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MOST U.S. MENTAL HOSPITALS ARE A SHAME AND A DISGRACE

by ALBERT Q. MAISEL

The author of this article, through his previous writing and his testimony before a congressional committee, helped instigate important improvements in the Veterans Administration's mental hospitals. The Ohio photographs were taken by Jerry Cooke with the permission of Frazier Reams, Ohio State Commissioner of Public Welfare, and the cooperation of the Ohio Mental Hygiene Association, an affiliate of The National Committee for Mental Hygiene.

In Philadelphia the sovereign Commonwealth of Pennsylvania maintains a dilapidated, overcrowded, undermanned mental "hospital" known as Byberry. There, on the stone wall of a basement ward appropriately known as the "Dungeon," one can still read, after nine years, the five-word legend, "George was kill here 1937."

This pitiful memorial might apply quite as well to hundreds of other Georges in mental institutions in almost every state in the Union, for Pennsylvania is not unique. Through public neglect and legislative penny-pinching, state after state has allowed its institutions for the care and cure of the mentally sick to degenerate into little more than concentration camps on the Belsen pattern.

Court and grand-jury records document scores of deaths of patients following beatings by attendants. Hundreds of instances of abuse, falling just short of manslaughter, are similarly documented. And reliable evidence, from hospital after hospital, indicates that these are but a tiny fraction of the beatings that occur, day after day, only to be covered up by a tacit conspiracy of mutually protective silence and a code that ostracizes employees who "sing too loud."

Yet beatings and murders are hardly the most significant of the indignities we have heaped upon most of the 400,000 guiltless patient-prisoners of over 180 state mental institutions.

We feed thousands a starvation diet, often dragged further below the low-budget standard by the withdrawal of the best food for the staff dining rooms. We jam-pack men, women and sometimes even children into hundred-year-old firetraps in wards so crowded that the floors cannot be seen between the rickety cots, while thousands more sleep on ticks, on blankets or on the bare floors. We give them little and shoddy clothing at best. Hundreds—of my own knowledge and sight—spend 24 hours a day in stark and filthy nakedness. Those who are well enough to work slave away in many institutions for 12 hours a day, often without a day's rest for

years on end. One man at Cleveland, Ohio—and he is no isolated exception—worked in this fashion for 19 solid years on a diet the poorest sharecropper would spurn.

Thousands spend their days—often for weeks at a stretch—locked in devices euphemistically called "restraints": thick leather handcuffs, great canvas camisoles, "muffs," "mitts," wristlets, locks and straps and restraining sheets. Hundreds are confined in "lodges"—bare, bed less rooms reeking with filth and feces—by day lit only through half-inch holes *in* steel-plated windows, by night merely black tombs in which the cries of the insane echo unheard from the peeling plaster of the walls.

Worst of all, for these wards of society we provide physicians, nurses and attendants in numbers far below even the minimum standards set by -state rules. Institutions that would be seriously undermanned even if not overcrowded find themselves swamped with 30%, 50% and even 100% more patients than they were built to hold. These are not wartime conditions but have existed for decades. Restraints, seclusion, and constant drugging of patients become essential in wards where one attendant must herd as many as 400 mentally deranged charges.

Paid wages insufficient to attract able personnel, even by prewar standards, and often working 10- and 12-hour days, these medical staffs have almost ceased (with some significant exceptions) to strive for cures. Many have resigned themselves, instead, to mere custodial care on a level that led one governor to admit that "our cows in the hospital barns get better care than the men and women in the wards."

Thus thousands who might be restored to society linger in man-made hells for a release that comes more quickly only because death comes faster to the abused, the beaten, the drugged, the starved and the neglected. In some mental hospitals, for example, tuberculosis is 13 times as common as in the population at large.

Such conditions cannot be explained away as a result of wartime personnel shortages; the war merely accentuated long-existing failings. Most hospitals have never had enough personnel, even by their own low schedules. Wages have always been desperately low. Even a year before Pearl Harbor we had already crowded 404,293 patients into buildings built to hold only 365,192.

