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The Ohio State University, Ph.D., 1968
Sociology, general

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ORGANIZATION OF HEALTH CARE
FOR THE MENTALLY ILL

Dissertation

Presented in Partial Fulfillment of the Requirements
for the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

by

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The Ohio State University
1968

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INTRODUCTION

In the last fifty years much attention has been paid to the various kinds of behavioral phenomena commonly known as mental illness. The rapidly growing body of literature on the subject is eloquent testimony to the seeming intransigence of the phenomena. It stubbornly refuses to yield to any single causal explanation and yet regularly produces correlation coefficients which tantalize the researcher into even more elaborate investigative ventures. (1) The strategies and tactics of such research are largely determined by the theoretical perspective of the researcher. Thus the biochemist seeks to determine a bio-physiological link to the behavioral phenomena called schizophrenia. The psychologist seeks to establish a link between child rearing practices and schizophrenia; the sociologist attempts to link structural factors, such as class, status, and mobility to the onset of schizophrenia.

Inter-disciplinary studies have attempted to combine several theoretical perspectives. An example of this approach can be found in the excellent epidemiologic studies of the Cornell University group under the general direction of Alexander Leighton.

Given all the past research and study in the broad area of mental illness it seems possible to make several generalizations. First, a large segment of this work has been idiographic in both data collection and interpretation and thus has been open to serious question
as to the applicability of the findings to wider areas. Much of the work of Freud and others in the psychoanalytic profession would be classified under this generalization. Second, a large segment of the study and research has used nomothetic data and interpretation, and hence has been open to question by reason of the acceptance of idio- graphically derived nomenclature and categories in identifying and classifying the dependent variable—mental illness. Much of the relevant literature in sociology falls within this perspective. (2) When the latter approach is taken and diagnostic categories are used as descriptive of pathological entities the result is less than meaningful for the sociologist. The sociologist is more concerned with the consequences for the functioning of the person, than with the naming of the entity.

Within the boundaries of sociological frameworks one can find indicators of several different vantage points for viewing what is called mental illness. A most comprehensive vantage point is taken by Weinberg. He defines psychiatric sociology and further claims it as a branch of sociology. Psychiatric sociology is

The study of mental disorders as social phenomena. It is concerned with (one) the social factors and social processes that contribute to mental disorders, (two) the social definitions of mental disorders as forms of social deviance, (three) the social facets in the treatment and care of disordered persons, and (four) the social aspects of the prevention of mental disorders. (3)

Weinberg elaborates further

Another more consistent version of psychiatric sociology, which I advocate, is concerned with the social facets of mental disorders and their care, treatment and prevention; as the etiology of these disorders may be influence by social processes. (4)
Seemingly Weinberg is taking the mental disorders as "givens." The subject matter is found in psychiatry and the analytic tools are found in sociology. This would seem a fair statement of the psychiatric sociology approach of Weinberg.

A somewhat different perspective is advanced by Scheff who attempts to explain the "so called chronic mental illness," in terms of a sociological process. In brief, his explanation posits most chronic mental illness to represent at least in part a social role; and, societal reaction to be the most important determinant of entry into that role. Scheff's theoretical postulates are of interest to this thesis and will be referred to at appropriate points later. (5)

Sociologists have also studied social life within mental institutions; established correlations between social variables and diagnostic categories of mental illness; studied the incidence and prevalence of mental illness; studied social factors such as age, sex, marital status, race and many other variables as these variables seem to be related to admission, length of stay, discharge and readmission. Indeed there has been a plethora of empirical studies manifesting the interest of sociologists in this area of social life. A recent bibliographic index in mental health, which focusses on studies of a systematic, molar and social nature, contains over 300 titles. (6) Driver lists 1547 items in his reference guide to the sociology and anthropology of mental illness. (7)

**THE RESEARCH PROBLEM**

The voluminous literature on mental illness shows that little attention has been given to the conceptualization and description of
the broad and complex system of services and the flow of patients through such a system. This research is aimed at this objective. The purpose is to delineate the boundaries and describe the components of mental health services in Ohio, one of the heavily populated industrial states; to describe the processes by which definitions of mental illness are attached to people and by which decisions are made in regard to these people's entrance into and flow through the services of care for the mentally ill. A further objective in this research is to answer a number of research questions which relate some of the characteristics of the mentally ill to the patterns of entrance and flow through the services for care.
CHAPTER I

The Conceptual Framework

This chapter will outline a conceptual framework to describe and explain the pathways to care organizations. The discussion and presentation of the framework can be divided into four parts. The first part outlines a general overview for the pathways to the care system. The second part of the conceptual framework deals with the process of social control and its relevance for the pathways to care services. The third dimension discussed is that of the definition-decision making process. The fourth and final part of the framework elaborates the movement into and out of the services for care of the mentally ill. Each part will be discussed in turn and literature will be cited to document the relevance of the proposed framework to important work in the field.

The General Overview

The behavioral phenomena which come to be designated as mental illness are socially recognized as existing in varying degrees of severity, requiring varying responses from society. The societal designations and corresponding societal responses constitute a flow-model for the processes which work to maintain the balance between the demand for services generated by the gradient definitions of mental illness and the variety of organizational responses which constitute the supply of services.
Figure 1 diagrams the general framework for this study. Society is seen as providing both the consumers and purveyors of the services in the mental illness care system. Entry into the services system is regulated by the process of social control. The sub-set of persons defined as mentally ill, and about whom a decision has been made to enter them into the services system, becomes eligible for a wide range of services. These services are provided by both the public and private sectors of society.

The Process of Social Control

The process of social control operates to define the entrants to the services. Norms and values of society provide the matrix around which social life is organized. Values relate to standards of desirability, and norms regulate conduct. Norms prescribe and proscribe certain kinds of actions by various actors in different situations. Cultural norms are widely shared by individuals in society. One way to know norms is by inference. In the case of mental illness, it can be said that persons defined as mentally ill reflect nonconformity to the shared norms of behavior. Thus society regulates the behavior of the members by sanctioning according to standards set and shared.

In industrialized and urbanized societies many sets of norms are formalized. Laws have been written to codify procedures used to deal with mental illness. The law and the legal system are one means of social control in the mental illness services system. The laws help define the conditions under which entrants to the mental illness system are deprived of certain civil rights and liberties. The mental
Figure 1. Conceptual Framework for the Organization of Health Care for the Mentally Ill.
illness services system represents one of the major articulating points in this society for the institutions of medicine and law. (8)

Estimates of Mental Illness

The number of mentally ill have typically been estimated by two methods: one, by counting the number of persons hospitalized, and two by incidence and prevalence studies. Table 1 shows the patients on the active records of mental hospitals in 1958.

TABLE 1
PATIENTS ON ACTIVE RECORDS OF MENTAL HOSPITALS 1958.*

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>State hospitals</td>
<td>839,644</td>
</tr>
<tr>
<td>Psychopathic (teaching-research) hospitals</td>
<td>5,622</td>
</tr>
<tr>
<td>Veterans' hospitals</td>
<td>119,403</td>
</tr>
<tr>
<td>Federal hospitals</td>
<td>6,549</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>80,807</td>
</tr>
<tr>
<td>General hospitals</td>
<td>188,852</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,240,897</strong></td>
</tr>
</tbody>
</table>

*Taken from Action for Mental Health, Basic Books, 1961, p. 19. Figures presented in Table 1 include all patients on active records of all mental hospitals and thus include persons on trial visits, home-care, etc.

Table 2 shows the numbers of patients resident in mental hospitals for the years 1954 to 1961. If the estimation of mental illness is limited to those who are hospitalized, the problem does not loom large. Another way of estimating the extent of mental illness has been by incidence and prevalence studies. These studies vary in methodology, in criteria used, and therefore in the results. In a review of the
TABLE 2
PATIENTS RESIDENT IN MENTAL HOSPITALS 1954-61*

<table>
<thead>
<tr>
<th>Year</th>
<th>All Hospitals (excluding clinics and institutions)</th>
<th>State-County Mental Hospitals</th>
<th>Veterans Admin.</th>
<th>Private General</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>629,005</td>
<td>553,979</td>
<td>54,905</td>
<td>13,965</td>
</tr>
<tr>
<td>1955</td>
<td>637,962</td>
<td>558,922</td>
<td>57,991</td>
<td>14,590</td>
</tr>
<tr>
<td>1956</td>
<td>632,804</td>
<td>551,390</td>
<td>60,080</td>
<td>14,096</td>
</tr>
<tr>
<td>1957</td>
<td>628,894</td>
<td>548,626</td>
<td>59,240</td>
<td>13,543</td>
</tr>
<tr>
<td>1958</td>
<td>627,314</td>
<td>545,182</td>
<td>59,885</td>
<td>14,471</td>
</tr>
<tr>
<td>1959</td>
<td>624,402</td>
<td>541,683</td>
<td>60,805</td>
<td>13,696</td>
</tr>
<tr>
<td>1960</td>
<td>617,869</td>
<td>535,540</td>
<td>60,158</td>
<td>13,795</td>
</tr>
<tr>
<td>1961</td>
<td>608,972</td>
<td>527,535</td>
<td>60,108</td>
<td>13,019</td>
</tr>
</tbody>
</table>


epidemiologic literature, Plunket and Gordon compare eleven field studies. The rates of total prevalence, that is for all types of mental illness, ranged from 1.7 to 33.3 per cent. The median for the studies surveyed was 8.1 per cent; the mean was 11.8 per cent. (9)

In a more recent study, carried out in the Midtown Manhattan area, the in-patient treatment census yielded 0.5 per cent; when outpatient treatment was surveyed, the rate was slightly higher at .78 per cent. (10)

The Definers of Mental Illness

The definers of mental illness come from several sources. There are three major categories of definers; the societally legitimated mental health professionals, the legally empowered societal agents,
and those who represent "significant others" to the protagonist, and the "self."

The Professional Definers.—The professional mental illness definers constitute what in our society have been called the "paid altruists." (11) This group is made up of physicians, nurses, psychologists and social workers. The persons in these professional groups probably now number 1,069,000, (305,000 physicians; 621,000 nurses; 125,000 social workers and 18,000 psychologists). (12) However, only a portion of each of these groups is likely to be engaged in the defining process. In the physician group, 92,000 general practitioners and 20,000 psychiatrists would constitute the primary defining group. Of the 600,000 nurses there are 18,010 who work in mental health establishments and 41,254 in public health nursing. Hence, there are roughly 60,000 nurses who have active potential as mental illness definers. Of the 125,000 social workers, 11,200 are working in psychiatric settings. More than any other group, all social workers could be categorized as primary definers of mental illness. Of the group of psychologists about 6,000 are in clinical psychology, and thus would be apt to be active in the defining process. This brings the total number of primary definers to 189,000. (13) This group might aptly be called, together with the police, the "gatekeepers" to the mental illness services system. (14)

Secondary definers would be physicians, nurses and psychologists who work in schools and industry; school teachers and the clergy. In the volume, The Churches and Mental Health, Dr. McCann reports that
while more than one-third of all counseling problems seen by the clergy are estimated to be of serious psychiatric dimensions, only one-tenth of these are ever referred to psychiatric resources. (15)

All together, the secondary definers constitute an unknown number of persons who may have, but not too often do have, a significant import on the entrance of persons into the mental health services system. It is likely that they serve as a kind of pre-screening and refer to the "professional help-givers" for definition, rather than make the definition directly.

The Legal Definers.—The law which is so intimately bound to the mental illness system in this country serves as the protector of society and of the individual. The law and its agents; the courts, the police, the health officials, serve as major gatekeepers for entrance to the mental illness care services.

The law provides the framework within which the legal definers do their work, and generally assumes both a medical and a moral stance. Typically, the individual is to be confined in a hospital when he is endangering lives or property. Just as it is true in criminal law, the law as it pertains to mental disability primarily serves those whose behavior is officially noticed. It is usually the enforcers of the law; police, deputy sheriffs, peace officers, etc., who have the greatest opportunity for defining a person as mentally ill. These agents have the authority to effect temporary and/or emergency confinement in all but twelve of the fifty states. Such confinement usually takes place in a state or county mental hospital, but in a few states the jail is
sometimes used. Almost all involuntary hospitalization for mental illness involves the use of legal enforcers. Schwartz states, "A court officer or a policeman is the patient's frequent escort, and often the patient is unaccompanied by friends or family." (16) Such circumstances would seem to have a profound bearing on the "defining process" as well as the potential outcomes for a person as he moves through the mental illness system.

