... wage paid insufficient . . .

1902.... better pay . . .

1904.... need full set of nurses; more help.

1906.... better wages; more attendants.

1908.... official force underpaid . . .

1910.... Few desirable young men will remain in service very long with the present scale of wages.

1912.... Kansas continues to pay lowest salaries . . . difficult to find men . . .

1920.... extreme shortage of nurses and attendants . . . procurement of help almost impossible . . . appropriations entirely inadequate . . . normal development and progress prevented . . . gradual disintegration due to financial and labor shortage . . . forced to employ men and women wholly untrained.

1924.... more and more difficulty securing the type of ward attendants and nurses we should like to have . . .

1926.... handicapped by recurring vacancies on the staff . . . more and more difficult to secure positions with the salaries paid by the state . . .

1930.... reluctance of state to pay a salary commensurate with type of service required . . . more attractive salary schedule must be adopted . . .

1932.... staff curtailed . . . burden of work unusually heavy . . .

1934.... additional help because of growing population . . .

1942.... lack of applicants for nursing . . .

1946.... major problem . . . the help situation. The medical staff consisted of approximately half the number needed to meet minimum requirements which was inadequate in normal times. Our nursing personnel was also inadequate. Much of the time we were compelled to carry on with approximately 50 percent less attendants than usually employed. It certainly is not reasonable to expect untrained nurses and attendants selected from practically all walks of life to give mentally ill patients proper care. Cottages for staff physicians quite badly needed. We haven't had anything like an adequate personnel; urgent need in practically all departments.
Kansas spends $245 a year to maintain each patient in its state hospitals

**WHAT DOES THIS FIGURE MEAN?**

![Graph showing how Kansas ranks among the 48 states.](image)

Only sixteen states have greater buying power than Kansas.

**yet**

Forty states spend more for their mental hospitals than does Kansas.

![Bar graph showing per capita expenditure for state hospitals.](image)

For the United States as a whole, the average per capita expenditure for state hospitals is fifty percent greater than that of Kansas.
.. The number and caliber of state hospital personnel is proportional to the amount of money available for salaries.

States with high standards of care use more than half of their expenditures to pay salaries.

Of the very limited funds allotted to Kansas state hospitals, only forty-four percent is spent for salaries.

Average per capita spent on salaries annually over the country as a whole  **$198.18**

Average per capita spent for salaries annually in Kansas  **$105.32**
what the superintendents said about

PSYCHIATRIC CARE

(Random excerpts from annual and biennial reports of Kansas state hospital superintendents.)

1875. . . . For those who recover the average cost per patient is $150. For the chronic cases the average cost is $3,240. It costs more to be deprived of adequate facilities than to possess them . . . The prodigious expense of providing for the chronic . . . There are today hundreds of chronic insane in the state for whom no provision has been made. 75 to 80% should have been and might be restored to reason and society . . . there would have been but 20 to 25% of the chronic cases . . .

1876. . . . More than half the admissions were chronic in character (75%) . . . The number of recoveries was largest from those whose duration was shortest before admission.

1906. . . . We have found that the better they are treated, the more comfortable and agreeable the surroundings, the less trouble we have with them and more of them recover.

1910. . . . After-care is needed . . . a reception service for the acute and curable.

1920. . . . Neglect of past legislatures to make adequate appropriations . . . without means of curative treatment, hundreds through pernicious, penny-wise policy, have become life charges of the state.

1922. . . . Mental illness gradually increasing . . . appropriations not sufficiently liberal to permit operation on an advanced basis of efficiency . . .

1926. . . . hampered by lack of proper finances . . . requests for appropriations refused . . . too little attention accorded to prevention . . .

Year by year we witness the increasing population of our institutions, with a proportionate increase in the maintenance of these, resulting in a gradually increasing burden of taxation. The necessity for employment of agencies for relief from these grave conditions must be impressed on the public. The most logical and hopeful field of endeavor is not in the hospital, where curative agents fail with distressing frequency, but in the community and in the home of the maladjusted individual, by intelligently organized and administered social service, extramural clinics, education of the public in principles of mental hygiene, and limitation of the procreation of the mentally unfit . . . Organized effort looking toward prevention of mental infirmity is a necessity.
1928. . . . Prevention is of greater importance than provision for care . . . Much might be accomplished by a social service organization, whose extramural activities would tend to materially reduce the number that are yearly admitted to our state hospitals and prevent or delay the return of those whose improvement under hospital observation has warranted parole.

