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"The Laggardly Eagle - A Transatlantic Commentary on Mental Health Services"

by

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I should like to submit as my text the following:--

> "The most significant difference apparent to one familiar with American mental hospitals is the greater respect for the patient as an individual noted in nearly all psychiatric institutions in Europe. It might have been expected that in the United States, where individual freedom is a revered tradition, this attitude would be reflected in mental hospital care."

Many of you will have heard this statement as the opening remark of Dr.[1] Barton recently at the Eighth Annual Neuro-Psychiatric Institute. It appears as the opening sentences of Observations on Psychiatric Practice in Europe, which is a report by three superintendents of hospitals in Massachusetts and the Chief Supervisor of Psychiatric Nursing in the Department of Mental Health in Boston.

I find it necessary to invoke your own countrymen to present this statement, for my own experience has been that such a comment from alien lips is unacceptable. Indeed, I suspect that already a certain erosion of the implications of such a statement has taken place in your minds. I hope not, but to me the most striking element in American Mental Health Professions is the adoption of the general national attitude (which may yet contribute to global disaster) and that is the apparent inability to countenance objectively the idea that America may not be the leader in everything she endeavors, that her sincerity and effort does not by definition make the best of all possible worlds, and that the chauvinism inherent in giant size, king size, newest, largest, fattest, greatest, superlativest, esti-i-est in the world is plainly ridiculous.

[1] Dr. Walter E. Barton, Farrell, Lenehan and McLaughlin.

Unfortunately, despite all the evidence, this lunatic misdirected advertising pride pervades professional thinking too and prevents us from examining soberly this vital matter of "respect for the patient".

I am a social worker, psychiatric of the species, and have practiced in England and in Europe, and for four years in the United States. I have visited with a professional eye most of the countries of Western Europe and 42 States of the Union. For the record, I have no old school-tie, do not wear a bowler, carry a cricket bat or fatuously exclaim "jolly good show". Likewise, I know that Americans do not all speak with a drawl, wear flashy ties, ten gallon hats and all own oil wells in Texas. England is not merrie, America not uncultured, and I should like to add that I believe the Revolutionary War was the War of Independence and that the outcome is not in doubt.

I am not here to provide you with a run-down of exotic services in far off lands or to be intimidated into acclaiming mine hosts virtues as would be a polite guest; I am not a guest - I am a member of our professional family and have no interest in national competitiveness. Never-the-less, the tone of my introductory remarks and the title of this paper acquaints you immediately with my considered judgment. Despite the fact that when it comes to expressing value judgments and opinions, I get excited, these are judgments arising from my primary concern for human suffering (which is not confined to any national boundary) and to the study of the means by which mankind has attempted to come to grips with what ails him. The attempts have much in common in the Western World but do have a real national flavor. On some other occasion, you might invite me to get excited about some of the poor aspects of mental health programs in England. Today I am going to be foolhardy enough to prod the American Eagle.

The medical and theoretical aspects of psychiatry do not differ very much

on either side of the Atlantic. They have a common root. Mid European psychiatrists found refuge in both our countries. Freud died in London. His disciples are known to us all. The influence of Jung is more apparent in England. Despite such characteristically American products as Sullivan and Rogers, the state of psychiatry - its talking, tranquilizing, convulsing and surgery looks much the same to me and if it isn't, I am not medically competent to remark upon it.

I would like to talk about the social aspects of psychiatry. Not merely an account of specific services such as open-door hospitals, day hospitals, halfway houses and the like. You will have heard the acclaim of American visitors to England regarding such programs. It is necessary to note that such services exist in the United States too. The context in which these programs exist, however, differ and in an extremely significant way. We must be clear that these services in England are part and parcel of the Governments acknowledged responsibility to provide medical care for all. In the United States such programs are too often part of a research demonstration project, financed either by a private foundation or an agency of the federal government, and are usually located in splendid isolation from the mainstream of medical care in one of the Ivory Tower agencies in a relatively few major cities. The visitor will probably be taken to these psychiatric tourist attractions in the new world.