"Close Others" as Definers.--The legal system and the family system support the idea that close relatives and close friends are expected to be involved in the process of making the definition of mental illness. The typical language of the law is "friend, relative, spouse, guardian or health officer." (17) Mechanic emphasizes that "community members," not the professional personnel, are the initial definers. (18) The importance of the family and others to the defining process is further underscored in this quote from a physician talking about those cases in which the family or close others initiated hospitalization:

"These cases are pretty automatic. If the patient's own family wants to get rid of him you know there is something wrong." (19)

Self As Definer.--Logically it would seem that all who voluntarily admit themselves to clinics, hospitals, etc., are in fact making the initial definition for themselves. What apparently is sought by these "self-definers" is validation that the definition is a tenable one. When self is the initial definer it seems likely there has been some prior involvement in the decision making by "close others."
The Societal Resources

The society invests certain of its resources to provide the array of services available to the persons defined as mentally ill. The resources have their source in the private or public sectors of the society. It is a historical fact that the cost for the care of mental illness has been largely borne by the public sector. The almshouses usually contained a section for the "lunatics." Later the States made provision for the care and confinement of the mentally ill. The Federal government, until the early 1950's, continued the stance adopted by President Franklin Pierce in 1854 when he vetoed the "12,225,000 Acre Bill" which would have given the States additional financial support for the care programs for the mentally ill. President Pierce held that "Congress did not have this power to usurp State's rights--even in defense of human rights." It was almost a century later that the Federal government began financial participation with the States in the provision of services. (20)

A President's Panel Report showed that in 1953-54, 5.4 per cent of the Gross National Product went for health and welfare services. This can be compared with 11.1 per cent and 11.5 per cent of Gross National Product for Denmark and Sweden respectively. (21) In 1957, Fein's estimate of the direct costs of mental illness were on the order of $1.7 billion annually. Approximately two-fifths of this amount comes from the States, a little more than two-fifths from the Federal government and a little less than one-fifth from the private sector. (22) More than half the States spend less than three per cent of their general budget to maintain the state hospital system. (23)
In 1959 mental health ranked eighth in total funds raised in ten leading voluntary health campaigns. The leading fund raiser, the Polio campaign, yielded roughly twenty times more than mental health, (437.2 million dollars to 22.5 million dollars respectively). (24)

In terms of total appropriations by Congress for major activities in the National Institutes of Health, mental health was toward the bottom in 1950, but in 1961 was ranked just after cancer: $111 million for cancer, and $100.9 million for mental health. (25)

The Array of Services

One way of classifying the array of services for the mentally ill is by two categories--out-patient services and in-patient services. These may be sub-classified by type of control--public or private.

1. Out-patient Services.--In the wake of the Joint Commission report, Action for Mental Health, out-patient services have expanded more rapidly than any other category of service. Typically the out-patient services are organized around the clinic model. The professional experts occupy offices in a physical structure, often attached to a general hospital, and the out-patient brings himself to the source of the service. In the past decade there has been considerable development of unattached clinics, that is, unaffiliated with the hospital. These facilities more often than not are found in smaller cities and towns. Some clinics are established in conjunction with the courts, usually juvenile courts.

Most clinics seem to be multi-purpose organizations. Their stated purpose in a broad sense is the prevention of mental illness,
Given the imprecise criteria about what behavior is to be defined as mental illness, it is not surprising that clinics are less than precise in stating organizational objectives.

Out-patient services would seem to be, in a large measure, becoming a "gatekeeper" for the in-patient hospital. Many of the cases who come to the clinic are referred by other community agencies: the schools, police, courts, public health nursing services, private physicians. Another large percentage of cases who present themselves to clinics are self or family referred.

a. Functions of Out-patient Services.—There seem to be two major functions, or organizational objectives, of the clinic as a type of out-patient services. One might be called validation services, the other treatment services. The validation function of a clinic is provided in the form of judgments about a person's health status that will be widely accepted by third parties, and is a major reason for referral to the clinics from other agencies. This validation role is illustrated in this citation from Fuchs.

Consider the following situation: a person is thought to be acting peculiar, he has various problems which seem to be worrying him. He complains and looks for sympathy from family, friends, neighbors and co-workers. He may seek to be relieved from certain responsibilities or to be excused from certain tasks. Doubts may arise in the minds of persons around him. Questions may be asked. Is he really ill? Is he doing all that he can to get well? A visit, or a series of visits to a clinic or a physician may be indicated. The patient may not have the slightest hope that these visits will help his health, and, indeed he may be correct. Nevertheless, the service rendered by the clinic cannot be said to result in no output. The visit to the clinic or physician is a socially or culturally necessary act. The examination, the diagnosis, and the prognosis are desired by the patient and the agency to provide confirmation to those who have doubts about him. Only the professional judgment can still the doubts and answer the questions. (26)
The second major function is direct care services. The individual may be accepted as an active case and treated. Treatment may include individual and/or group psychotherapy, the prescribing of medication, occupational therapy, occasionally electro-shock therapy, and infrequently some form of ambulatory insulin therapy. Any one or a combination of several of the above may constitute the therapeutic modality for the direct care service function of the clinic.

Another organizational objective may be operative in the workings of the out-patient clinic, the delivery of mental health services to the community. In this instance the community is conceptualized as the patient. Treatment is delivered by educating "key professional groups" in mental health concepts. Target groups are teachers, nurses, general medical practitioners, clergymen, etc. Consultation for mental health problems is offered to established social welfare agencies. The "lay population," (P.T.A. groups, home study clubs, service clubs, and voluntary organizations) is also a beneficiary group for this mission.

b. Other Organizations Related to Out-patient Services.—Within a community there is usually a group of health and welfare organizations. All of these agencies bear a direct or indirect relationship to mental illness care services. Directly, their function may be counseling for the ostensible purpose of prevention of mental illness; for example, some family and children's agencies. Indirectly, the function may be prevention through education; for example, the educational programs of a mental health association. The numbers and kinds of these health and welfare agencies in a given community will likely affect
the rate and direction of the flow into the mental illness services system.

c. Community Help Givers as a Part of Out-patient Services.--
Persons in help giving occupations who operate entrepreneurially represent part of the out-patient services provided by the society. This category would include psychiatrists, psychoanalysts, non-medical psychotherapists (usually clinical psychologists), and perhaps an occasional psychiatric nurse or psychiatric social worker practicing independently. Marginal to the above group of more or less "legitimate" help givers are the palm readers, fortune tellers, consulting astrologists, soothsayers, spiritualistic mediums, and others of this genre. Both types of entrepreneurs have as their chief purpose the giving of help to persons who are troubled, for a fee. In general they provide out-patient services for those who can muster the economic resources to afford them. The former type, because it is the more legitimate, has many more ties to the established mental illness services system. The latter type operates in a largely marginal position with regard to the society as a whole and seldom has a direct point of articulation with the mental illness care services. (27)

d. Single Service Organizations as a Type of Out-patient Service.--Organizations sometimes develop in a community to service a single aspect of the spectrum of mental illness. The various services for "would-be-suicides," the Alcoholics Anonymous Groups, Synanon, Parents Without Partners, and Senior Citizens, are representative of this type of group. Their relationship to the mental illness system
is likely to be partially determined by the degree to which the organization is professionally controlled. Some of this genre seems to have as an ostensible purpose the reduction of "stigma." Albeit the group and the concern of the group is a deviant concern, the clustering together of "we are all of a kind" provides a kind of support for persons who possess a "stigmatized self." (28) Many persons are likely to be extruded from these service groups because they fail to act in sufficiently normative manner for the "deviant" group. In a sense this type of group serves as both a catchment for products of the in-patient services and as extruder for those who "fail" even within shelter of the "stigmatized" group.

e. Borderline Groups in the Provision of Out-patient Services.--
Borderline to out-patient and also to in-patient services is a group of services offered by agencies in the community, usually with the general aim of preventing the need for full time hospitalization. Such services may include a "home" for alcoholics, day care and/or night care in conjunction with the mental hospitals.

f. After-Care Services--A Type of Out-patient Care.--After-care services for the mentally ill show a wide variation in the nature and kinds of services provided. All after-care services are explicitly expected to help the former patient re-establish himself in the community. The high recidivism or re-patient rate in mental illness suggests that perhaps in no other area of deviancy is this feat so difficult to accomplish.
The most common pathway which after-care takes is to the outpatient clinic. The hospital is obliged morally and often also legally to "guarantee" that the ex-patient will not be "turned loose" into the community. One needs only to read a newspaper account of a crime involving a personal offense, committed by an ex-patient or a patient on "leave" from a mental hospital, to assess the very serious nature of the bargain which hospitals and the community strike with one another.

The after care clinic characteristically, then, keeps an "eye" on the ex-patient. Medication, particularly the psychotropic drugs, perhaps some psychotherapy, and always the assistance of the social worker, constitute the staples of the after-care clinic. (29) The social worker is essential, either to assist in job placement or to help in negotiation of the bureaucratic maze ways to secure the financial assistance necessary if a job is not available, feasible, or tenable. (30)

Other types of after care services are foster home care and nursing home care. These are plans whereby the mentally ill patient is, in effect, transferred to a different care setting. These options seem most often used in planning for the elderly and the chronic patient. Hence they are after-care services in a very limited sense.

Halfway houses—temporary homes to bridge the gap between hospital and community—represent another form of after-care services. Sheltered workshops and vocational rehabilitation centers are important in after care services. In American society it is "good" to work. Work establishes a place in society for a person. Job and work training programs constitute an important part of after-care services.
Ex-patient clubs are an interesting, if not widespread, type of after-care program. These "therapeutic clubs" are formed by ex-patients to facilitate social adjustment. Perhaps the best known of these is Fountain House in New York City. There it is claimed that ex-patients who avail themselves of this service have a return rate to the hospital of 3.6 per cent compared to an average return rate of about 25 per cent. (31)

G. Goal of After Care Services.--The eventual goal of the after care services is to facilitate the ex-patient's re-entry into the community and to maintain the entry once it has been established. Present data suggest that this successful ending is not often attained. More recently the effect has seemed to be more like a revolving door to the community than a one-way exit from the hospital. Indeed it may be that the after-care system perpetuates the return flow in unintended ways.

2. In-patient Services.--In-patient care is provided in a variety of organizational settings. The historic fact of the Federal government's abdication of the responsibility for the care of the mentally ill to the States has resulted, in American society, in the state mental hospital becoming the largest single type of organizational response to mental illness. (32) In-patient mentally ill facilities are also provided by the Veteran's Administration, voluntary non-profit hospitals and proprietary hospitals.

a. The State Mental Hospital.--One distinguishing feature of
the typical state mental hospital is its large size. Of the 337 long-
term non-Federal psychiatric hospitals, 276 have 500 beds or over.
Better than 60 per cent of these hospitals are large hospitals; some
reach a magnitude of 17 or 18 thousands beds. Other, salient charac-
teristics of the typical state mental hospital are low personnel-
patient ratios, low expenditure rate per patient day, and low patient
turnover. In Ohio there are ten hospitals of this type.

b. **Comparison of Hospitals.**—The characteristics of state
and local government psychiatric hospitals compared to Federal govern-
ment, voluntary, and proprietary hospitals are summarized in Table 3.