Nor can any of these horrors be excused on the grounds of "common practice" or as "the best that can be done for the insane." For some states have managed to eliminate overcrowding. Some states discharge, as cured or improved, three and four times as high a proportion of patients as others. A few, notably tiny Delaware, have managed to secure an adequate or nearly adequate number of doctors, nurses and attendants.

Even within individual states some outstanding superintendents have managed to raise their institutions to a decent level despite low pay scales and heavy overloads. By ingenuity, leadership and hard work some have succeeded not merely in discountenancing beatings and restricting the use of restraints and solitary confinement but in eliminating these relics of the dark ages entirely.

The sad and shocking fact, however, is that these exceptions are few and far between. The vast majority of our state mental institutions are dreary, dilapidated excuses for hospitals, costly monuments to the states' betrayal of the duty they have assumed to their most helpless wards.

Charges such as these are far too serious to be based solely upon the observations of any single investigator. But there is no need to do so. In addition to my own observations in a dozen hospitals, in addition to court records and the reports of occasional investigating commissions, there is now available for the first time a reliable body of data covering nearly one third of all the state hospitals in 20 states from Washington to Virginia, from Maine to Utah. A by-product of the war's aggravation of the long-existing personnel shortage, this data represents the collated reports of more than 3,000 conscientious objectors who, under Selective Service, volunteered for assignment as mental hospital attendants

The majority are still in service and, with Selective Service approval, these serious young Methodists, Quakers, Mennonites and Brethren have been filling out questionnaires and writing "narratives" for use in the preparation of instructional material for mental-hospital workers.

One may differ, as I do, with the views that led these young men to take up a difficult and unpopular position against service in the armed forces. But one cannot help but recognize their honesty and sincerity in reporting upon the conditions they found in the hospitals to which they were assigned. Supported as they are by other official data, their reports leave no shadow of doubt as to the need for major reforms in the mental-hospital systems of almost every state.

Consider, for instance, the shocking data on brutality and physical abuse of the patients. One report from a New York State hospital reads as follows:

"… The testimony revealed that these four attendants slapped patients in the face as hard as they could, pummeled them in their ribs with fists, some being knocked to the floor and kicked. One 230-pound bully had the habit of bumping patients on the back of the head with the heel of his hand—and on one occasion had the patient put his hands on a chair, then striking his fingers with a heavy passkey . . . ."

From a state hospital in Iowa comes the following report:

"Then the 'charge' (attendant) and the patient who had done the choking began to kick the offender, principally along the back, but there were several kicks at the back of the neck and one very painful one in the genitals which caused the victim to scream and roll in agony.

Something more than 20 kicks must have been administered. Finally he was dragged down the floor and locked in a side room. When I asked the 'charge' how it started, he said 'Oh, nothing. That— ought to be killed.' The victim was in handcuffs all the time; had been in cuffs continuously for several days." From an Ohio state hospital:

"An attendant and I were sitting on the porch watching the patients. Somebody came along sweeping and the attendant yelled at a patient to get up off the bench so the worker-patient could sweep. But the patient did not move. The attendant jumped up with an inch-wide restraining strap and began to beat the patient in the face and on top of the head. 'Get the hell up . . .!' It was a few minutes—a few horrible ones for the patient—before the attendant discovered that he was strapped around the middle to the bench and could not get up."

These are but samples among score upon score of cases described and corroborated in the records of the National Mental Health Foundation. The ultra skeptical may feel that they represent the exaggerated views of impressionable conchies with a moral ax to grind. But this idea is fully refuted by the facts concerning other cases, which have broken into the newspapers and reached the courts.

The state hospital at Nevada, Mo. was investigated as a result of the death of a patient, Cordell Humphrey, last July 6. An autopsy performed by Dr. Van Urk of Carthage, Mo. showed that Humphrey had been beaten severely a short time before his death. "There were marks on the arms, legs, chest, abdomen and head, and injuries to the brain that could have caused the death," Dr. Van Urk reported. As a result of this incident Attendant Massey Cloninger was sentenced to five years in the state penitentiary and another attendant is awaiting trial on charges of assault.

At Hastings, Neb., in February of this year, former State Hospital Attendant William L. Skelton was convicted of assault in connection with the death of Alfred T. Anderson, a patient. Skelton helped hold Anderson down while another attendant beat him with a blackjack.