However, the most outstanding feature of American psychiatry to the observer is private practice. Private practice is the overwhelming form of medical service in the United States and has many features in common with the national orientation to business. Having said this, I should explain that this aspect particularly strikes the British observer for in the British Isles this species is almost extinct so that its predominance on this continent is particularly

startling. This observation is reinforced when one looks at public care in the United States and one sees it staffed predominantly by foreign nationals. For example, in New Jersey the state mental hospitals for a patient population of 21,000 employs 141 full time physicians, 99[2] of whom are foreign trained. Essex County Hospital with a 3600 population has 24 of the 29 physicians foreigners. The Americans are usually the Superintendents, the Pathologists and the top echelons. (You will understand that I have no bone to pick with foreigners.) But so predominant is this foreign element in public hospitals, that one cannot help wondering whether such public service is an Un-American activity. These are not training programs. Often these doctors are seeking official entree via the public hospital to be allowed to practice private medicine in the United States. In passing, one wonders what their own countries, who are so less fortunate in many ways than the United States, are doing to find sufficient medical men to serve their own medical needs as well as those of the United States.

However that may be, the point to be made is that generally speaking, public mental hospitals are not attractive to professional personnel. It is not difficult to pick up over $20,000 a year in private practice. Top flight jobs in public service do not pay such salaries, and where they even approach such rewards it is not for the practice of medical skills but for administration. Over and above this, the doctor finds himself in a position of accountability unknown in the private sector. The miracle is that skilled and dedicated men work in public service at all.

[2]Of these 99, 15 are certified, 34 have applied and 50 are ineligible for certification. It may be that when standards are enforced, the State will have to face the social implications of losing 50 of these 141 physicians.

No one would argue that skilled psychiatrists should not receive an
ropriate income and we cannot blame the medical profession for the failure
provide a structure through which they can remain faithful to the Hippo-
atic Oath and apply full medical knowledge and skills to the sick irrespec-
ve of their ability to pay. The ultimate responsibility lies with the
ople, or the "community", that nebulous entity we hear so much about in
nerica. I do not need to document for you the evidence of neglect in this
atter of public medical care; it is there for all who will not blind themselves
o see.

However, when writing this paper, I came across two items that caught my imagination on this very vexing question and I would like to share them with you. The first is not really respectable, taken as it is from TV Guide. Apparently, the wild west embodies the American medical dilemma and finds an intriguing solution, for I am told in the Johnny Ringo program:-

> [3]"The bank refuses to lend Wes Tymon money to provide medical attention for his wife. When Mrs. Tymon dies, Wes goes gunning for Cartwright, the town banker."

Note this slice of American folklore. It's the banker Tymon goes gunning for, not the doctor mind you. Secondly, the First National City Bank of New York had a large ad in the Times celebrating its 10th million loan which had "helped with family needs".

> [4]"To begin with a million and a half of these loans (almost a half billion dollars) went for medical expenses -- you can 'they say' if you like, think of this as a lot of sickness".

How is it that the American family whose credit is good with the First National City Bank finds itself pushed into mortgaging its future in order to meet medical expenses?

[3]TV Guide - September 15, 1960.
[4]New York Times - September 29, 1960

Before getting to the public responsibility for the provision of medical care, I would like to urge doctors to cast off their organizational bigotry. One would expect doctors to be excited at new ideas and forms in public health. Yet, in the past few years, I have carefully kept an eye open for American accounts of the British Health Service. Only once have I seen in the New York Times a mildly favorable article on the theme that the National Health Service was not an issue in the general election. Indeed, it is now firmly part of the national life and of no real political consequence. Hardly anyone knows that there is no compulsion either to doctor or patient to join the service or that the patient is free to have any doctor he chooses. There are only 600 out of a total of 24,000 general practitioners still outside of the service. The service includes medical, mental, pharmaceutical and dental care. If I had more time, I would be delighted to discuss with you further many exciting aspects of the service. For our purposes, however, I must tell you that until I came to America I had never heard of socialized medicine - a term of abuse not altogether uncondoned by that distinguished body the American Medical Association. Like all terms of abuse, it serves to obscure the nature of the real issues. You will be interested to know that in August of last year a letter appeared in the [5]New York Times from the British Medical Journal (not the most radical of publications) accusing the AMA of misrepresenting facts about the National Health Service. Organized medicine in England and throughout the world seems to have vigorously opposed every attempt to make inroads on the non-medical and public health aspects of medical care and it behooves the profession to look carefully at what constitutes a proper area of authority for which medical training and experience

[5]New York Times - August 28, 1959.

prepares and what is frankly a power ploy protecting the tribute that it exacts from the sick, the suffering and the desperate.