**TABLE 3**

**HOSPITALS BY TYPE AND CONTROL FOR SELECTED CRITERIA**

<table>
<thead>
<tr>
<th>Hospital Type and Control</th>
<th>No.</th>
<th>Beds</th>
<th>Annual Admissions</th>
<th>Personnel Per 100 Pts.</th>
<th>Total Expense Per Pt. Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran Adm. (P)</td>
<td>44</td>
<td>67,034</td>
<td>69,504</td>
<td>77</td>
<td>15.02 (P)</td>
</tr>
<tr>
<td>Veteran Adm. (G)</td>
<td>119</td>
<td>60,177</td>
<td>554,525</td>
<td>145</td>
<td>32.22 (G)</td>
</tr>
<tr>
<td>Vol. Non-Profit (P)</td>
<td>73</td>
<td>10,510</td>
<td>45,664</td>
<td>127</td>
<td>22.39 (P)</td>
</tr>
<tr>
<td>Vol. Non-Profit (G) 3,402</td>
<td>498,677</td>
<td>18,616,697</td>
<td>247</td>
<td>42.47 (G)</td>
<td></td>
</tr>
<tr>
<td>Proprietary (P)</td>
<td>88</td>
<td>6,189</td>
<td>38,812</td>
<td>132</td>
<td>21.99 (P)</td>
</tr>
<tr>
<td>Proprietary (G)</td>
<td>870</td>
<td>46,022</td>
<td>1,848,658</td>
<td>212</td>
<td>43.01 (G)</td>
</tr>
<tr>
<td>State and Local (P)</td>
<td>326</td>
<td>674,688</td>
<td>357,282</td>
<td>40</td>
<td>6.65 (P)</td>
</tr>
<tr>
<td>State and Local (G) 1,440</td>
<td>176,111</td>
<td>5,521,908</td>
<td>236</td>
<td>38.57 (G)</td>
<td></td>
</tr>
</tbody>
</table>

P = Psychiatric Service

G = General Service

Table 3 shows that by type of service, psychiatric hospitals on the criteria of personnel and expense lag almost 50 per cent behind non-psychiatric hospitals. By type of control between the State and local hospitals the difference is of a greater magnitude. The differential spread within psychiatric hospitals category shows the state and local controlled hospitals to have personnel and expense at about 50 per cent of the Veterans Administration hospitals' rate and about 25 per cent of the voluntary not-for-profit hospitals' rate.

c. Short-term State Hospitals.—The public sector in recent years has attempted to mitigate some of the stigma, failure and despair of the large state mental hospital. Hence the smaller hospital has developed and evolved, with an emphasis on short-term care, higher expenditures for services, and higher personnel-to-patient ratios. In Ohio there are six hospitals of this type.

d. Private In-patient Care.—The private sector provides mental illness care services by units in short-term non-governmental hospitals, and proprietary psychiatric hospitals. In 1966, 12.4 per cent of the short-term non-governmental hospitals had in-patient psychiatric facilities. Generally the larger the size of the hospital the more likely is it that it will offer psychiatric services. In general, hospitals with over 500 beds, 80 per cent had in-patient psychiatric facilities. (33) It is probable that this type of service is differentially utilized as a pathway for economic reasons.
Social Control and Mental Illness

When society is viewed in a problem-solving perspective, two problems are of concern. First, the problem of adaptation to man's bio-social nature, and hence the development of societal arrangements for the care of illness is viewed. Second, the problem of adaptation to collective living is considered. Hence rules are elaborated to cover the gamut of human relations. The way in which a society opts to solve these problems will derive in part from the values shared at large in the society. The development of norms to regulate the conduct of the members of society, in part, reflect the values of the society, but also may contravene the values. As regards mental illness, a complex set of norms has evolved to guide the process of social control. Further, a complex set of organizational arrangements has also developed to care for the mentally ill. Such norms and arrangements can be expected to vary with such factors as age, sex, marital status, sub-culture, rural-urban residence and a host of other factors. However, several features seem to be common in the overall process of social control. First, the norms typically carry both official and unofficial sanctions. Second, the arrangements for care are simple or complex, depending on the structure of the community, particularly the mental health manpower resources. Figure 2 diagrams the interconnections of these complex features of the process of social control in mental illness.

Values, Norms and Mental Illness

Values

The dominant values in this society are typically those of the
Figure 2. The Structure of Social Control of Mental Illness.
middle class. Kingsley Davis recognized the significance of this fact in relation to the mental hygiene movement. Davis specifically notes the moral-scientific dilemma:

Mental hygiene cannot combine the prestige of science with the prestige of the mores, for science and the mores unavoidably conflict, and the point where they most readily conflict is precisely where "mental," i.e., social phenomena, are concerned. (34)

Almost twenty years later, John Seeley argues that since the Industrial Revolution the market has come to be the dominant institution, and there has been a decline in the mystical organizing qualities of the family, the church and the guild. Thus, no one institution firmly proclaims what is the good life, what is the order of the virtues and so on. This has created a power vacuum and it is into this vacuum that the mental health movement has been drawn. Seeley credits the mental health movement with making the society aware of the inner life of man and its relation to his external life. According to him the mental health movement has become an arbiter between scientific knowledge and lay utilization of that knowledge. He states:

What seems to be emerging is a situation in which laymen--ordinary men and women--in their everyday activities are coming to use a new body of knowledge and techniques of analysis with reference to themselves and to one another. The importance of this may not be immediately evident, but the effect is almost as though another dimension (and another complication) had been added to life.

He also strikes a note of alarm:

The mental health movement is underway--no one can alter that broad sweep of events, but the moral responsibility of the mental health movement is clear--proximate and remote consequences of the values and ideas promoted must be subjected to close and continuing research, for to do otherwise is to invite disaster. (35)

Empirical support for the Davis-Seeley position is found in a
content analysis study of mental health pamphlets. The conclusion reached was that the middle class prototype and the mental health prototype are in many respects equivalent. The authors say that with Davis, they conclude that the mental health movement is "unwittingly propagating a middle class ethic under the guise of science." This study also suggests that the class bias in the mental health movement, while it purports to foster individual integration, to the extent that it supports middle class social organization, may in effect be producing that which it intends to combat. (36)

Norms

The vast majority of persons trained in mental health professions come from middle class backgrounds. This suggests that the mental health professions share the middle class bias. This in turn influences both legal and medical aspects of social control to the mental illness services system. However, even in these groups there is lack of consensus about what the norms should be. For example in the survey of the literature done by Marie Jahoda, for the Joint Commission on Mental Illness and Health, she concludes that there is no standard, all purpose definition of mental health. In fact, different people have different standards and these vary widely. In the last chapter of the Jahoda statement, the psychiatric clinician, Dr. Walter Barton expresses a viewpoint wherein the absence of mental illness is the key—"If they are not sick, they are well." (37)

The establishment of unofficial norms is rooted in the biases of the middle class ethic. The unofficial system of social control
seems to have its primary source in the better educated, the mental health professionals, and other assorted helping professions. These groups claim to have the expertise to make the mental illness definition and the claim is usually honored. (38) Studies tend to document the use of very broad norms by the professional help providers. Apparently, the more education a person has the broader the criteria become. (39) One study finds that psychiatrists, when presented with six case histories, tended to define mentally ill to non-mentally ill in a ratio of 9:1. The average ratio for the laymen was 1:2. The lay criteria used as a guide for decisions seemed to be based on the "raving maniac" stereotype. Cumming and Cumming assert that for the layman anything less than that stereotype is assessed as "it's just a quirk--a little nervousness--personality traits--nothing serious." (40) Part of the professionals' criteria is that early recognition of symptoms can prevent severe consequences. Although that criteria has not been well documented, it continues to be used. In fact, it continues despite some evidence to the contrary. (41) Yet it seems a valid assumption elsewhere in the sphere of medicine, thus perhaps the basis for its continued use by the mental health professions. Nothing in recent history suggests that the gap in views between the professionals and the laity is narrowing. The Cummings and Seeley have documented the sad fate of mental health educational efforts at the community level. (42)

The end result of the process of social control is that the person sanctioned by whatever norms is moved into mental illness care services. Central to understanding this movement is knowledge about
the definition-decision making process. We now turn to that discussion.

**The Defining-Decision Making Process**

It is logically necessary to conceptualize the definitional process as a decision making process. For example, to label a given behavioral event "sick" serves only to name it, or to categorize it with a similar class of events. But to define a behavioral event as "sick" is to make a decision about meaning. To give an event meaning is to imbue it with past, present and future significance for both the definer and the defined. The action of giving meaning is a dynamic act which purports a future consequence for both the definer and the defined. Thus a course of action is prescribed in which the protagonist is moved into the mental illness services system. (43) Figure 3 diagrams the possibilities for varying patterns of definition-decision making as a part of social control.

Scheff, in his explanation of stable mental illness as residual deviance, states as his final causal hypothesis: "Among residual rule breakers, labeling is the most important cause of careers of residual deviance." (44) There is agreement that labeling is of crucial importance to careers of residual deviance; while labeling may be sufficient to explain "stable mental illness," it does not seem sufficient to explain entrance into the mental illness services system. In the present view it is not the rule breaking that is crucial, but the sanctioned official or unofficial definitional process, the process which results in moving the person into mental illness care services.
Scheff also recognizes that:

The likelihood that residual rule-breaking in itself will not lead to labeling as a deviant draws attention to the central significance of the contingencies which influence the direction and intensity of the societal reaction. One of the urgent conceptual tasks for a sociological theory of deviant behavior is the development of a precise and widely applicable set of such contingencies. The classification that is offered here is only a crude first step in this direction.

Although there are a wide variety of contingencies which lead to labeling they can be simply classified in terms of the nature of the rule-breaking, the person who breaks the rules, and the community in which the rule-breaking occurs. Other things being equal, the severity of the societal reaction is a function of, first, the degree, amount and visibility of the rule breaking; second, the power of the rule-breaker, and the social distance between him and the agents of social control; and finally, the tolerance level of the community, and the availability in the culture of the community of alternative nondeviant roles. Particularly crucial for future research is the importance of the first two contingencies (the amount and degree of rule-breaking), which are characteristics of the rule-breaker, relative to the remaining five contingencies, which are characteristics of the social system. To the extent that these five factors are found empirically to be independent determinants of labeling and denial, the status of the mental patient can be considered a partly ascribed rather than a completely achieved status. The dynamics of treated mental illness could then be profitably studied quite apart from the individual dynamics of mental disorder by focusing on social systemic contingencies. (45)

The position taken in this investigation of the mental illness services system differs somewhat from Scheff’s: this framework assumes a mental illness services system in the society with differential access based on a number of factors. It further speaks to a broader spectrum of deviance, whereas Scheff confines his explanation to residual rule-breaking and residual deviance. Becker advises that it is fallacious to assume that all who have broken a rule will be labeled deviant, or that all who are labeled deviant have in fact broken a rule. (46)
The view taken here is not a psychiatric one, but rather a sociological one. A view which says that when a person is defined in such a way that leads to a decision for entrance into the mental illness services for care, a significant alteration has been made in that person's social life. Hence, more than labeling is involved in the process, though labeling may be a part of it.

**Patterns of Definition-Decision Making**

Figure 3 suggests that different patterns may develop in the relationships among the persons in categories A, B, and C. The power referred to in B and C can be distinguished by the source of the legitimation of the power: that is, B is impersonal power and the source of legitimation is in the social structure. C is personal power and the source of legitimation is in the interpersonal structure. It is where A, B and C meet at point D to make a decision about A that the "personal troubles of milieu and the public issues of social structure" converge. Until this time, what has been a trouble has been a private matter and according to Mills it now becomes as issue—"...which often involves a crisis in institutional relationships." (47) Several possible patterns or pathways are indicated by the conceptual framework.

**The Others-Official Pattern**

The A, B, D, E pattern can be referred to as an "others-official" pattern. It is likely to occur when there is a poverty of relationships in C. This pathway is a most typical one for entry of the state mental hospital. The empirical studies which have findings that relate high rates of mental illness to categories of persons in "disen-
DECISION TO DEFINE AS
Gradient of Mental Illness

THE PROTAGONIST
The Behavioral Event

INTERPERSONAL CONTROLS
Family and "Close Others"

SOCIETAL CONTROLS
Legal-Medical Systems

SOCIETALLY LEGITIMATED AGENTS
With Legal, Ethical, Moral, and Scientific Power

DECISION TO DEFINE AS
Gradient of Mental Illness

INTERPERSONALLY LEGITIMATED AGENTS:
Self or "Close Others" With Social; Moral Power

MOVED INTO MENTAL ILLNESS SERVICES

Figure 3. The Definition-Decision Making Process.
gaged" statuses—the aged, the widowed, the formerly married but now not married, etc.—document this pattern. (48)

The "Others-Unofficial" Pattern

The "others-unofficial" pattern, the A,C,D,E pattern, acknowledges power differentials within networks of interpersonal relationships. It further suggests that there is a possibility of entrance into the mental illness system, without reference to the official agents of control in the social system. It is likely the less status "self" has in reference to the "significant other" the more likely is "other" to be the prime definer. Hence, one would expect parents to be able to define their young children, but adult children to be able to define their elderly parents.

The "others-unofficial" pattern is vulnerable and must often have post facto validation for the definition to hold. Thus a variant pattern develops. Here the "self" or "close others" ask the societal agents to validate the definition and ratify the decision. Goffman has referred to this kind of pattern from the point of view of the protagonist as the "betrayal funnel." (49) Scheff, in one study, came to the conclusion that in metropolitan areas the legal and medical decision making was largely ceremonial—that the crucial decisions were already made by the relatives or others who brought the cases to court. (50) Kutner further documents the almost automatic ratification of the definition and decision already made by lay persons (51)

Complementing these studies is an investigation by Wenger, who asked the question, what happens if the protagonist is represented by legal counsel at the ratification hearing? Wenger calls the group
studied "pre-patients." In the present conceptual framework they would be seen as having already entered the services system, and the hearing would be for the purpose of ratifying a decision already made. Hence, the commitment hearing would determine if the definition is to hold. As Scheff and Kutner have noted, this process is usually perfunctory. Wenger showed the presence of legal counsel and release from a commitment hearing to be highly correlated, (.942). Seemingly, the agents of the legal system acting in behalf of the protagonist can affect the medical decision. Hence, the original decision made either in B or C, while usually ratified by agents of B, is subject to reversal, but seldom is as Wenger further reports: of 81 patients who were observed, 65 were committed; 61 of these were without legal counsel. (52)

The "Self-Official" Pattern

The "self-official" pattern is represented in the A to D to B to E pathway. The protagonist makes his own definition and seeks validation for it by the societally legitimated definers, receives it and enters the services system. Goffman refers to this as the "dubious privilege of the upper middle class." It is this route that is often taken to the out-patient clinic or the private psychiatric hospital, the psychoanalyst's couch and the psychotherapeutic hour. Generally, though not always, the gradient is defined in mild terms; emotional exhaustion, overwork and fatigue; excessive nervousness, etc. Failure of this pattern to achieve what was desired by either the protagonist or the legitimator is discernible in several ways. First, the protagonist may withdraw, as happens so often in clinics. Second,
the legitimator may decide a re-definition in terms of the gradient factor is needed. Here there are at least three alternatives. The legitimator may directly act to re-define the situation in official terms; or he may seek to involve the persons in category C and persuade them to define the situation in such a way as to move the protagonist into another part of the services system. Thirdly, the patient may be referred to another part of the services system.