. . . Number of first admissions, number remaining in the hospital and the number (of mentally ill) per 100,000 have increased . . .

1932. . . . Logically, there are two major considerations in relation to handling the mental patients:

1. The prevention, insofar as possible, of mental illness by the establishment of effective agencies for the teaching of mental hygiene and the institution of an intelligent social service program.

2. Adequate facilities for the care of those who, despite efforts at prevention, succumb to the stresses of life and develop mental illness, in order that such as may be amenable to cure may be restored to economic pursuits in the shortest possible time, thus avoiding the chronicity that in the past has been the most discouraging, expensive and pitiable feature of mental illness.

1934. . . . Prevention is better than cure . . . extramural service, mental hygiene and child guidance clinics needed . . . psychiatric service to these, probate courts, schools, etc., needed.

1936. . . . The patient should be returned to society as soon as possible . . . Need a service to care for him . . . psychiatric social service . . . Most pressing need to get patients home when they are able to go so that these improved patients will not remain in the hospital until they deteriorate into the chronic type. If one psychiatric social worker succeeds in getting and keeping only 10 patients out of the hospital in one year, she could accomplish a reduction in the per capita cost of $2,100, actually a saving as large as her salary. Such a service would contribute markedly to the solution of the problem of overcrowding . . .

There is no well-rounded program of medical endeavor that does not include a campaign for the prevention of disease . . . A campaign for the prevention (of mental diseases) should be launched and fostered . . . a wide dissemination of knowledge about mental conditions and delinquency, their cause and prevention, as well as their treatment, should be the first concern in such a program of prevention.

It is from the operation of such (out-patient) clinics that the present investment in effort and resources should pay large future dividends in keeping many mentally ill people out of state hospitals and correctional institutions, thus in a considerable measure obviating the necessity for building more and more buildings in the future.

1938. . . . prevention, intensive treatment, follow up . . .
no one would expect a doctor to interpret
a fine point of law -- yet --

in Kansas -- decisions concerning the mentally ill -- are made by a judge

In Kansas today the average person afflicted with a mental illness and requiring psychiatric treatment or care in a state hospital faces the following ordeals. Briefly, the first prescribed step is the sworn "complaint" that must be filed with the judge of the Probate Court. The judge then issues a "warrant" legally placing the person in the custody of the sheriff and commanding that he be brought before the court for a hearing. Thereupon an inquest is held either before a commission or a jury at the discretion of the judge——

Legal commitment on the basis of a court hearing, usually before an appointed commission whereon the examining physician need not by law be a psychiatrist, is the commonly accepted procedure of admitting patients to the state hospitals. In other words, the admissibility of mentally ill persons to the specific treatment facilities provided by the state depends basically on the decision of the judge rather than on the decision of physicians specially trained in the field of mental disorders.

Sometimes the mentally ill person must remain in prison for a long period of time awaiting court action. If adjudged insane, he is likely to spend even more time in jail until there is a vacancy and he can be admitted to the state hospital.
what the superintendents said about

LUNACY LAWS

(Random excerpts from annual and biennial reports of Kansas state hospital superintendents.)

1875... laws are defective, inappropriate and unjust... inconvenient and unnecessary expense... judicial farce...

1900... lunacy laws should be revised...

1906... patients should not be tried as criminals...

1910... provide for voluntary admissions...

1934... archaic, inhuman and needlessly expensive procedure (for) admission... air of semicriminality...

“Dear Sir:
    “A few years ago, while I was county attorney of...............County, Kansas, I prosecuted a case in which...............was convicted of insanity and sentenced to your institution...”

1944... laws inadequate...
Kansas laws must be amended to recognize mental illness as a medical problem instead of a legal one. *Illness requires treatment—not punishment*

The best modern laws governing admission to mental hospitals are designed to give patients direct access to the facilities in question, without unnecessary delay, without prejudice to their social or legal rights as citizens, and with every consideration possible given to the feelings of the patient and the family. Such admissions, in the great majority of cases, should be considered voluntary. Questions of diagnosis, suitability, or admissibility for either observation, treatment or care, as well as of financial considerations and other matters pertaining to the hospitalization, should be routine matters of hospital functioning under appropriate statutory provisions covering the various factors involved.
what can happen in Kansas
Kansas was a mature state in 1946

Another great war was only recently over. Veterans of the bitter campaigns around the world were seeking the peace and security they once knew in the friendly environs of the high plains. This was the reward they wanted. But many found no peace and security, and many of those who found it could not enjoy it. For the unseen illnesses that often plague men were given greater impetus by the tragic experiences of war. Having already been alerted by the many reports of men rejected from military service, as the numbers of mentally ill increased the public became more aware of the problems of mental illness, the problems of caring for those who could not go to federal veterans hospitals, and who had long been neglected in Kansas.