I wish to assure you that my view of the private provision of service is not a matter of dogma but a pragmatic conviction that private auspices have failed to come to grips with the problems. We should not need to be reminded that mental health services especially - now we give them a community rather than custodial emphasis - are meaningless from the social point of view outside of the whole matter of social welfare and a people's determination to prevent social disasters piling up upon those visited by physical and mental misfortune. Yet in America, we cling tenaciously to the myth of the Voluntary Principle. The first response subsequently successfully challenged of the national level of a voluntary organization close to me, recently when approached to consider a scheme for doing something creative about fees, replied that this matter was traditionally the sphere of doctor-patient negotiation and not the business apparently of citizen organizations.

Despite the pitiful inadequacy of Voluntary Agencies to handle the magnitude of misery and their increasing inability to raise money to hold the line, let alone make significant advances; in the teeth of the fratricidal competition that takes place between the hearts, the livers, the kidneys and what have you, the myth remains. Municipalities, the counties, the states and the federal government, in that order, can only legitimately, according to this view, step in where all else fails. The mentally ill by and large are the charges of government <u>because</u> all else has failed. We then project our social failure upon the patient - for we give him the title "indigent".

The principle that, "we the people" and - who are the people unless in a democracy it is organized government in the hands of the people - the principle

that government is responsible for the welfare of its people is not accepted here. The myth of rugged individualism continues and government is good that governs least, local right to stagnation is upheld vehemently. All this despite the fact that (according to figures from a recent Rockefeller study) government already by 1928 was spending 7 times more than philanthropies for health and medical care and has continued to do so; by 1958 it was about 9 times as much.[6] Deny it as we may, government plays a major role whether government is prepared to recognize it or we like it or not.

Let us then turn to Government. First, a word of warning. George Bernard Shaw said that England and America are nations divided by a common language. Words like "Government" and "politics" have different meanings in our respective countries. I suggest an English-American Dictionary would read something like this.

> English definition: denotes an effective social organization for carrying out the expressed will of the people. Served by politicians and civil servants who, being men of good-will, honored by their countrymen, derive status, and endeavor to further the national well-being.
>
> In American: that group of incompetents who step in when all else fails. Served by crooks, gangsters and blackguards seeking their own anti-social ends. Men of good-will endeavoring to participate find themselves used and besmirched.

Obviously, I have painted the picture in black and white but we cannot discuss social organization in democracies without insisting that if politics is dirty and government incompetent, we do not throw up our hands and abandon it, but that it is our bounden duty as civilized people to see that is is otherwise.

[6] Voluntary Health and Welfare Agencies in the U.S. - Their Role and Responsibilities. An exploratory study by an ad hoc committee undertaken at the invitation of the Rockefeller Foundation, May 1960.

Let us get some perspective. The Elizabethan Poor Law which is still the basis for most of American welfare programs has been completely swept away in England. A silent revolution has taken place and a small part of that revolution was the enactment of the National Health Service. In 1953, five years after this enactment, a Royal Commission was set up to consider more specifically the mental health aspects and in 1959 the Mental Health Act demonstrates that the present government - one of a very different persuasion than the initiating government - is today vigorously continuing the inherent underlying social philosophy. These central government Acts actually affect 50 million citizens and they are not paper Acts either. In many places the services precede the determination to legitimize and univeralize them throughout the land.

Here, in the United States, despite the apparent break through in the early '30's, the battle continues along the lines that Dorothea Dix fought when in the time of President Pierce, she made a plea for the intervention of the federal government in the cause of the mentally ill. In 1854, the President's veto upheld the view that the federal government's intervention was unconstitutional. Today the principles of social security may be entrenched in regard to Old Age Insurance, and possibly Aid to Dependent Children, (though this is doubtful in many states; Louisiana being a particularly topical example. Ludicrously, I read reports that food and clothing parcels are being sent by Britons to families in that southern state.) The underlying idea of government responsibility is still not a major part of American thinking.