A Variant Pattern

A variant pattern is initiated in organizations which deal in personal services. The personnel in schools and universities, the public health nursing service agencies, and welfare agencies are frequently charged with the responsibility of "case finding." The "cases" in this context are usually referred to as psychiatric or mental health problems. Once found, the "cases" are usually referred to a mental health professional whose task it is to validate or refute the tentative definition made by the "case finder." If the definition is validated, the decision to act with reference to the decision, that is to move the person into the mental illness services system, is usually then referred to the "significant others."

The "Self-Unofficial" Pattern

The A,D,E pathway is seen in voluntary admissions to hospitals and self-referrals to clinics. Goffman argues for "willing and unwilling" as a useful distinction in terms of who comes to the mental hospital. (53) He suggests that only a relatively small group of pre-patients come into the hospital willingly. However, it seems possible
that the self vs. others distinction operationally defined as voluntary vs. official commitment to the hospital can be a useful way of conceptualizing the differential degree of control the defined person may have over the situation in which he finds himself. The network of relationships in which the "self" operates are occasionally so impoverished that perhaps it makes little difference whether the patient is voluntary or officially committed. But in most networks of interpersonal relationships it would seem likely that this contingency, voluntary vs. official, would have many ramifications upon that network of relationships.

This discussion has not exhausted all of the possible variations in the definitional-decision making process. Rather, the focus has been on the major patterns. Social psychologists have well demonstrated the richness, variety and complexity of the patterns discussed here. (54)

Movement Into and Through Mental Illness Services

It has been indicated that once the definition-decision has been made, movement follows--movement into the system of services for care. We now turn to a discussion of the concomitants of that movement, and some of the factors which influence entry and exit. Figure 4 diagrams the interconnections of the factors which affect the flow into the facilities for care, the types of facilities and some factors which influence outcome.
**A. Definition-Decision**
1. Self-official (ADBE)
2. Self-unofficial (ADE)
3. Others-official (ABDE)
4. Others-unofficial (ACDE)
5. Other variants

**B. Facilities for Care**
1. Private-outpatient
2. Public-outpatient
3. Private-inpatient
4. Public-inpatient, a) Short term
   b) Long term

**C. Concomitants & Outcomes**

<table>
<thead>
<tr>
<th></th>
<th>Stigma</th>
<th>Role Disruption</th>
<th>Movement Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>O ++</td>
<td>O - +</td>
<td>Good</td>
</tr>
<tr>
<td>2</td>
<td>+ - +</td>
<td>O - +</td>
<td>Good - Fair</td>
</tr>
<tr>
<td>3</td>
<td>+ - +</td>
<td>+++ - +</td>
<td>Fair - Moderate</td>
</tr>
<tr>
<td>4a</td>
<td>++ +++</td>
<td>+++ - + + +</td>
<td>Fair - Moderate</td>
</tr>
<tr>
<td>4b</td>
<td>+++ - + + + +</td>
<td>+++</td>
<td>Moderate - Poor</td>
</tr>
</tbody>
</table>

**A. Contingencies**
1. Socio-demographic factors
2. Self or others definition
3. Characteristics of the community of residence

**B. Contingencies**
1. Community Resources
2. Community Resource Characteristics
3. Economic factors

**C. Contingencies**
1. The combination of A & B contingencies

**Notes:**

- The plus (+) signs represent crude assessments. Thus: + = slight; ++ = moderate; +++ = very great; ++++ = inevitable.
- The data used in this study are derived from Ohio, therefore the model is directly applicable only to Ohio. However, the model should compare to the Mental Illness care system throughout the United States with some modifications.

Figure 4. Mental Illness - The Flow.
Factors Influencing Definition-Decision

Major factors which influence the definition-decision process are socio-demographic variables: age, sex, race, and marital status. The factor of self or others as definer, and the official or unofficial status of the definition will likely affect the mode of entry and the type of service. The kind and numbers of facilities for service in a community will likely be related to the total mental health manpower in the community. This also affects the rate of entrance to care facilities. These factors have been stated as research questions:

1. Does the age of the entrants seem to affect the rate of entrance to care services or the type of facility entered?
2. Does the sex of entrants to care services seem to influence the rate of entrance to care services or the type of facility entered?
3. Does the race of entrants seem to influence the rate of entrance of type of care facility?
4. Does marital status seem to affect the rate or point of entry into the services for care?
5. Is self or other definition related to rate of entrance or type of facility for care?

Factors Affecting Facilities for Care and Movement Through the Services

The social characteristics of the community of residence--size and facilities for care--are important factors influencing rates and directions of pathways into the mental illness services system.
Another factor would be the economic resources of the individual. This would influence the point of entry into the services system. The degree of complexity of the mental illness services system is thought to be a factor influencing the flow through the services. The numbers of mental health professionals in the community of residence are an additional factor which would likely influence rates of entry into the system. Differential distribution of the various types of mental health manpower would be expected to influence rates and points of entry. For when there is a demand for services created by decisions made about gradients of mental illness, there is likely a response to the demand from the supply of agents and agencies, which are also gradiently defined. Uneven distribution of supply services will create problems of uneven access. Success in the sense that the services supplied are equal to the demand is often complicated by mismatched gradients. When this happens, negotiation is required. The consumers and suppliers may bargain for other arrangements. Decisions may then be made to re-define the gradient in different terms which requires further movement within the system by the consumer. (55) The foregoing discussion leads to additional research questions:

6. Will high mental health manpower rates seem to affect the rates of entrance to care services?

7. Will high mental health manpower rates be a factor in the numbers and types of facilities available in a community?

8. Does the type of care facility seem to be a factor in the type of psychiatric diagnosis given the entrants?

Chapter III will attempt to answer these questions.
CHAPTER II

The Research Methodology

Sources of Data

Data for this study have been gathered from various sources. All the data utilized represent the State of Ohio. As pointed out in the introduction, the attempt in this work is to reconstruct a comprehensive picture of the organizations of care for the mentally ill. And further, to answer some research questions related to the process of decision making regarding services and the flow of patients through them. Obviously, the task of collecting primary data for such a study would present definite limitations to the feasibility of the study. Therefore, heavy reliance was placed upon data from secondary sources. Although such data were collected for different and varied purposes, they are marshalled and organized in this work to bear upon the research questions posed. The sources of data utilized in this work include the following:

3. "Study of Discharged Psychiatric Patients From General Short-Term Non-Governmental and Private Psychiatric Hospitals From


Data supplementary to the above were obtained through personal access to all the data collected by the Bureau of Research and Statistics of the Department of Mental Hygiene and Correction, State of Ohio. Some of the data for mental health manpower were obtained personally from the Division of Personnel, Department of Mental Hygiene and Correction. In some instances, where needed information was not available, personal interviews were utilized to attempt to fill in some explanations.

Strengths of the Data

The data in reference to private in-patient care services is taken from the only large study of this type of care facility known to the investigator. It covers a large number of cases which allows for more stable conclusions than those reached in studies of smaller samples.

The total number of cases available for use are as follows:

1. Public in-patient services: 22,365 cases in residence, 19,195 admission cases.
2. Public out-patient services: 6,357 cases.
3. Private in-patient services: 9,906 cases.
4. Private out-patient services: 10,519 cases.

In addition to the large number of cases, the data are thought to be enhanced by reason of their non-reactive nature. The use of
official records is subject to some biases. But in regard to the dimensions used in this study, the risks are thought to be minimal. (56)

Limitations of the Data

The data used in this study suffer from the usual limitations characteristic of those collected through secondary sources. One type of limitation is the absence of measurement or indicators that would have been useful to include in the analysis. Another limitation lies in the ways the data are classified which may not be the most appropriate ways for the purposes of this study. Efforts were made wherever possible to re-classify the data within the framework of this research. A third limitation in the data relates to the degree of generalizability to other populations. Data used in this study are representative of the State of Ohio. In one sense this may be considered as a case study of one state. In another sense the units of services and the population of the mentally ill in the state used in this study may be considered as a "purposive" sample of others in other states. The limitation in generalizability applies to the latter case and caution is indicated by reasons of the differences in population composition and organization of services from one state to another.

Classification of Data

The Entrants

Persons who enter the services for care have been classified on six dimensions.

1. Age: youth/adult/elderly.
2. Sex: male/female.


5. Type of entry: self-defined/other-defined/official/unofficial.


The Care Facilities

The care facilities have been classified by type of control, type of facility, resources and mission.


Other classifications have been made based on rankings of differentiating features among care facilities. These are:

1. Patient-employee ratio.

2. Professional manpower.

3. Twenty years and over patient stay.

4. First admission to re-admission ratio.

5. Admission to discharge ratio.

6. Transfer in.

The term "end of the line" hospital also has been used to denote a care facility which receives a proportionately high number of transfers in from other hospitals.

Mental Health Manpower

As used in this study, mental health manpower is the total of the aggregates of professional mental health workers; physicians, psychiatrists, psychologists, social workers and nurses. But not all persons in the mental health manpower category are definers of mental
illness. The professionals working in in-patient facilities seldom define the entrants to services. Thus when mental health manpower is considered in relation to cases generated, these professionals have been subtracted from the total group of mental health workers.

Regions of the State

The State of Ohio has been classified into nine geographical areas. These areas conform to the areas defined in the official mental health planning programs for Ohio. Hence, much of the available data was collected using this classification. (See Appendix I.)

The Analytic Design

The data are treated in two major ways. First, a descriptive analysis of the system of care and second, an analysis of the relational features of entrants, flow and types of care facilities.

The Descriptive Analysis

The major focus for the descriptive portion of the study attempts to place the services for care in a societal and temporal framework. Historical data, cross-societal comparisons and current societal features are used to examine the setting for mental illness services in Ohio.

The Relational Questions

The relational questions are examined in connection with the characteristics of the entrants and the type of care facility entered, and to outcomes. Characteristics of entrants treated in the analysis are age, sex, race, marital status, self or other definition and
diagnostic label. The care facilities are categorized in four ways; public in-patient, public out-patient, private in-patient and private out-patient. Of the factors used as characteristics of entrants, three are demographic factors which operate independently of any other possibility of influence or change. These factors are age, sex, and race. The other three factors selected for analytic use—marital status, self or other definition, and diagnostic label—are classified as interdependent factors, for they are open to the possibility of choice, change and reciprocal interaction.
CHAPTER III

Presentation and Analysis of the Data

The presentation in this chapter is divided into three major sections. The first section is comprised of descriptive data and discussion of the care services in a societal context and in the specific context of Ohio. The second section is concerned with analysis of data as related to the research questions posed earlier. The final portion includes data and discussion related to outcomes.

Care Services and the Society

Societal Comparisons

A complex set of care services for the mentally ill seems to arise in societies which are industrialized, urbanized, and have a high level of technology. This statement can be illustrated only in gross terms. First, we might look at comparisons across societies and second at an historical comparison in Ohio.

Useful empirical indicators are the numbers and types of care facilities for mental illness developed in a society. Table 4 presents some comparisons.

Table 4 shows the wide variation in the number of hospital beds in different societies. The high ratio of beds to population is most marked in western societies. For instance, Ghana, a transitional society has not yet developed the clinic pattern. When "westernized" psychiatry was introduced in Ghana, the number of resident patients in
TABLE 4

COMPARISON OF SERVICES FOR CARE IN FOUR SOCIETIES.