There were those who could imagine themselves walking up the grey stone steps of a state hospital, guided by deputy sheriffs, and accompanied by the vivid image of an unseen bettor who droned into their ears, "Two to one you won't leave here well." There were those who thought of the kind of care an overburdened hospital could give, of wasted lives behind the steel barred windows, or the continuing burden they might be on society.

Morbid though the image was, there was some basis in fact for it. But it need not remain so. Kansas can change. For the aged and senile Kansas can establish a hospital for adequate domiciliary care. For the acutely ill, Kansas can establish psychopathic hospitals for rapid, intensive, thoroughgoing treatment. For early stages of mental illness and to assist those who could be discharged if there were adequate supervision, the State can set up mental hygiene clinics.
Kansas can raise appropriations

to adequately pay sufficient numbers of trained personnel. Kansas can establish training facilities to supply skilled personnel not now available. Kansas can support research to uncover the causes of mental illness, and improve methods of treatment. Kansas can educate its people for better mental health and wage a comprehensive campaign against the known causes of mental illness. Kansas can change its laws so that the mentally ill may be treated as sick people instead of criminals.

Kansans must be kept well. If they become ill, they must be given every opportunity to recover. If they become enfeebled by the ravages of the time, they must be adequately cared for.

Kansas can do all this and save money. Every commitment prevented, not only saves the state from $5,000 to $7,000 but also enables that individual to remain a functioning, constructive member of the community in which he lives. When it is realized that 1 out of every 20 children will someday suffer from some form of mental illness under existing conditions, the enormous task of prevention and treatment confronting Kansas can no longer be delayed.

The figures in these pages might be your friends.
The dots on these graphs might be your relatives.

THE STATISTICS OF TOMORROW—WHO KNOWS?
What are other states doing?

Massachusetts

In 1910 Boston recognized the need for an observation hospital and in 1912 the first Psychopathic Hospital in America was established. In 1922 the advantages of the psychopathic hospital were expressed by Doctor Briggs: “I know of no way in which the state can do more to conserve the mental health of its citizens than by means of well-organized out-patient clinics. Not only can the maximum number of patients be treated at the minimum cost, but they make contact with the physician during the early and incipient stage when assistance is made available at a time when the patient is still capable of appreciating his own needs. It is rendered in a manner that makes it acceptable and compatible with the patient’s social and economic obligations. It permits him to carry on his work, continue to dwell in the family circle, and be rehabilitated in the environment in which he must continue to live in order to play his part in the social scheme of things.”

Ohio

This state has fine receiving hospitals, all established since 1945. “According to statute, the purpose of the receiving hospital is for the observation, care, and treatment of the mentally ill, and especially for those whose condition is incipient, mild, or of possible short duration.

“The great advantage to the receiving hospital system is that commitment procedures are not necessary. The 1946 figures from the Youngstown receiving hospital indicate that 86.4 percent of the admissions were voluntary; 1.5 percent were emergency
cases; and 12.1 percent were court placements. There are advantages for such a system for both the individual and the state. For the person who is mentally ill, there are the advantages of emergency care for a short period without the need of court action or waiting in jail; of court placement for observation and treatment without commitment; and, for the person who seeks voluntary admission, of encouragement and immediate treatment without delay which might allow the illness to progress. For the state there are the advantages of higher discharge rate and quicker patient turnover, resulting in a lessening of the need to provide long term care. In addition, the total program tends to greatly reduce public prejudice against institutional treatment of mental illness."

Figures from the Youngstown Receiving Hospital reveal that 73 percent of the patients were released as improved, while data from two state institutions of the older type for mental patients show that only 45 percent was discharged as improved. Since the receiving hospital is set up to treat patients for a period of not more than 90 days, the 73 percent were improved within that length of time.