In 1941 five attendants at Connecticut's Fair-field State Hospital were charged with complicity in two separate beatings of patients, one of whom died. Two of these attendants were convicted of manslaughter and one of assault. Early in 1942 two attendants were arrested for abusing five patients at the Middletown State

Hospital and one of the attendants received a jail sentence. As a result the Public Welfare Council and the U. S. Public Health Service made a thorough investigation of all of the Connecticut mental institutions. Yet only last November serious charges of maladministration at the Fairfield State Hospital brought about another inquiry which ended with the resignation of the hospital superintendent. Hospital administrators do not, of course, countenance beatings in Connecticut or elsewhere. Yet in case after case, instead of bringing criminal charges, they have been satisfied merely to admonish or, at most, discharge the guilty attendant—leaving him free to move on to other states or even to other hospitals within the same state. A typical instance of this sort came to light in Cleveland last year when Attendant Aaron Copley was tried and convicted in Municipal Court on a charge of assault and battery upon a patient. Copley contended that he was "being made the goat" and that brutality was commonly practiced in the Cleveland hospital. He submitted charges involving seven separate beatings by three other attendants. When the court probation officer investigated these charges

he found that Attendant Hunter, one of those accused by Copley, had a record of previous conviction for arson and had been an inmate of the Veterans Administration mental hospital at Perry Point, Md. Yet despite this record, elicited in a single week by a few letters from the probation officer, Attendant Hunter had had no difficulty in securing and retaining employment at the Cleveland hospital, even after suspicious "accidents" had occurred in his ward while he was on duty. The hospital had never bothered to make even a cursory check of Hunter's character and background.

The fact is that beatings are merely the extreme end product of a system which thrusts upon overworked, poorly trained and shamefully underpaid employees the burden of controlling hundreds of patients whom they fear and despise. Far more frequent than beatings are the endless cruelties involved in the use of restraints. Although some hospitals have managed to dispense with physical restraints entirely and others permit their use only on written order from doctors, the all-too-widespread practice is to leave the decision to tie down a patient or throw him into solitary up to the harassed and fearful attendant.

The investigators of the Connecticut hospitals in 1942 cited the presence of 16 patients in restraint and 32 in seclusion at Norwich State Hospital in February of that year. Deploring this, they expressed the pious hope that "the use of such measures be materially decreased." Yet in a single month in 1945, according to records cited by two "conchie" attendants, 26 patients in this same hospital spent 6,552 hours in canvas lacings, mittens and sheets. Eighty others spent 13,900 hours in solitary seclusion!

One conscientious-objector attendant, reporting from a state hospital in New York, gave the following account of the way in which restraints are abused. He wrote: "We have one patient, E. E., who has been in restraint sheets for a period of several months; often he is not even toileted once during the day. . . . Another patient, A. H., has been in a camisole for over a month and the only time it is taken off is once a week for bathing."

In Pennsylvania, the State Bureau of Mental Health has issued repeated detailed orders, ever since 1925, limiting the use of restraints. In theory, under these orders, restraints "should be applied only on written order of a physician and for a specified period." In theory a complete and detailed record on the use of restraint is supposed to be kept.

Yet the notes of a conference of 30 members of the conchie unit at a Pennsylvania hospital in August 1944 read:

"Sheet restraints are used considerably but *never reported;* the usual practice for the first half day in hydrotherapy (female) is to put patients tautly in restraints with hands above heads, often causing immobility of arms when restraints are removed. . . . Towels are frequently used on both male and female sides for temporary restraint. . . . Cuffs and straps are in general use, in all combinations, partial and complete; sheets are used to tie ankles, necks and chests to beds, benches, chairs. Hands and feet are often observed in swollen condition because of insufficient supervision in such cases."