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>Denmark</th>
<th>U.S.S.R.</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (1961)</td>
<td>216,100,000</td>
<td>4,637,000</td>
<td>184,742,000</td>
<td>7,340,000</td>
</tr>
<tr>
<td>Psychiatric Beds</td>
<td>775,108</td>
<td>6,792</td>
<td>207,800</td>
<td>1,700</td>
</tr>
<tr>
<td>Psychiatric Beds/ per 1,000 pop.</td>
<td>4.2</td>
<td>1.51</td>
<td>.96</td>
<td>.23</td>
</tr>
<tr>
<td>Psychiatric Clinics</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

The Accra Hospital increased 48.4 per cent in a five year period. (57)

Hence, it would seem that modern industrial societies provide a milieu favorable to extensive psychiatric care facilities.

Historical Comparison

If the same society is considered over time it should be possible to determine if the nature of the care facilities for mental illness have changed, and if so, how. We shall use Ohio as a base for historical comparison. First we want to know how patients entered the facilities and what were the available facilities.

The earliest legislation upon the subject of "idiots and lunatics" in Ohio was in 1792, ten years before the organization of the state's government. The territorial legislature provided for trial in the question of insanity and appointment of guardians with plenary powers. In 1815, an act of the state provided for trial, but also required that the jury decide upon the question of confinement. Thus it was possible to be judged insane but not confined. But if the verdict were for confinement, the person was to be committed to a jail unless his friends
posted bond for his safekeeping. In 1838 an act was passed to provide the government with the Ohio Lunatic Asylum. This act also required the jury to make a decision between idiocy and lunacy, i.e., "without mind or so furiously mad as to render him dangerous." If the person was judged to be a lunatic and a pauper, a warrant was issued for his confinement to the asylum. While he awaited application to be made to the asylum, he was to be kept in the poorhouse, (if there were one) if not, the jail. The law further required a "skillful physician" to attend the lunatic while he was awaiting entrance to the asylum. This was the pathway to services of the pauper adjudged a lunatic. If he were adjudged an idiot he was not to go to the asylum but to the poorhouse. Those who went to the asylum and were found incurable were required to be removed unless they were clearly dangerous. (58) Pay patients to the asylum could be received upon the certificate of two reputable physicians, providing there was room for them. Four years after the Central Ohio Lunatic Asylum was opened, its superintendent asked for changes in the law to permit the acceptance of only recent cases, and for re-admission without the formalities necessary for first admissions, and further that the preference for paupers be taken away. Already the system seemed to be producing discontent. Table 5 compares the care services in 1845 to those in 1965.

As shown in Table 5, the numbers of facilities and the numbers of entrants have changed in the 120 year period. It is noted, though, that this table does not show the additional facilities
TABLE 5
COMPARISON OF MENTAL ILLNESS CARE SERVICES IN OHIO IN 1845 AND 1964-5. (12 MONTH PERIODS)

<table>
<thead>
<tr>
<th></th>
<th>1845</th>
<th>1964-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population^a</td>
<td>1,769,786.00</td>
<td>10,081,000.00</td>
</tr>
<tr>
<td>Psychiatric Hospitals^b</td>
<td>1.00</td>
<td>17.00</td>
</tr>
<tr>
<td>Psychiatric Hospital Beds^b</td>
<td>340.00</td>
<td>22,430.00</td>
</tr>
<tr>
<td>Beds/1,000 population</td>
<td>.19</td>
<td>2.70</td>
</tr>
<tr>
<td>Hospital Admissions^b</td>
<td>150.00</td>
<td>19,775.00</td>
</tr>
<tr>
<td>Admissions/1,000 population</td>
<td>.08</td>
<td>1.80</td>
</tr>
</tbody>
</table>

^a U.S. Census
^b State-supported

such as private psychiatric hospitals, psychiatric clinics, etc., which are part of today's services. A further historical comparison can be made between the level of complexity of the legal norms. In a foregoing paragraph the law of 1845 was presented. It seems fairly straightforward and uncomplicated. A person was to be committed if found luna­tic and adjudged to need confinement by a jury. (59) Today's legal provisions reveal much more complexity. What follows is a summary of the provisions in the Ohio Code for admissions to mental hospitals. It is presented to support the historical comparison, and also to give the reader the background for the referents of "self" and "other definers," official and unofficial entrants, as used later in the analysis.

Types of Admissions

Admissions to hospitals under the new code (1963) for mental illness are placed in two categories, judicial and non-judicial. The first refers to all admissions provided by action of the courts.
The second covers admissions without court involvement.

Non-Judicial Admissions

1. Voluntary - Any person aged 18 or over may apply and no medical certificate is now required. Otherwise procedure is as before except that the hospital may not request judicial detention unless the patient submits a request for release.

2. Emergency - This now covers the admission of urgent cases of mental illness.
   a. By request of any person acquainted with the facts and the certificate of a physician. With this type of admission there is a time limit of sixty days.
   b. By request of health or police officer without certificate of physician—this has a time limit of five days. If the hospital finds him not a source of danger, he is discharged within the five day period.

3. Admission by Certificate - If a person (who does not object in writing) is examined by two physicians who report him in need of hospitalization any interested party may request admission. This carries a time limit of ninety days.

All non-judicial admissions may request release in writing within ten days; the hospital may either agree or apply to the court for judicial action.

Judicial Admissions

1. Pre-Hearing Order for Hospitalization - After filing of an affidavit by any person familiar with the facts, court may order an individual detained at a hospital until a hearing may be held. The court may investigate the case if it chooses before hearing. A medical examination and report is obtained either by an appointed doctor or the hospital where the patient is detained. If report advises hospitalization, a hearing is held by the Probate Court. The Probate Court has the right to allow a reasonable period of time to elapse before the first hearing. It may be at the hospital and the patient may be excluded if advisable.

2. 90 Day Order of Hospitalization - If the court decided the patient is in need of treatment, it may then order him to a hospital or other psychiatric care for a 90 day period for examination and treatment. During this period the patient may request voluntary status. If the hospital finds the patient not mentally ill, it so notifies the court; otherwise at the
end of the 90 day period the hospital reports its findings to
the court which may then order indeterminate hospitalization
after the second hearing.

3. Indeterminate Hospitalization - This is in general, equiva-
ent to the former probate court commitment and involves loss
of competency and an indefinite period of confinement at the
discretion of the Superintendent who may also discharge the
patient when advisable without approval.

On discharge legal competency is automatically restored.
After discharge, if re-hospitalization is requested, it must
be accompanied by a medical certificate if the former patient
so requests.

4. Common Pleas Evaluation - When a person has been convicted
of one or certain specific crimes, the court is obligated to
refer him before sentence to a State Hospital or other des-
ignated psychiatric facilities for evaluation for a period of
not longer than sixty days.

Where any person convicted of a felony (with exceptions)
appears to the court to be possibly mentally ill, he may be
referred as above for evaluation.

When a person accused of a crime is under investigation by the
Common Pleas Court for "present insanity" which has been set
up as a defense, the court may refer him for evaluation to
appointed psychiatrists or to a hospital for not more than
thirty days. Such examiners may testify if called, in addition
to a written report of evaluation.

When the report indicates presence of mental illness, and this
is upheld at a hearing, the accused is committed to a State
Hospital but may be remanded for sentence when recovered.

If any convicted case where the evaluation report indicates
that the person is mentally ill, the judge imposes sentence
which is suspended and the person sent to the State Hospital
on an "indefinite commitment" after a hearing. This is ana-
logous to the "indeterminate hospitalization" of the Probate
Court except that the patient is subject to return to the Com-
mon Pleas Court when "sanity is restored." (60)

It seems evident from the foregoing that since 1845 the legal norms have
developed and evolved in complexity and thus added to the complexity of
the pathways to the care services.
Mental Health Manpower

American society has highly specialized division of labor, reflected in mental health manpower, which in turn may be related to the numbers and types of care services for mental illness. In Chapter I it was argued that the mental health movement has its roots in middle class values. It is thought that these values are also largely those of the mental health professionals. A question arises in terms of how these elusive qualities are related to mental illness services for care. Do communities with high ratios of mental health manpower have more services for care? Table 6 shows the situation in Ohio with reference to mental health manpower and facilities for care.

TABLE 6
RATIOS OF MENTAL HEALTH MANPOWER AND FACILITIES FOR CARE IN OHIO BY REGIONS: OHIO 1964-65*

<table>
<thead>
<tr>
<th>Region</th>
<th>Mental Health Manpower</th>
<th>Private Hospital Beds</th>
<th>Psychiatrists</th>
<th>State Hospital Clinic Teams</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleveland</td>
<td>56.6</td>
<td>26</td>
<td>10.0</td>
<td>.42</td>
<td>15.4</td>
</tr>
<tr>
<td>Columbus</td>
<td>35.7</td>
<td>24</td>
<td>10.1</td>
<td>.62</td>
<td>14.5</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>38.3</td>
<td>26</td>
<td>12.3</td>
<td>.70</td>
<td>15.0</td>
</tr>
<tr>
<td>Akron</td>
<td>21.6</td>
<td>5</td>
<td>3.7</td>
<td>.69</td>
<td>15.6</td>
</tr>
<tr>
<td>Dayton</td>
<td>19.8</td>
<td>14</td>
<td>4.7</td>
<td>.62</td>
<td>17.3</td>
</tr>
<tr>
<td>Toledo</td>
<td>14.8</td>
<td>8</td>
<td>3.8</td>
<td>.60</td>
<td>17.7</td>
</tr>
<tr>
<td>Youngstown</td>
<td>11.2</td>
<td>7</td>
<td>2.4</td>
<td>.56</td>
<td>16.8</td>
</tr>
<tr>
<td>Athens-Portsmouth</td>
<td>15.4</td>
<td>0</td>
<td>6.5</td>
<td>.14</td>
<td>23.4</td>
</tr>
<tr>
<td>Cambridge</td>
<td>6.4</td>
<td>13</td>
<td>2.7</td>
<td>.40</td>
<td>45.5</td>
</tr>
</tbody>
</table>

*All the numbers in the table are ratios based on 100,000 population.

*aMay reflect the presence of the V.A. Psychiatric Hospital located at Chillicothe.
Another question may be asked in connection with mental health manpower: do regions in Ohio with high rates of mental health manpower have high rates of entrance to services for care? Table 7 presents the data as it relates to this question.

Table 7 shows that the rates of entrants generated per 100,000 population seem closely related to high mental health manpower rates. The relationship is most evident in the high mental health manpower regions. In the low mental health manpower regions the relationship seems less clear.

A further question can be raised: can it be that modern society is in fact "conning itself?" This is an open question. If the middle class ethic serves to define broadly the conditions for entrance to the mental illness care services, and if the affluent society produces more help givers as a response to technological shrinkage in other areas of work, and if the help givers define more and more behavior as being needful of service, it may well be that the organizations for mental illness care really function to "cool out the marks."

(61) Goffman suggests that sustained personal disorganization is one way in which the "mark" can refuse to be cooled out. This idea suggests that organizations in the mental illness system of care may in part function to convince the "mark" that he should accept his loss. (62)

The data in Table 7 can be re-assembled to show the differential pathways of entrants to types of services for care. The three regions with high mental health manpower generate almost three times as many entrants as do the lows, and about forty per cent more entrants than the three medium low regions.
TABLE 7
RATES OF ENTRANTS TO CARE SERVICES BY REGIONS
AND MENTAL HEALTH MANPOWER. OHIO 1964-65*

<table>
<thead>
<tr>
<th>Region</th>
<th>Mental Health Manpower</th>
<th>State Hospital Admissions (Long Term)</th>
<th>State Hospital Admissions (Short Term)</th>
<th>Private In-Patient Hospitals</th>
<th>Out-Patient Clinics (Pub.-Priv.)</th>
<th>Out-Patient Psychiatrists</th>
<th>Total Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleveland</td>
<td>56.6</td>
<td>34</td>
<td>107</td>
<td>218</td>
<td>346</td>
<td>119</td>
<td>824</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>38.3</td>
<td>96</td>
<td>67</td>
<td>263</td>
<td>340</td>
<td>156</td>
<td>922</td>
</tr>
<tr>
<td>Columbus</td>
<td>35.7</td>
<td>152</td>
<td>0</td>
<td>222</td>
<td>321</td>
<td>86</td>
<td>781</td>
</tr>
<tr>
<td>Akron</td>
<td>21.6</td>
<td>54</td>
<td>113</td>
<td>54</td>
<td>184</td>
<td>28</td>
<td>433</td>
</tr>
<tr>
<td>Dayton</td>
<td>19.8</td>
<td>136</td>
<td>0</td>
<td>177</td>
<td>152</td>
<td>16</td>
<td>481</td>
</tr>
<tr>
<td>*Athens/ Ports.</td>
<td>15.4a</td>
<td>130</td>
<td>176</td>
<td>0</td>
<td>73</td>
<td>22</td>
<td>401</td>
</tr>
<tr>
<td>Toledo</td>
<td>14.8</td>
<td>201</td>
<td>0</td>
<td>119</td>
<td>154</td>
<td>14</td>
<td>488</td>
</tr>
<tr>
<td>Youngstown</td>
<td>11.2</td>
<td>56</td>
<td>154</td>
<td>120</td>
<td>194</td>
<td>10</td>
<td>534</td>
</tr>
<tr>
<td>Cambridge</td>
<td>6.4</td>
<td>236</td>
<td>0</td>
<td>73</td>
<td>274</td>
<td>16</td>
<td>599</td>
</tr>
</tbody>
</table>

*Rates are expressed as per 100,000 population.