Witness the current debates of medical care for the aged -- all the old hand-out indignation was given an airing and the sacred rights of voluntarism upheld, along with the piety of private insurance. Even the party who had nailed

into its platform a program to meet this crying need, a program mild indeed in relation to the welfare programs of most western nations, this party was unable to rally its leaders to the social security principles in this decisive election year. The federal government, then, one concludes is relatively uncommitted to a real attack on the problems of the mentally ill. Its most outstanding achievements are probably in relation to that particularly favored group, the veterans, and in the research stimuli of the National Institute of Mental Health of which I shall have more to say later.

Let us then look for progress in the States. The state I know best is New Jersey. Recently when discussing with Dr. Gebirtig the lack of advance on the mental health scene, he took me to task and referring to his years of experience at Greystone, maintained that one only had to walk through the grounds and the wards to see the great strides that had been made. I am sure he is right, but I don't think that we can take comfort from the fact that "here in other days and presently in other places, things were and are worse". This matter should be looked at more closely. What measurement do we use for progress? I am sure that walking through downtown Newark or on the eastside of far-off Manhattan or in Spanish Harlem, conditions are better than they were 30 years ago. Inside and outside the hospital, times have changed. The general standards of living and expectations have been raised. But has there been such enormous strides with regard to the mentally ill compared to our technological advances and our material well being? Granted, the sight and smell of our hospitals have changed with the advent of E.C.T. and the tranquilizers, but does not this kind of advance make doubly important the provision of community services for the sick before the possibility, and after the fact, of hospitalization? There is indeed a current declared emphasis on community rather than custodial services. Let

us examine this.

Here in New Jersey, 1957 marks adoption of the Community Mental Health Services Act, a device to put State money into community services through our old friend, the matching dollar. This amounts to 20¢ per head of the population per year. An amount totalling less than we collect in tolls on the New Jersey Turnpike in 14 days. [7]88% of all the State money goes to children's services and no more than 3 services in the whole state receive these funds for serving adults predominantly. Indeed, it is the Department of Institutions and Agencies avowed intention that monies be used for children's services and the 20¢ figure is based on an estimate of child guidance needs. Meanwhile, the State's out-patient facilities for adults have withdrawn from business in the community and have placed themselves in the hospitals. A patient in Bergen County, for example, now has to find his way to Greystone. This is so difficult to do by public transportation that it would try the patience of the most collected of us, let alone the troubled person seeking help.

In 25 years of demonstration, the community has remained essentially uninterested in supporting services for the adult patient and still can hardly be expected to raise the sentimental fund raising image regarding the problems of the unattractive schizophrenic as it does when giving money to children's services.

The Department's priority of funds to Child Guidance Clinics comes just at the time when an emerging family orientation in psychiatry may make such services an anachronism, and the Department's influence in its idiosyncratic interpretation of the Community Mental Health Services Act, which at present discourages community concern with the problems of the adult patient, to my mind

[7]Checking this figure, I calculate a figure of at least 92%.

not only flies in the teeth of the conception of a modern network of community services but is extremely narrow and a clearly more restrictive view than the Act intends. Yet we hear on the highest authority in regard to New Jersey at the 1960 Ortho' Conference in Chicago and I quote:

> "It was determined that a program of state-operated mental hygiene clinics would be discontinued in view of the gratifying development of community mental health clinics under financial and technical assistance of the state through the Community Mental Health Services Act of 1957."[8]

As far as the adult patient is concerned, this statement is an exquisite example of the full unlovely nakedness of what I call the Emperor's New Clothes Syndrome - the administrative art of seeing services which do not exist.

Soon after my arrival in New Jersey, I was astonished one day at a National Conference to be told of how progressive we were in this State. You have a day hospital, I was told, (day hospitals then being the rage). You have a day hospital in a state facility -- this is achievement indeed. When I returned to New Jersey, I determined to find out about the day hospital and, sure enough, under the stairs of Trenton State Hospital is an excellent day arrangement. 12 patients are served and 12 patients have been served, as far as I can tell, for the past 8 years. Isn't 12 a bit puny in relation to our 21,000 institutionalized population and our crowded waiting lists? When is the 12 to become 120, and when are all the hospitals in the State to have such an arrangement? Nevertheless, the favorable publicity value of having a day hospital certainly is worth every cent we spend on it. It is not my intention to minimize the real achievements of our state institutions, but I do feel that to ask some of these pertinent questions might unite us in our common interest in dealing with the problems at

[8] V. Terrell Davis. "From Asylums to Hospitals in New Jersey".

and. Often I get the impression that to raise such questions in the interest of the public is somehow to be letting the team down. So much then, or so little, for the States.