"Records show an average of 38 or more in restraint; there are some cases when actual number in restraint is greater than the recorded number. Some have been in restraint in B [building] for the seven months that one attendant has worked there; some are in [restraint] on the female side for weeks and months without the doctors seeing them 'because the doctors don't like to go up stairs.' "

In the more "enlightened" hospitals chemical restraints *(i.e.,* drugs) are used to keep the patients under control so that they will be less trouble to the attendant. In theory these drugs can be prescribed only by physicians or registered nurses. In practice they are often sent up to the wards in batches and administered at the discretion of untrained attendants. A case cited by one conchie at another Pennsylvania state hospital (and corroborated by another from the same unit) illustrates the end results of such "free hand" administration of drugs:

"L. was a young man about 25 … so quick and strong that they had a great deal of trouble trying to overpower him. He was given sedation—sodium Phenobarbital—every three hours. . . . After a while, after I had objected to the doctor, sedation was stopped and he made a serious attempt to save the boy. I made a copy of his sedation record. In 108 hours he received at least 90 grains of sodium Phenobarbital—making no allowances for probable overdoses and a good bit of Hyoscine. The last few shots were given when he had a fever. He had had so many sedatives, however, that it was hopeless and he died."

OVERWORK BREEDS BRUTALITY

When one studies the almost endless parade of cases such as these, the correlation between mistreatment and brutality on the one hand and low pay, long hours and overcrowding on the other hand is immediately apparent.

At Warren, Pa. for instance, the hospital is supposed to have a capacity of 2,074. Actually its average daily resident-patient population is 2,560; a 23% overload. The scheduled number of employees is 500 . .. the actual number in recent months has averaged 371. There have been four physicians—one to every 640 patients — when the official schedule calls for 12 and any decent standard would require from 18 to 25. The "secret" of these personnel shortages—which have existed since long before the war—is readily apparent when one examines the wage scales. Attendants in Pennsylvania state hospitals start at the magnificent base pay of less than $900 a year plus maintenance. By contrast the same state starts its prison guards off at $1,950 a year plus maintenance, although the psychiatric attendant's job is more dangerous and certainly far less pleasant than that of the prison guard.

Nor is Pennsylvania by any means the worst among the states. At the state hospital at Howard, R.I. there were approximately 200 vacancies among attendants on Dec. 13, 1945. The starting wage for attendants was $55 a month and maintenance.

The rated capacity of Cherokee State Hospital, Iowa is 1,200 patients. On Dec. 20,1945 it had 1,725 on its rolls. Yet of 20 "budgeted" nurses only two were on the rolls; of 130 budgeted attendants only 62 were actually employed. Attendants' wages start at $65 a month.

Penny-pinching is not limited to wages. Between skimped budgets and a lack of help scores of hospitals have not been able to maintain even a minimum standard of building maintenance. From one of the Virginia state hospitals comes the following report:

"There is no shower in the infirmary and senile ward . . . only two bathtubs for approximately 65 patients. … In one bathroom dirty water from pipes in a bathroom overhead drips into our bathtub and on the patient being bathed, as well as on the attendant doing the bathing."

From a New York state institution:

"On Ward 41 we keep the more disturbed and untidy patients . . . who frequently break the window panes. During the summer no attempt was made to replace broken panes. When cold weather came there were still no window panes put in. For two weeks we attendants called the attention of the supervisor to this condition but [he] merely passed it off as unnecessary, not bothering even to go out to the day room to investigate." Even the food is skimped. In 1940 the average value of the food consumed by patients in mental hospitals throughout the U.S. was 23.3 cents per day. Some states were trying to feed patients on as little as 17 cents a day and even in such high-cost areas as New York the daily food consumption was only 26.8 cents. In most cases these figures include the food raised by patient labor on hospital-farms.

Investigators are often fooled by elaborate menus prepared by dietitians are carefully filed in the hospital records. How deceptive these menus can actually be is demonstrated by the records kept by one objector-attendant at a Connecticut state hospital.

One morning in August 1944, when the patients' breakfast menu called for Maltex and soft-cooked eggs, the patients got merely Maltex. That night instead of a menu-listed ration of "macaroni, tomatoes and cheese" their supper consisted of nothing but lima-bean soup. A few days later breakfast was supposed to have consisted of "orange halves, corn meal and scrambled eggs." The patients got only corn meal. For dinner that day they were supposed to have "beef stew and steamed rice with raisins." They actually ate frankfurters, squash and potatoes. For supper they were scheduled to get baked beans and coleslaw. They actually got bean soup and nothing else.