*aMay, in part, be due to presence of large psychiatric V.A. Hospital in this region.
TABLE 8

DIFFERENTIAL ENTRANT RATES TO TYPES OF SERVICES FOR CARE BY MENTAL HEALTH MANPOWER RATIOS. OHIO 1964-65

<table>
<thead>
<tr>
<th>Mental Health Manpower</th>
<th>Public Long-Term</th>
<th>Public Short-Term</th>
<th>Private In-Patient</th>
<th>Out Patient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highs (3 regions)</td>
<td>282</td>
<td>174</td>
<td>703</td>
<td>1,007</td>
<td>2,166</td>
</tr>
<tr>
<td>Medium Lows (4 regions)</td>
<td>521</td>
<td>289</td>
<td>350</td>
<td>563</td>
<td>1,727</td>
</tr>
<tr>
<td>Lows (2 regions)</td>
<td>292</td>
<td>154</td>
<td>193</td>
<td>468</td>
<td>1,105</td>
</tr>
<tr>
<td>Totals</td>
<td>1,075</td>
<td>617</td>
<td>1,246</td>
<td>2,038</td>
<td>4,998</td>
</tr>
</tbody>
</table>

*Combined number of cases generated in the 1964-65 fiscal year expressed as rates per 100,000 population.

Table 8 also shows the differential entrant rates to different types of services. Where mental health manpower is high, out-patient and private in-patient care are the dominant modalities. Where it is low, public long term facilities are dominant.

The figures in Table 8 can also be compared with those in the Midtown Manhattan Study. While the sources of the data are not exactly comparable, Table 9 strongly suggests the effect of the factor of mental health manpower. Manpower differences are noted in that Midtown had 57 psychiatrists and clinical psychologists per 100,000 population; Ohio had ten for the same population unit. Table 9 sets forth a comparison of entrant rates by type of service for care. (63)

The data presented in Tables 8 and 9 seem sufficiently conclusive to suggest that mental health manpower does markedly influence
TABLE 9
ENTRANT RATES BY TYPE OF SERVICE FOR CARE, MIDTOWN AND OHIO. (AGE INCLUSIVE)*

<table>
<thead>
<tr>
<th>Type of Service for Care</th>
<th>Midtown May 1, 1953</th>
<th>Ohio (All) 1964-65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics</td>
<td>168</td>
<td>226</td>
</tr>
<tr>
<td>Office (Private Psychiatrists)</td>
<td>620</td>
<td>51</td>
</tr>
<tr>
<td>State Hospitals</td>
<td>435</td>
<td>191</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>46</td>
<td>142</td>
</tr>
<tr>
<td>Total</td>
<td>(1,269)</td>
<td>(610)</td>
</tr>
<tr>
<td>In-patient</td>
<td>481</td>
<td>333</td>
</tr>
<tr>
<td>Out-patient</td>
<td>788</td>
<td>277</td>
</tr>
</tbody>
</table>

*All expressed as entry rates per 100,000 population.

the rate of entry into the mental illness services as well as the point of entrance. For example, in Table 9, it is noted that Midtown provides access at the out-patient level for almost two-thirds of the defined population, and one-third are in in-patient care facilities. In Ohio better than half are located in in-patient facilities and a little more than one-third in out-patient facilities.

Some Comments on the Society, Social Control and the Services for Care

Our data do not permit interpretation at the societal or community level for differences in social control. Yet these differences do exist. Thus we shall briefly note them before going on to the consideration of the remaining questions.

Official control of access to the services for care in mental illness is patterned through the legal system, its ramifications and contingencies. Unofficial control of access to the mental illness
system is largely in the hands of the better educated and the professional help givers. Life and form are given these constructs when they come together in the community. Much of the variation in the means and forms of social control comes out of the warp and woof of the community fabric. When the individual is in action, he is in action in some community of others. Were his fate to live on a desert island alone, he could escape entrance to the services for care of mental illness. But men do not live on desert islands; they work, play, and live out their lives in relational networks with other men. Thus the community context in which these networks exist bring additional meaning to the process of social control. One example must suffice to illustrate the point. We have chosen to use the oft quoted study of the Hutterites. When professional definitional norms were applied to the Hutterite population the rate of psychosis in that group was quite high. But, the usual means and forms of social control are not utilized by the Hutterites. Hence, while some members of the Hutterite community are mentally ill, they do not enter the mental illness system. Eaton and Weil describe it as follows:

How does the Hutterite culture deal with mental illness? Although it does not prevent mental disorders, it provides a highly therapeutic atmosphere for their treatment. The onset of a symptom serves as a signal to the entire community to demonstrate support and love for the patient. Hutterites do not approve of the removal of any member to a "strange" hospital, except for short periods to try shock treatments. All patients are looked after by the immediate family. They are treated as ill rather than "crazy." They are encouraged to participate in the normal life of their family and community, and most are able to do some useful work. Most of the manic-depressive patients get well, but among neurotic patients recovery is less common. Most of the epileptics were either cured or took drugs which greatly relieved the condition. No permanent stigma is attached to patients after recovery. The
traumatic social consequences which a mental disorder usually brings to the patient, his family and sometimes his community are kept to a minimum by the patience and tolerance with which most Hutterites regard these conditions. (64)

Factors Influencing Definition-Decision Entrants

This section presents the data and analysis which concern the factors which influence definition-decision making as these are related to points of entry within the care services. The factors which affect facilities for care and their relationship to entrants will also be treated.

Age

The age status of entrants to care services seems related to the type of service for care entered. Age bears an interesting relationship to definition and decision making, and the flow within the care service. At one end of the aging continuum are youth and children. In this category there seems very little chance of entering services for care. But when youth or children do enter, it is usually at the point of out-patient services. Even then, if movement follows into an in-patient facility, the chances are very great that those services will be better staffed, equipped, etc., than comparable in-patient services for any other age group.

At the other end of the continuum are the aged; 65 years and older. This group's chances of getting into the services for care are comparatively very good. One study showed a hospitalized rate for this group of 164.4 per 100,000 as compared to an overall rate for all age groups of 78.7 per 100,000. In another study, the 60 years and
over group had an in-patient prevalence rate of 2,111 per 100,000; the 70 years and over group rate was 1,447 per 100,000. For this age category the point of entry is more likely to be in-patient services and less likely to be out-patient services. The 70 years and older had an out-patient clinic entrance rate of 0. The 60-69 age group had a clinic rate of fourteen per 100,000. By contrast the 5-19 age group showed an out-patient rate of 400 per 100,000. (65)

While both the old and the young seem to show a tendency to greater use of public in-patient care than private in-patient care, the public hospitals for the young typically receive much more financial support than do hospitals serving a primarily adult population. Further, a within-hospital difference between care units for the elderly and care units for others, is readily apparent to even the most casual observer of the typical public hospital care units. The stigma seemingly is additive; to be old and defined as mentally ill is to be twice wounded. The services for care deliver fewer and qualitatively poorer services to this doubly vulnerable group. Clearly then, age is a variable which impinges on definition, but more importantly on the decision as to where the person enters the services for care. The out-patient clinics seemingly favor the young. Possibly an effort is made to send the young there in order to avoid the stigma of in-patient care. This pattern seems similar to the patterns of social control associated with juvenile delinquency. (66) Age in the Ohio services for care shows some interesting variations. In out-patient clinics there appears to be a selective bias favoring the young and all but ignoring the elderly. Table 10 shows the age distribution of entrants by type of facility.
### TABLE 10

AGE DISTRIBUTION BY TYPE OF SERVICE FOR CARE. OHIO 1964-65

<table>
<thead>
<tr>
<th>Facility</th>
<th>Under 9 N</th>
<th>10-14%</th>
<th>15-24%</th>
<th>25-34%</th>
<th>35-44%</th>
<th>45-54%</th>
<th>54-64%</th>
<th>65-over %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient private clinic</td>
<td>2113</td>
<td>20</td>
<td>1660</td>
<td>15.8</td>
<td>2430</td>
<td>23.0</td>
<td>1894</td>
<td>18.0</td>
<td>1373</td>
</tr>
<tr>
<td>Out-patient public clinic</td>
<td>168</td>
<td>2.7</td>
<td>188</td>
<td>3.0</td>
<td>1361</td>
<td>18.0</td>
<td>1540</td>
<td>24.0</td>
<td>1532</td>
</tr>
<tr>
<td>In-patient private</td>
<td>--</td>
<td>--</td>
<td>98</td>
<td>96</td>
<td>1312</td>
<td>12.8</td>
<td>1908</td>
<td>18.6</td>
<td>2396</td>
</tr>
<tr>
<td>In-patient public short term</td>
<td>18</td>
<td>1.8</td>
<td>123</td>
<td>12.0</td>
<td>159</td>
<td>15.7</td>
<td>163</td>
<td>16.1</td>
<td>233</td>
</tr>
<tr>
<td>In-patient public long term</td>
<td>10</td>
<td>0.5</td>
<td>96</td>
<td>0.50</td>
<td>1105</td>
<td>5.3</td>
<td>1735</td>
<td>8.3</td>
<td>3007</td>
</tr>
</tbody>
</table>

*Includes unknown of 183 or 1.8%.
Sex

When sex is treated singly as a variable, it seems to have very little relationship to mental hospital admission rates. Most studies find some slight differences; usually women seem to have slightly higher rates than men. One study shows an average rate, per 100,000, for women of 81.2 and 76.3 for men. In this same study when age and sex were combined, women had a consistently higher rate at all ages than did men, except for the 65 and older group. Here men had a rate, per 100,000, of 172.2; women, 162.6. (67) In the Midtown Manhattan Study, when sex was taken within age categories, there appeared to be no significant differences between males and females in prevalence rates. (68)

Data from Ohio suggests, within age categories, sex differentiates in relation to the point of entrance for care services. Almost twice as many boys as girls are seen in out-patient clinics.

Table 11 presents the available data. In the under 17 age group males have almost twice the risk of females of being defined as mentally ill. In the over 17 age group the females have a slight edge over the males. This seems to demonstrate a high preference for defining juvenile males as mentally ill. This picture remains until age 20, then the balance becomes fairly even. Over 20, it shifts slightly to favor women.

Table 11 shows that at the point of in-patient hospital care, the public and private short-term hospitals typically enter more
TABLE 11
ENTRANTS TO CARE SERVICES BY TREATMENT FACILITY, AGE AND SEX. OHIO 1964-65

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Age</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 17</td>
<td>Over 17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Out-patient private</td>
<td>4,020</td>
<td>1,987</td>
<td>2,923</td>
</tr>
<tr>
<td>Out-patient public</td>
<td>307</td>
<td>199</td>
<td>2,266</td>
</tr>
<tr>
<td>In-patient short-term (all)</td>
<td>127</td>
<td>62</td>
<td>344</td>
</tr>
<tr>
<td>In-patient long-term public</td>
<td>177</td>
<td>111</td>
<td>10,597</td>
</tr>
<tr>
<td>Total N</td>
<td>4,631</td>
<td>2,359</td>
<td>16,490</td>
</tr>
<tr>
<td>Per Cent</td>
<td>66.2</td>
<td>33.7</td>
<td>48.3</td>
</tr>
</tbody>
</table>

women than men. The difference appears to level out at the point of the long-term hospital. Apparently, sex, while it may not be related to "mental illness as an illness," is a factor in access to and use of agencies for care. (69)

Marital Status

The data available for this study did not include marital status for all the types of care facilities. Therefore, no definitive statement can be made about marital status. Data from Ohio on public in-patient entrants indicate that 22 per cent are single, 45 per cent are married, 10 per cent are divorced, and 10 per cent separated or widowed. When these percentages are compared with census data, the disruptive marital statuses (divorced, separated, and widowed), enter in-patient public services at rates nearly three times greater than their distribution in the population as a whole. Data from Ohio about in-patient private facilities suggest a married rate very close to that of the population as a whole; divorced and widowed rates are
approximately double those in the general population. Even so, the widowed status is certainly confounded by age, and hence may be more related to age than to the disruption of status.