As for the municipalities, suffice it to say that in Newark, a city of one-half million, the City Council has procrastinated for three years, and procrastinates still, to decide to allocate $30,000 to match State funds for a basic child guidance service. Martland Medical Center provides a kind of dungeon for the insane while arrangements are made to send them to the county or state hospital. Why? Because per patient, Martland costs the city $15 a day. It costs the county or the state about 1/3 of this they argue. Why should the city pay?

What this all amounts to is that in terms of social service there is a refusal to define clearly what level of authority is to be held responsible for initiating and developing and financing of service. Federal, State and local structure, or lack of it, which may have been appropriate in the 17th, 18th and 19th century for other purposes, now stultifies growth and needs to be drastically overhauled. We are trying to launch welfare satellites with bows and arrows.

This is recognized specifically in our New Jersey Alexander Report and unexpectedly a sentence appears in the Newark Welfare Federation Survey which says:

> "The public program should be responsible for those programs which are expensive and those that are used by large numbers of the citizenry. If the public job is done well, the voluntary agencies can concentrate on their special areas."[9]

It would seem that voluntary services are seeing the writing on the wall.

[9] Newark Community Survey, Vol. 1, directed by Laurin Hyde Associates. Sponsored by Welfare Federation of Newark, Irvington and West Hudson.

This brings me to the extraordinary dichotomy between the public attitude towards private spending and towards public spending. Privately, it is almost unheard of not to be spending beyond one's income. During the '50's, consumer indebtedness rose three times as fast as personal income, installment loans by banks rose four times as fast as deposits,[10] but still there has to be a "balanced budget" in regard to public spending. This in a country that spends more on armaments than half the total national income of Great Britain. Balance we may note tells us nothing about the appropriate volume of spending - only its relationship to taxation.

Both presidential candidates are trying to tell us that taxation is a kind of cardinal sin that can only be resorted to in times of national military emergency. They have forgotten Oliver Wendell Holmes who said "When I pay my taxes, I buy a piece of civilization". But we, the professionals, are intimidated and feel the tax dollar has to be constantly justified and the general belief that public funds are wasted are hand outs and the pickings for politicians, lead us constantly to tell the public what value they are getting for their money and what splendid achievement is being made. The voluntary agencies are no better, competing as they are for the voluntary buck. They turn out success story after success story. Minor activities are given glowing publicity. Always achievement. Next, let's conquer mental illness - always something new; new service, new first, etc. etc. Nobody presents the draining problem of the majority, the "unsuccessful" chronically ill. We must have success.

Who will stand up and say "we are doing a crummy job. That's all you can expect from the miserable pittance that this, the wealthiest nation in the world,

10- Vance Packard. "The Waste Makers"

lavishes on its welfare services". 20th Century care and treatment is 20th Century expensive. It demands 20th Century organization, and 20th Century financing, and requires most of all a 20th Century set of values. It requires us not to blind ourselves with the dazzle of splendid sounding achievement but to see how paper thin our services are and how few benefit from all this achievement. On paper, progress seems overwhelming, but a look at the impressive list of agencies and services in the community doesn't begin to show how incomplete, unintegrated and inadequate they are. Let the story be told.

Perhaps the greatest strength of America in this mental health field is in research and in publications. Relatively speaking, much money and effort is spent here; however, there is a seamy side. Much research is presented with gimmickry, something new to attract foundation funds. What concerns me is what use is made of research. Demonstration projects which often, for lack of conventional services, deteriorate into providing basic service do not find local support. As for spreading good service throughout the land, nobody seems to be concerned. Much of our research is, therefore, wasted and often is used as an excuse for <u>not</u> doing something. I think it would be true to say that if we were to declare a morotorium on research for the next 20 years and really implement what we already know, the picture of mental illness in this country would change beyond all recognition.

Let us return to the patient. He is the recipient of all our social blundering and insensitivity. He will have found poor or non-existent services to help keep him out of hospital. In hospital, he will find himself treated by low paid, lowest status medical men, often with language barriers and with a poor grasp of the patient's daily background, served by relatively untrained, overworked staffs and aides in overcrowded conditions in unattractive surroundings.