From a New Jersey state hospital, an attendant writes:

"At its worst, which we see daily, the plates take on the appearance of what usually is found in most garbage cans. … I have seen coleslaw salad thrown loose on the table, the patients expected to grab it as animals would. . . . Tables, chairs and floors are . . . many times covered with the refuse of the previous meal."

The inadequacy of the patients' food is often aggravated by the assignment of the finest foods to the hospital staffs. The dinner menu for the doctors at a Pennsylvania state hospital on a Tuesday in August 1945 consisted of "prime rib roast beef with gravy, broiled potatoes, roast corn on the cob, bread (white, whole wheat, rye or raisin) with butter, salad of cucumbers, lettuce and celery, apple-apricot pie and coffee, tea, iced coffee, iced tea, or milk." On the same day patients in several buildings got "hard-boiled eggs, lima beans, beets, white bread without butter and milk or black coffee."

Pennsylvania state law requires that all milk except Grade A be pasteurized. Grade A milk is required to have a bacteria count of fewer than 50,000 per cubic centimeter. On 22 separate occasions from January 1943 to December 1944 tests were made of the milk served in the patients' dining room at Warren State Hospital. On only six occasions did it comply with the law. The average bacteria count of this unpasteurized raw milk was 398,100. On three occasions it exceeded 1,250,000 and on one occasion it exceeded 3,200,000!

OVERCROWDING MEANS FEWER CURES

Abuse and the punitive use of restraints, overcrowding, underfeeding and dilapidation might all be condoned if only these hospitals achieved a reasonable standard of treatment and cure. But the fact is that the vast majority of them fall far below the achievements of the few better hospitals and far, far below what could be achieved if cure rather than mere custody were the primary objective.

Annually, in the U. S. as a whole, for every 100 mental patients fewer than 12 are discharged as improved. Even of these, more than 40% have to be readmitted and reconfined, usually within a few months.

The discharge rate tends to fall as overcrowding rises. Again using pre-Pearl Harbor figures, New Mexico, overcrowded by 107.5%, achieves a discharge rate of only 4.1%. Illinois, on the other hand, has only a few hundred more patients than its buildings were designed to hold. Its discharge rate is 15.9%, nearly four times as high as that of New Mexico.

There are eight so-called "special therapies" which provide a good index of the degree to which any hospital attempts to achieve cure or improvement for the large proportion of cases where modern medicine offers hope. In most of the northern and central states all eight of these types of treatment are, at least theoretically, available to the patients. But the figures of 1939, before war emergencies arose, indicate that North Carolina offers only two of the eight; South Dakota, Vermont, New Mexico, Arizona and Nevada offer only three; Alabama, Utah and North Dakota offer only four.

In some hospitals the shortage of personnel and the patient overload have progressed to a point where physicians make little pretense of treating any large proportion of the patients. The vast majority of patients get whatever treatment they do receive from unskilled and untrained attendants. A Mental Health Foundation report from an Iowa state hospital reads:

"Attendants give medications constantly and without doctor's signature, on oral orders only. They decide restraint problems and no reports are made. They receive no training. There are *no* nurses in this hospital."

A similar report from another Iowa hospital says:

"There is no systematic review of classification and parole-eligibility by the staff. Such review was begun a year ago but given up as hopeless within a few weeks. . . . Many patients are good parole prospects but are not considered except upon request of relatives … no longer any special diets for diabetics. Such diets used to be prepared some time ago but have been discontinued. Diabetics eat the same meals as other patients now."

Despite work loads that would break the strongest men, many state hospital physicians labor to the point of exhaustion in a sincere effort to do their very best under discouraging circumstances. In the many hospitals I have visited I have seen numerous men and women physicians doing jobs of truly heroic proportions. At Dayton, Ohio a 73-year-old woman physician has come out of retirement to work long hours, often visiting her patients in a wheelchair

TOO MANY DOCTORS ARE INCOMPETENT

Others, however, are incompetents, alcoholics and psychotics who could hold no position in well-run institutions where cure is the objective. All too often the end result can be described in the terms used in a report from an Indiana state hospital:

"During my three months there I never saw the ward doctor give any but a cursory physical examination. He usually would stop but for a moment at the bedside of new patients. He was nicknamed 'the Butcher' by the nurses, after his manner of lancing boils. He seldom came to the ward to declare an expired patient dead. He would be called on the phone by a nurse when a patient was thought to have expired. Usually he would say 'Oke' and that would be the end of it. On outwards, patients are prepared for and sent to the morgue without ever a doctor appearing on the ward."