Therefore, only very tentative conclusions can be reached about the relationship of marital status to entry. This statement is in no way intended to undercut the body of literature and studies which have documented the crucial relationship of family networks to facets of mental illness pathways. (70)

Race

As with marital status, the data available are incomplete with regard to this variable. What data we do have suggests that Negroes are over-represented in the in-patient public facilities for care—13.2 per cent, and under-represented in the in-patient private facilities—five per cent. In 1960 the Negro population in Ohio was 8.1 per cent.

What seems likely is that being Negro is more related to socio-economic status, than being Negro per se. If we were able to control the data for socio-economic status, the relationship would likely not hold. Hence no claims are made for the significance of race as a single variable impinging forcibly on the type of pathway to the services for care system. Only the tentative direction pointed to above is feasible.

Factors Influencing Type of Facility for Care

Self or Other Definition

When self is the source of decision, private in-patient
facilities seem more likely to be the point of entry into the services for care. To check this assumption the data about type of referral or the type of admission were dichotomized to self and other categories. Others include all others whether they are interpersonally or societally legitimated definers. Table 12 presents the data from Ohio as it relates to self-other definition and type of care facility.

### TABLE 12

**SOURCE OF DECISION BY TYPE OF FACILITY, ALL AGES. OHIO 1964-65**

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Source of Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self</td>
</tr>
<tr>
<td>Out-patient facilities (all)</td>
<td>21.0</td>
</tr>
<tr>
<td>Private in-patient</td>
<td>78.0</td>
</tr>
<tr>
<td>Public in-patient short-term</td>
<td>46.4</td>
</tr>
<tr>
<td>Public in-patient long-term</td>
<td>29.6</td>
</tr>
</tbody>
</table>

The data as presented show entrants to private in-patient care to be more than three-fourths "self" defined. It can be argued that these entrants are "a priori" medically defined. While this is probably so, the equally "a priori" contingency is that "self" must have presented the psychiatrist with the tentative definition for validation.

Of further interest in the data as presented in Table 12 is the progressive decrease in the percentage of "self" definers from in-patient private facilities, to in-patient public short-term and then to in-patient public long-term facilities. A continuum in terms of in-patient facilities pathways seems to be operative here. This may well have consequences for the outcome. In a study by Spitzer and
Denzin, it is suggested that a patient's legal entry status and the source of the treatment decision influenced how staff viewed the patient. Generally, nurses seemed to view patients, whose admission status was voluntary and where the decision had been made by the patient or his family, as the more conforming to the expected patient role. Given the reciprocal nature of role relationships, it is likely that the more favorable the attitudinal stance of the staff, the greater the likelihood for a harmonious staff-patient relationship, and perhaps the better over-all prognosis. (71) The data, in all, are at best only suggestive. They do promise that this dimension is an important one, and warrants additional study.

Source of Legitimation of "Others"

The classification of "others" as definers can be further classified as to where the definition received its legitimation. Thus, the courts, police, school physicians, social workers and psychologists become sub-categories of "others." Table 13 presents the data for within the category "others" by type of facility.

Table 13 shows that medical legitimation is most characteristic of the out-patient and private in-patient facilities. The courts and police legitimate most of the "other" definitions to public in-patient facilities. Perhaps the best conceptualization of the relationships between the prime legitimation source and the type of facility is a reciprocal one. Out-patient services obviously cannot care for a "wildly raving maniac." It also may be that there are stereotypical bundles operating within the care organizations, serving
"OTHERS" AS DEFINERS BY TYPE OF CARE FACILITY AND PRIME SOURCE OF LEGITIMATION. OHIO 1964-65

<table>
<thead>
<tr>
<th>Facility</th>
<th>Prime Legitimation</th>
<th>Psychol. Soc. Worker</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient (all)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(79.0%)</td>
<td>17.5</td>
<td>48.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Private in-patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(22.0%)</td>
<td>3.3</td>
<td>14.2</td>
<td>--</td>
</tr>
<tr>
<td>Public short-term in-patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(53.8%)</td>
<td>21.5</td>
<td>1.2</td>
<td>--</td>
</tr>
<tr>
<td>Public long-term in-patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(71.4%)</td>
<td>32.2</td>
<td>10.0*</td>
<td></td>
</tr>
</tbody>
</table>

This category is largely represented by transfers in from other mental hospitals, usually short-term to long-term.
to define what is suitable and unsuitable for entrance. The use of these stereotypical bundles would serve as guides for "gatekeeping" the pathways. Thus in Table 13 it can be noted that the courts tend to "gatekeep" much of the entrance to public in-patient facilities. The medical profession "gatekeeps" more to out-patient facilities and private in-patient services.

Of interest to this point is a study by Mishler and Waxler. They studied patients referred, accepted, and admitted to a psychiatric hospital. They utilized a small short-term state supported hospital and a private hospital for the sample. They found persons referred for admission were most likely to be accepted if they were physician referred, male and mentioned the presence of a relative. But once accepted for admission, the decision made about admission was a function of decision making by the hospital. At this point the hospital disproportionately selected males and persons with no previous hospitalization record. Thus the investigators stated that the power over the decision to enter the hospital was diffuse and centered out in the community—but it was the hospital which made the final decision about admission based on organizational criteria, i.e., the stereotypical bundle. (72)

The data have shown that legal legitimation of definition-decisions is a factor operative at the level of public services for care. The implications for this finding are tentative but suggest that public facilities are likely to be entered more by those who have frequent contact with the legal agents of the society.
Outcomes for Entrants to Services for Care

Psychiatric Diagnosis and Type of Care Facility

Differential psychiatric diagnosis seems to be related to the type of care facility in that public facilities show higher percentages of psychotic diagnoses than do private facilities. The fine points of psychiatric diagnosis do not concern us but the gross distinctions seem useful. To confer a "psychotic" diagnosis connotes prognostic malevolence. A non-psychotic diagnosis connotes a more favorable future. Table 14 shows by type of facility the percentage of psychotic and non-psychotic diagnoses. Omitted from consideration

<table>
<thead>
<tr>
<th>Facility</th>
<th>N</th>
<th>Functional Non-Psychotic</th>
<th>Psychotic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient (private)</td>
<td>12,720</td>
<td>68.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Out-patient (public)</td>
<td>6,193</td>
<td>27.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>In-patient (Private)</td>
<td>9,906</td>
<td>51.5%</td>
<td>32.6%</td>
</tr>
<tr>
<td>In-patient (public short-term)</td>
<td>6,944</td>
<td>28.3%</td>
<td>43.0%</td>
</tr>
<tr>
<td>In-patient (public long-term)</td>
<td>9,678</td>
<td>24.3%</td>
<td>38.6%</td>
</tr>
</tbody>
</table>
are the cases diagnosed as organic in nature. There seems to be a differential assignation of diagnosis by type of care facility. A study which compared voluntary patients at the Menninger Hospital, Hillside Hospital and the Massachusetts Mental Health Center found that at the latter two hospitals, 74 per cent were diagnosed psychotic and at Menninger, 53 per cent were thus diagnosed. Viewed in terms of median class position, the Menninger patients also had the highest status, Class II. (73) This seems to offer additional support for the data presented in Table 14.

Socio-economic status is not available in our data; hence it cannot be controlled for. Thus the assumption of a relationship between care facility and diagnosis can only be tentative. Yet if one accepts the proposition of role as a complementarity of actions, then irrespective of social class, the data in Table 14 seem significant to the outcomes of the entrants.

Out-Patient Services

Table 15 shows, at the out-patient level, nearly a third of the entrants withdrew. Two-fifths were referred to other care givers. Fifteen per cent were referred to in-patient services. Five per cent were referred to private physicians or private sources for medical care. Another five per cent were referred to a paid help giver or help giving agency. Almost ten per cent were referred to the court or a correctional facility. Thus out of the 19,916 persons who were moved from out-patient services, slightly more than half left the system unencumbered, (53.3 per cent). The remaining 46.7 per cent were
### TABLE 15

**DISPOSITION OF TERMINATED CASES, BY TYPE OF CARE FACILITY, OHIO 1964-65. ALL AGES**

<table>
<thead>
<tr>
<th>Facility</th>
<th>N</th>
<th>Patient Withdrew</th>
<th>No Referral</th>
<th>Referral</th>
<th>Should be Referred</th>
<th>Transfers</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-pat. (all)</td>
<td>19,916</td>
<td>31.5%</td>
<td>21.8%</td>
<td>42.8%</td>
<td>4.17%</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>In-pat. private</td>
<td>9,986</td>
<td>3.2%</td>
<td>33.4%</td>
<td>69.0%</td>
<td>0.30%</td>
<td>4.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>In-pat. public short-term</td>
<td>7,121</td>
<td>--</td>
<td>84.0%</td>
<td>--</td>
<td>--</td>
<td>11.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>In-pat. public long-term</td>
<td>9,016</td>
<td>3.0%</td>
<td>80.0%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

sorted out into other types of care facilities. Hence, there is a fifty-fifty chance of moving on in the care service when entry is made at the out-patient level of care.

**Outcomes from In-Patient Private Services for Care**

Date from the in-patient private facilities show that 36.8 per cent did not have referral to other services for care. Of that percentage two per cent did not get referred for reason of death; 11.3 per cent needed to be referred but the patient or family were thought not to be ready for additional hospital service; 85.5 per cent did not need further care at the time of exit. Seventy-three and
two-tenths per cent of the private in-patient discharged did have referral. Of that percentage 4.3 per cent went directly to the state mental hospital; 12 per cent to an out-patient clinic; 75 per cent to psychiatrists or other types of medical practitioners. Very few were referred to public health agencies, welfare agencies, the court, schools, or other assorted community resources—only about one per cent. Thus, for the person whose pathways to the mental illness services for care begins at the level of private in-patient care, there is about one chance in four that he will leave it unencumbered. Three times out of four he will continue to remain in the care system but usually at the level of private care, with about a fifteen per cent chance of moving on to public facilities. It is of interest to note that the decision for private or public care, at this point, seems largely based on economic considerations. The data show that only 242 out of 9,906 cases were "free" cases; and of that number, 229 were cared for in teaching hospitals. Similarly, payment by various governmental programs accounted for 250 cases out of 9,906 or 2.6 per cent. More than 50 per cent were covered by Blue Cross, 30 per cent by commercial insurance, and 11 per cent were financed independently. Obviously a powerful factor in access to remaining in private in-patient care is the financial wherewithal to pay for the service. Similarly, the lack of the financial resources all but eliminates this avenue of care. The proprietary private hospitals are very direct about it—care terminates regardless of condition when the money runs out. The data do not prove it, but strongly suggest that the 326 who were referred to state mental hospitals and the 855 who were referred to
out-patient clinics were moved in those directions for economic reasons.

**Outcomes from Public In-Patient Short-Term Facilities**

Somewhat more than a tenth of the entrants at this level go directly to the long-term state mental hospital. In general, one has nine chances out of ten of getting out of the short-term hospital. But coupled with this is a fifty-fifty chance or greater of readmission. There is no data available to encompass the referrals from this type of care facility. It is known that referrals are made. In talking with personnel from these hospitals, they suggest that about one-third of all patients who leave are followed in after-care by hospital personnel; about one-third are referred to various social and welfare agencies in the community, and another third receive little or no follow-up; presumably they make an unencumbered exit. A study done in 1957 using data about patients discharged from a short-term state facility showed that the hospital had a high release rate (95.15 to 92.48 per cent) and a relatively high re-hospitalization rate in the five to six year period following release (64 per cent). The researchers suggested a concept of "intermittent patienthood" to describe this pattern. (74) These findings offer some support for the statement that about one-third leave the care system unencumbered, when entered at this level.

**The Public In-Patient Long-Term Facility**

An interesting aspect comes to view when this type of service
for care is examined for outcomes. First let us look at outcomes in those long-term hospitals who by virtue of their location receive the failures from the short-term hospitals. They are located at Cleveland, Hawthornden, Longview, Massillon, and Athens. Table 16 shows the ten public in-patient long-term facilities ranked on six dimensions. The dimensions are: overall patient to employee ratio; professional manpower ratio (includes physicians, nurses, social workers, and psychologists); the transferred-in; patients in residence 20 years or more, as a measure of chronicity; ratio of first admissions to readmissions; and admission to discharge ratio. The five hospitals which serve as "the end of the line" achieve the lowest composite rankings on the selected indices. Clearly, the stigma of failure must be effective in discouraging professional personnel from working in such treatment settings. The overall ethos which likely builds from the ethos of chronicity seemingly takes its toll in terms of outcomes for individuals who enter the system at this level of care.