A drain on public resources - indigent - and often having had to demonstrate his pauperization in order to get help. Bad enough for the man and his family hit by physical misfortune, but as Dr. Henry Davidson[11] points out - for the depressed, self accusatory, anxiety ridden patient, this experience is destructive and inconsistent with his medical needs. When he leaves hospital, there is little means of rendering him support and helping with this transition, and usually he has to sink or swim alone. The total experience of "make-do" service does not reflect "respect for the patient" which brings me the long way round to my theme.

Dr. Barton, in his report, (and I have heard this elsewhere) suggests that one of the reasons that things are so much better managed in England in the mental health services is that the public themselves have a different cultural attitude towards authority. They have greater respect, he says, for authority and authority figures. There seems to me a certain suggestion of obsequiousness and servility in this idea, and I would like to comment - I am sure that all of you are familiar with the work of Stanton & Schwartz[12] - you will remember that they traced every event of pathological excitement and incontinence on a refractory ward, and were able to relate it directly to a covert disagreement between members of the staff towards the patient. This irrespective of the patient's psychiatric condition. Thus, there is evidence to suggest that the attitudes of authority are related to the behavior of patients.

What I am suggesting here is that the respect for the patient that is seen in the hospital and the respect of the patient for authority adds up not to

[11] An unpublished paper, "No Throughway - The Problem for the Family". Delivered at the Abraham Z. Barhash Conference 1960 Mental Health on Main St. Mental Health Association of Essex County.

[12] Stanton & Schwartz "The Mental Hospital". Basic Books.

servility but to a mutual respect. I am suggesting that authority in the guise of doctors and staff, in the guise of government, in the guise of social service personnel has acted respectfully toward the patient and has, thereby, earned his respect in exchange. This respect is not forthcoming in the United States, not because of inherent cultural factors, but because this respect in practice is not afforded to the patient. It is with all this in mind that I have dubbed the Eagle laggardly.

There is an enormous amount to admire in the United States; the vigor and energy and wealth of the nation is breathtaking. If the United States were determined to come directly to grips with the social problems of the day, I have no doubt that it would transform the lot of its more unfortunate citizens in the same way as it has transformed the wilderness into the treasure house of the world.

I am reminded that the eagle is not only a bird of prey but is reknowned for its strength, its swiftness, and its keenness of vision. One implores that these aspects of its nature will be realized. I think it appropriate to conclude with the three lines from William Blakes "Proverbs of Hell". He crys

"When thou seest an eagle, thou seest a portion of genius;
Lift up thy head"!

Discussion of "The Laggardly Eagle"

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Because of time limitations I am restricting my comments to those points I feel best qualified to discuss.

It is obvious that Mr. Drucker set about to present a stimulating and provocative paper and he has certainly succeeded. My "taking him to task" on one occasion apparently accomplished little, which is probably par for the course. I must disagree with some of the opinions he has expressed because they simply are not consistent with fact and in my opinion the Eagle is not as laggardly as he would have us believe. I feel sure that he has anticipated my disagreement with him, just as I believe that one purpose of his paper is to keep us from becoming too complacent.

To begin with, the American Mental Health professions are accused of adopting the general national attitude of needing to be the leaders. How can we reconcile this statement with the fact that in recent years many of the leading psychiatrists from the Northeastern States, including New Jersey, have spent some time in Great Britain and on the Continent studying what appear to be superior methods of psychiatric care in the hope of improving our own programs. What is more, the 8th Annual Neuro-psychiatric Institute held this year at Princeton dealt entirely with psychiatry in other countries.

As for Mr. Drucker's concern about our foreign-trained physicians, I would remind you that, as a result of the A.M.A.'s efforts through its E.C.F.M.G. requirements, the basis for this concern will be eliminated as of

January, 1961. By that date all foreign-trained doctors will be required to pass an examination testing not only their medical knowledge but also their ability to communicate. Failure to do so will mean that they cannot continue on the Staffs of our hospitals. Contrary to Mr. Drucker's opinion, many of these same doctors have provided some excellent medical service to our patients.