From a Pennsylvania state hospital a report reads:

"On one occasion a young patient with a fractured hip was sent to us (2-West, Male Infirmary) and we got him up into a wheelchair for several days, not knowing what was wrong with him. No doctor corrected our mistake until five weeks later."

From Utah comes the report:

"A patient became ill and his rectal temperature was found to be 105.4. The doctor who was called replied, 'He gets a high temperature every once in a while, so don't worry about it.' "

Such instances of callousness and incompetence—and the records are replete with hundreds more—cannot, of course, be excused in men licensed as physicians and pledged to the Hippocratic oath. Yet the major burden of blame must be placed elsewhere than upon physicians' shoulders when reports such as this one from a Rhode Island state hospital are considered:

"After much persuasion our ward doctor finally examined a patient suspected of having tuberculosis and sent him eventually to the sanitarium. The patient died two days later of active tuberculosis. The doctor had far too many patients to handle. He was responsible for 550 at the hospital plus some 200 men at the state prison."

As evidence mounts up one is led, inevitably, to the question, "Can things like this ever be corrected?" Fortunately, the answer is "Yes," or rather, "Yes, but it takes hard work." For in the state of Ohio, where conditions were as bad as anywhere in the U.S., a major reform movement is now under way.

It started in 1943 when a group of conscientious objectors stationed at Cleveland State Hospital interested two leading Cleveland citizens, the Rev. Dr. Dores R. Sharpe, executive secretary of the Cleveland Baptist Association, and Walter Lerch of the Cleveland *Press.* Before these men the conchies laid a stack of affidavits a foot high, affidavits covering conditions such as those I have described and other horrors even worse.

After confirming the accuracy of the affidavits by his own investigations, Lerch broke the story on the front page of the Cleveland *Press* in October 1943. Day after day he brought forth more evidence—proving the beating and shackling of patients, proving the inadequacy and revolting nature of the food, the overcrowding, the low salaries, the neglect of treatment.

At first the stories were met by officials with shocked cries of "It ain't so." But when Haden Blake, an attendant, was ordered arrested for beating a patient and when Blake was permitted to walk out the back door and escape when the arresting officers came for him, the governor was forced to authorize an investigation. Even so, for a period an attempt was made at cover-up and whitewash. The "investigation," conducted by the state welfare director —himself under criticism as the man ultimately responsible for the operation of Ohio mental hospitals—brought forth a report asserting gross exaggerations.

THE SCANDAL GROWS

The entire matter might have died at this point, as have so many other newspaper exposes, had not the Cleveland hospital superintendent, a Dr. Hans Lee, made the mistake of seeking to oust the complaining conscientious-objector attendants instead of those charged with beatings. Lerch sailed in once again, showing that one objector, who had confessed to beating a patient, was being retained while the complaining witnesses were being dismissed. Within a few days another attendant was under arrest. A day or two later a patient walked off the grounds and to the great embarrassment of the authorities committed suicide in public. Church groups and civic bodies rallied around Lerch and Sharpe, calling for a real probe and, after eight weeks of charges and countercharges, Governor Bricker finally named a representative committee to conduct a real investigation

For months Lerch kept the fires of criticism hot with further charges. It was shown that four female patients had arrived at the hospital only to be thrust into strong rooms and left there unattended until all four came down with pneumonia. Their unconscious bodies and high temperatures were discovered only on the day of their death.

It was shown that rats, in a makeshift basement morgue, ate away the face of an aged patient while his body awaited burial.

It was proved that only 13 beds were provided for tubercular cases in interior rooms having neither sunlight nor ventilation. It was demonstrated that during at least one two-week period no medical officer, except the superintendent on a routine tour, had seen these desperately ill people.

Lerch kept hammering away with more and more evidence until, in May of 1944, seven months after the first expose, the soon-to-retire governor appointed Dr. Frank F. Tallman to the long-vacant post of State Commissioner of Mental Hygiene. Then things really began to happen.