"The type of treatment contemplated at the Longman Receiving Hospital will not differ from treatments of the present except that increased personnel and more adequate space will allow for more intensified treatment and speedier results. We hope to follow the standards of the APA by supplying a ratio of one nurse per patient and one attendant per six patients. We plan adequate space for the different types of patients, treatment rooms, a mental hygiene clinic, occupational therapy rooms, and recreational facilities. Our therapeutic program is composed of complete diagnostic studies which are directed toward physical or emotional therapy or both. The psychia-
trists, psychologists, physicians and social workers work closely together in the evaluation of incoming cases and it is hoped to bring in professional recreation and occupational therapists in efforts to expand more adequately the therapeutic program. Insulin and Electric Shock therapy as well as more recently Electronarcosis treatment will continue to be given, though probably at a more accelerated rate.”

**Texas**

The Psychopathic Hospital at Galveston was built as a part of the teaching facilities of the Medical Branch of the University of Texas and has the function of teaching primarily, but also treats acute voluntary mental problems.

The principal advantage of this hospital is that each physician has a load of only ten to twelve patients and therefore individual treatment is possible. It is also possible to have immediate and prompt detailed phys-}

cical, neurological, laboratory, and psychological studies done.

The discharge statistics show that between 75 percent and 86 percent are discharged as improved or cured. The average stay in the hospital runs from 30 to 35 days.

**Indiana**

It was estimated that if the state's present system of community mental hygiene services were extended to cover the entire state, from 15 percent to 20 percent of the patients treated, who would under ordinary circumstances be committed, would not become institutional cases, thus saving the state approximately $583,440 each year. It was estimated that this state could save $285,452 more annually by the discharge of approximately 15 percent of the institutional cases if adequate mental hygiene clinics existed for parole supervision.
COLORADO

The Psychopathic Hospital was erected in 1920 as a part of the Colorado Medical School and Hospital. In classifying patients eligible for admission it is first specified that the hospital is conducted, not for chronic illness, but for the care and treatment of those patients afflicted with a mental disorder which can probably be remedied by observation, treatment and hospital care. Its use as a refuge for chronic cases would completely destroy its value to the state. It is further provided that patients may be admitted on either a voluntary or committed basis.

Psychiatric consultation is made available to community agencies, schools, and to many social agencies.

The first traveling units of the Colorado Psychopathic Hospital were established in 1925. The original purpose of such clinic service was to further the early recognition and treatment of mental disorders and defects. Each community is visited regularly once a month. The main functions of the traveling clinics are to reveal the widespread prevalence and disruptive social results of emotional illness, of demonstrating the effectiveness of a psychiatric orientation, and of extending the range of medical service making preventive psychiatry available on a state-wide basis. Preventive psychiatry means a program designed to help people living in the community with the every day problems of personal relationships which, when disrupted, lead to forms of mental illness complaints.

The Psychiatric Liaison Division was organized in 1934 to provide psychiatric services for the Colorado General Hospital. One out of every 28 admissions to the General Hospital and one out of every 16 admissions to the out-patient department are cases presenting problems requiring the services of the psychiatrist.
what can I do?

WRITE NOW!

The fruits of a democracy are nurtured by the people. You have now read of the vain attempts of your state hospital superintendents to obtain, alone, some help from your legislators over the decades.

Will YOU remain silent while your fellow Kansans gradually die in misery and obscurity with such heavy odds against their recovery? Will you see no evil, hear no evil, nor speak out against evil?

As a Christian, as an American, and as a Kansan—write—or speak to your legislative representatives.

RIGHT NOW!
Factual data in this publication were derived from the following sources:

Annual and biennial reports of Kansas State Hospitals and the Kansas State Board of Agriculture.

Newspaper clippings on Kansas state hospitals, Kansas State Historical Library, Topeka, especially those of 1898, 1903, 1906, 1911, and 1948.


Sales Management, May, 1944, 53: 98.


What Other States Are Doing


Letter to the writers from Dr. Thelma Brown, Psychologist, Longman Hospital, Cincinnati, Ohio, 4-13-48.

Letter to the writers from Dr. Jack R. Ewalt, Director, Psychopathic Hospital, Galveston, Texas, 3-26-48.

Charles N. Meader, “The Functioning of the New Medical Group,” Colorado Medicine, October, 1924.