Certainly it is gratifying to know that people in Government and politics in England fall into the category which Mr. Drucker defines. As for his suggested American definition I am reasonably sure that he offered it more or less - and I hope more - with "tongue in cheek". The fact is that in New Jersey over a period of at least 30 years of my experience there has been no political interference in our State Institutions. What is more, the progress that has been made in recent years would have been extremely difficult, if not impossible, without the support and encouragement of our Government leaders. I cannot accept the implication that England has a monopoly on "Men of good will" in politics and Government because I know from experience that the English definition applies equally to the majority of our Government leaders in New Jersey.

As for Mr. Drucker's contention that the Community Mental Health Services Act as presently administered is essentially child oriented at the expense of service for adults, I can agree with him only in part. In the case of Bergen County, which he has used as an example, I would point out that most of the General Hospitals, including Bergen Pines, do offer psychiatric service to adults. I would also point out that in those instances where transportation to our Outpatient Clinic at Greystone Park is a problem we are able to provide that transportation through our Volunteer Services. It is interesting to note that in the past year approximately 100 adult patients who have had no previous contact with the hospital, have managed to avail themselves of our Outpatient service.

We must recognize the fact that we cannot be all things to all people. I think you would all agree that if a choice has to be made between child and adult services the children should have priority. Experience has proved, as it did in our Mental Hygiene Clinic at Greystone Park that even in the case of an all purpose clinic the ratio of children to adults is consistently about 70% to 30%. Of course we must not overlook two important facts: First, that the successful treatment of a disturbed child almost invariably includes the treatment of related adults, and second, that there is the important element of prevention in the early recognition and treatment of the emotionally disturbed child.

I was intrigued by the speaker's comments about the Day Care Program at Trenton State Hospital to the extent that I checked on the figures last Friday. At the risk of implementing his criticism I must tell you that presently there are only 4 patients instead of the 12 that he mentions, availing themselves of this service. I must hasten to add, however, that since 1955 118 patients have been admitted to that facility and 114 discharged. The present low census is apparently only temporary, pending a realignment of their Outpatient Department to include the Day Care Program. When we reorganized our Outpatient Department at Greystone Park we were prepared to consider the establishment of a Day Care Program if there was any indication of need for such a service. This need could not be demonstrated, primarily because of our relative isolation. We are, however, providing a night care service whenever the need arises - without fanfare, publicity or government subsidization. We have found that this can be an important service in promoting the patients' readjustment to community living.

I must take exception also to Mr. Drucker's statement that our post-

hospitalized patients must "sink or swim alone". He must know that one of the chief functions of our Social Service Department is to plan for the rehabilitation of our patients from the time of their admission to the hospital. By the time the patient is ready to leave the hospital, every possible effort has been made to formulate plans to help him with his successful readjustment in the community. These plans may include the family physician, a private psychiatrist, a family service agency, a community clinic, an employment service, a public health nurse or attendance at our Outpatient Department with continuity of service by the professional personnel of the hospital. Incidentally, the Social Service Department conducts special group meetings for patients who are about to leave the hospital and for their relatives for the purpose of answering any questions they may have. Also we distribute to patients and their relatives what I believe is an informative pamphlet spelling out the services that are available in the community and encouraging them to communicate with us regarding any problems that may arise. In the past year approximately 300 patients on Convalescent Leave have availed themselves of our Outpatient services at Greystone Park.

You might be interested to know that one of our social workers is presently making a study of the reasons for the patients' return from Convalescent Leave, in an effort to determine to what extent we may be responsible for these failures. Again, this is being done without publicity or subsidy, simply because we are interested in improving our services to our patients.

Finally, it is my considered judgment based on many years of experience in this field that gratifying progress has been made in our Mental Health programs and services. In recent years the pace has accelerated impressively. Given the

necessary time. I could readily outline the many specific advances that have been made and I could also point out the emphasis on both the humanistic approach to the patient and the respect for his individual dignity. What is most important to me is that I have every reason to believe that this progress will continue at an accelerated pace, particularly at the grass-roots level.

I cannot avoid the impression that basically Mr. Drucker has more admiration than he indicates for "the Eagle". Certainly we have nothing but admiration for the progress that is being made in the British Isles and on the Continent. Our concern is not with leadership or competition but with the most effective treatment for our patients. I trust that we will continue to profit by any superior methods or programs which may be developed in any part of the world.