Within a few weeks, the superintendent at Cleveland "came to the conclusion" that he might best resign. The governor's Griswold Commission came in with a scathing report, confirming the previously denied charges and recommending a $36,700,000 program for additions and new hospitals.

Yet Sharpe and Lerch and Tallman were hardly satisfied, for recommendations are not appropriations and the proposed "brick and mortar" building program, while desperately needed, did nothing to raise employee standards or solve personnel shortages. They kept on campaigning and in January 1945 got another break when Sharpe was appointed foreman of the Cuyahoga County Grand Jury.

Under the dynamic preacher that runaway jury took the old common law literally and proceeded to investigate the Cleveland hospital from dank cellars to dark attics. It finally issued a special presentment which concluded with an unprecedented indictment of the state itself as "the uncivilized social system which enabled such an intolerable and barbaric practice to fasten itself upon the people."

With Lerch, now joined by other newspapers, making the most of Sharpe's presentment, a reluctant legislature voted $17,000,000 for new hospitals. Under Tallman many of the worst abuses are being eliminated and the long, hard climb toward a decent standard begun.

A prime point in the new program calls for a chain of receiving hospitals, special institutions to which new cases are sent for diagnosis and three months or less of intensive therapy without the stigma of court commitment and incarceration in an "insane asylum." The first of these was opened last November at Youngstown with a capacity of 80 patients and a staff of 60, including two physicians, a psychologist, two social workers and 14 graduate nurses.

Intensive treatment of this sort is expensive. It costs $6 a day as opposed to $1.20 a day in Ohio's large and essentially custodial mental institutions. But it produces dramatically effective results. In the first three months of the Youngstown Hospital's operation 89 patients were discharged after an average stay of only six weeks. Of these 71 were discharged back to their homes as "improved" and capable of at least a trial at adjustment to life in the outside world. Only 18 were sent on to other institutions.

The gain to the state is obvious. For something less than $300— spent on six weeks of intensive treatment—the state receives a high proportion of useful, economically productive citizens, while the custodial institutions, harboring identical cases, spend as much or more per patient at their deceptively cheap daily rate and, in the end, fail to restore the majority of these citizens to society.

In addition to these small intensive-treatment hospitals, Ohio has acquired hundreds of new beds since the reform movement started and has thousands more under, or awaiting, construction. A strong drive is under way to acquire new personnel and—even more important—to train new help so that they can function as medical personnel rather than as keepers. Many of the outstanding sadists and incompetents of the old regime have been dismissed; abuse and mistreatment of patients is no longer tolerated complacently.

Yet the leaders of Ohio's mental-hospital reform movement— both within and outside of the administration—are by no means satisfied with the progress that has been made. Their principal difficulty1 centers around the pitifully low pay of attendants, nurses and physicians and the impossibility of securing adequate personnel to work 12-hour days for such small wages. Here, up to now, they have been stymied for lack of appropriations.

But they are carrying on the fight. Under the leadership of Dr. Sharpe the newly formed Ohio Mental Hygiene Association has become a rallying point for everyone interested in hospital improvement. Governor Lausche has promised to press for funds for additional personnel and for a changeover to the eight-hour day. If these gains—plus substantial salary increases all the way down the line—can be wrung out of what has been a reluctant and penny-pinching legislature, Ohio will be well on the way to the leading position in the care of the mentally sick which the state once occupied 50 years ago.

For the rest of the country the Ohio experience, demonstrates an effective technique through which reform can be achieved. It is no easy formula to follow. It requires years of hard work and the intense interest of at least a few leading members of the community. But spark-plugged by understanding and dynamic leaders and properly presented to the people, a hospital reform movement can sweep any state—just as it has Ohio. For what happens to the mentally sick in our present hellhole hospitals is not the sad experience of some other fellow. Every minister, every doctor and every leader of any community organization knows that mental illness can strike down members of his immediate circle. Given the facts and given leaders of the caliber of Sharpe or Lerch, the people of any state will rally, as have the common people of Ohio, to put an end to concentration camps that masquerade as hospitals and to make cure rather than incarceration the goal of their mental institutions.