Two items are of special interest in Table 16. First is the close ranking of Cambridge to the five transfer-in, "end of the line" hospitals. This hospital is located in a relatively sparsely populated area of the state. It has an improbable 4.55 state hospital beds per 1,000 population. The overall State average is 1.74. The Cambridge area has for the use of the citizens of that area 2.6 times more state hospital beds than the rest of the State. The problem for the organization, then, is how to stay in business. In view of the limited mental health manpower in the region, it would seem unlikely that enough cases could be generated from that source to keep the organization operating. Inspection of the data from this hospital reveals
<table>
<thead>
<tr>
<th>Long-term Hospital</th>
<th>Patient-Employee Ratio</th>
<th>Professional Manpower</th>
<th>Transfer In</th>
<th>20-year Plus Patients</th>
<th>First Admission to Readm. Ratio</th>
<th>Admission to Discharge Ratio</th>
<th>Composite Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Athens*</td>
<td>5</td>
<td>6</td>
<td>(7)</td>
<td>6</td>
<td>2</td>
<td>7</td>
<td>5.5*</td>
</tr>
<tr>
<td>Cambridge</td>
<td>4</td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>5.4</td>
</tr>
<tr>
<td>Cleveland*</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>5.6*</td>
</tr>
<tr>
<td>Columbus</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>Dayton</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>Hawthornden*</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>2</td>
<td>4</td>
<td>9</td>
<td>6.8*</td>
</tr>
<tr>
<td>Longview*</td>
<td>8</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>8</td>
<td>10</td>
<td>6.8*</td>
</tr>
<tr>
<td>Massillon*</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>8.1*</td>
</tr>
<tr>
<td>Tiffin</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Toledo</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4.6</td>
</tr>
</tbody>
</table>

*Used as transfer in hospitals, from short-term state hospitals—"end of the line" services.
what must certainly reflect certain operational decisions at the administrative level. Fully 60 per cent of this hospital's admissions are voluntary. Of the male patients, more than one-third are over sixty-five, and alcoholism accounts for almost half of the diagnoses. Cambridge's admission rate for the elderly runs about twice that of the other nine hospitals. This hospital also leads in the death-to-admissions ratio, with 24 deaths for every 100 admissions. Thus, Cambridge apparently "gatekeeps" very little and thus enters a disproportionate number of alcoholics and elderly. This may, in part, account for its resemblance to the five hospitals that have been characterized as "end of the line."

A second item which deserves explanation in Table 16 is Cleveland's ranking as first on the admissions to discharge ratio. This is difficult to interpret. By its designation as an "end of the line" facility, it should rank in the bottom half. In a conversation with Tourau Ishyiami, Ph.D., Director of Special Services at Cleveland State Hospital, some tentative clues were obtained. Cleveland State, in the year under study, was the beneficiary of two grants from the Federal government. One supported in-service training for hospital staff—the other was a Hospital Improvement grant which funded a day-care treatment program. Hence, additional staff was employed, and funds were made available which are not accounted for in the official data at hand. Thus, in part at least, the seemingly contradictory ranking is explained. (75)

The movement pattern through the long-term hospitals is somewhat unpredictable. In general, however, the "end of the line"
hospitals, excepting Cleveland, afford about 20 chances in 100 that death will occur in the hospital. In the other five hospitals the chance of death is about 12 in 100. The five "end of the line" hospitals admit about 150 patients to each 100 discharged. Thus whether one enters the "end of the line" hospital or one of the other five will influence the probable outcomes.

No precise figures are available for the aftercare patterns of referral for releases from the long-term hospitals. Brill has said that after five years in residence the probability of return to the community is slight. (76) In the five "end of the line" hospitals, an average of 64 per cent of the patients had been hospitalized five years or longer—45 per cent in the other five hospitals. Seemingly, then, the movement in the public in-patient long-term care facilities is partially affected by the location of the hospital in relation to other care facilities.

Several studies are relevant to this discussion of the long-term public hospital. One study used demographic characteristics to predict length of stay. The predictive model utilized Baye's theorem and predicted with 86 per cent accuracy stays of more or less than thirty days. The conditional probability of a stay of less than thirty days was highly correlated with being male, white, Protestant, white collar occupation, under sixty-five years of age, and without criminal charges. (77) These data would partially seem to support the data from long-term hospitals from Ohio.

In another methodologically sophisticated analysis, data were
used from the Warren State Hospital first admissions during the period 1948-52. The most consistent finding in this study is that the per cent released is highest among married patients regardless of diagnosis and age for both males and females. Generally the younger, under 45 age group achieved a better release rate. Further, from this study, the more one has living siblings, and the greater the number of those siblings, the better the chances for release in all age groups. (78)

Summary of Outcomes

The patterns of flow within the services for care suggest that once in the services, getting out and staying out are difficult to achieve. The professionals usually make an assessment at the time of release, or termination of the case. Those assessments paint a dismal picture for the promise of "early help." To illustrate: the out-patient private clinics thought that 72 per cent of their treated adult cases, and 75 per cent of the children's cases were improved. In the private in-patient facilities only 23 per cent were thought to need no further care.

A Note About the Criminal and Mental Illness Services

Criminal charges may invoke the question of mental illness as a defense or a pre-sentence investigation of mental illness for the benefit of the court. As noted earlier in this chapter, the common pleas courts, municipal and other trial courts have recourse to the mental illness services for care to assist in decision making. Only 20 such cases were seen in the 10 long-term hospitals in 1964-65,
and none in the short-term or private hospitals. Nine hundred forty-five cases were sent to Lima State Hospital through the various provisions of the law. Nine hundred of these cases were male. Four hundred sixty-one of these were in regard to specific felonies, usually "sex crimes." Only six were for evaluation of insanity, when insanity was planned for a defense. In the overall picture, the number in this latter category are very few, yet they receive a tremendous amount of notice via the popular media, and perhaps feed into the public stereotype of the "killer-madman."

Lima State receives entrants from the courts directly, from correctional institutions, and from the other state hospitals. In 1964-65 Lima received 126 persons from correctional institutions, 60 from other state in-patient facilities. These latter transfers eventuate because of some act of violence on the part of the person already hospitalized. These are the ways in which Lima State integrates with the rest of the services for care.
CHAPTER IV

Summary and Conclusions

Summary

The major task of this investigation was to conceptualize and describe the broad and complex system of services for care in mental illness. First, the services for care were described in a societal context using Ohio as a base for data. Then, by use of a conceptual framework the process by which pathways to care services are structured and the factors which influence their use was delineated. Emphasis was given to factors which influence the definition-decision making process as it operates to induce entrants to the services for care. Factors which influence the rate and points of entry were specified. Possible pathways through the care services and factors which influence outcome were detailed.

Data were collected, assembled and analyzed from the population base of Ohio, July 1, 1964 to June 30, 1965, to answer certain research questions. The analysis treated the entrants as groups of persons with differentiating characteristics and the types of facilities for care services as structures with distinguishing features. The research questions mainly dealt with the interrelationship of these two components.

Some features of the care system were not treated, due to
gaps in the data. However, trends were identified and some tentative directions were elicited. The findings and their implications were discussed.

The Sociological Bias

The conceptual approach in the investigation was formulated at the analytic level of social group and social structure. No attempt was made to tie the concepts or the analysis to individualistic conceptions. Hence, the effort has not been tied to a disease model or a medical model for mental illness. Rather, the attempt has been partially, at least, to emulate the sociology of deviance model. Much of the recent effort in that field has focussed on the social processes which produce and control deviance. In the area of mental illness, some sociological work has focussed on structural features as they relate to causes of illness or types of illness. The approach here has been to focus on those structural features which seem implicated in the organization of the services for care and the allocation of persons within that organization. It has been our belief that this represented a sociological vantage point and that it offered a different way of viewing the phenomena. From a pragmatic point of view, such a view seemed to offer considerable utility for planners and purveyors of services.

The Findings

The findings showed that the complexity of services for care seemed related to the type of society. The data suggested that contemporary society may be implicated in the high production rates of
entrants into the services for care. The groups with high rates of entry to the services for care were shown to share some common attributes. Shared attributes were also useful in the location of points of entry and exit, as well as movement within the care services. The locus of the definition-decision was demonstrated to bear a relationship to the utilization of a given type of facility for care. Characteristics of the care facilities seemed to have a reciprocal relationship to the types of entrants. More is needed to be known before these relationships can be noted directionally.

Implications of the Findings

The conceptual framework and the findings suggest that two variables are of major significance to establishing relationships among the interconnecting parts of the services and the pathways to the services. The first variable is that of the "self or other" nature of the definition-decision making. The conceptual framework provided in Figure 3 needs to be elaborated and tested. What are the nature and type of the relationships which obtain in category B, for example? Do the police have informal arrangements with the hospitals? Do the various facilities for care have informal agreements among them which affect the pathways? These are only a few of the questions which might be asked.

The second variable is that which has as its concrete indicant the type of care facility utilized as the point of entry to the care services. Facile generalizations about societally defined mental deviance based on studies done in one type of care service may not hold
when other types of service are studied. It might even be possible to control for this effect if sufficient data were available about distinguishing features of the types of care facilities.

In sum, the study seems to convey a message. Pathways to mental illness care services are delineated in the main by social-structural factors. The entrants and the services are differentiated so as to provide for differing levels of care services which vary widely in their accessibility for entrance and the feasibility of exit. In this respect, the structure of care services for mental illness more closely resembles the structure of response to criminal behavior than to any medical illness. This analogy, while not perfect, is possible. At the level of in-patient private facilities, persons are selected who seem similar to the types of persons implicated in "white collar crime." The public in-patient facilities select in groups of entrants not too unlike those persons whose crime results in jail sentences. But, the analogy must not be pushed too far.

The Future

What of the future? Demone as observer of the contemporary scene predicts the future in this manner:

The exercise of social controls, traditionally a police activity, becomes a more appropriate function for other social institutions. Medical definitions take precedence over the legal. The afflicted are perceived as ill rather than criminal...for mental illness, alcoholism and drug dependence--progress is being made. The contemporary American philosophical trend to treat problems pragmatically will eventually dominate. (79)

Perhaps Demone is correct. But if the framework here is correct, we cannot foresee this solution without drastic alteration in the
stratified care system and the markedly differential allocation of help givers. Yet, given a more equitable distribution of help givers and facilities, there still must be faced the problem of treatment results. There is no known cure for the deviance labeled "mental illness." Further, there is no way in sight to avoid the disability concomitant with the stigma. No amount of prating about a revolution in psychiatric care will redo the centuries old attitude. Careful, considered and rational plans need to be evolved by communities. The present community mental health movement may well be a fad. Caution needs to be exercised that it does not become a "monster." Keniston's eloquent satire in Trans-Action is a horrifying picture of ten years hence.

Already, plans evolved by the Department of International Mental Health and this Community Mental Health Organization call for the international deployment of Mobile Treatment Teams and Overseas Mental Health Corps volunteers, some operating with the assistance of local governments, others courageously risking their lives in communities where pathology has infiltrated even the highest levels of government....But of one thing there can be no doubt: The Community Mental Health Movement will play a leading role in our progress toward a mentally healthy society at the head of a mentally healthy world. (80)

The parallel here to iatrogenic diseases in medical practice is striking. The protean nature of the phenomena defined as mental illness requires societal efforts of diverse types. One psychiatrist argues that Americans need to emulate Britain's Comprehensive Community care and rehabilitation of the psychotic, the elderly and those with chronic social handicaps. (81) Given the socio-political differences in the two countries, such advice may be more hopeful than realistic.

We need not become mental health demagogues nor anti-mental
health demagogues to appraise the present. A course can be steered wherein integrity can be shown. This demands that we distinguish carefully among personal beliefs, scientific constructs and evidence and personal ambitions.

The goal of this investigation has been to demonstrate the structure of mental illness services for care as it operates in American society, using Ohio as a case study. The social structure of the mental illness care services is useful for some segments of the society and profoundly inadequate for other segments. If this thesis serves in any way to focus attention and concern on the consequences of those structural arrangements for care, it will have been worth the cost in time, effort, and energy. If it only has enlightened the writer, it still may be worth its cost.
Appendix I

Region I: Cleveland
Region II: Youngstown
Region III: Akron
Region IV: Cambridge
Region V: Athens
Region VI: Columbus
Region VII: Dayton
Region VIII: Cincinnati
Region IX: Toledo

2. A notable exception to this has been the approach found in Srole, et al., *Mental Health in the Metropolis*, New York: McGraw Hill, 1962.


4. Ibid., p. 3.


8. F. T. Lindman and D. M. McIntyre. *The Mentally Disabled and the Law*, Chicago: University of Chicago Press, 1961. This is the product of an American Bar Association committee. In addition to surveying the laws which presently obtain in mental disability they have drafted a model act which has been partially adopted in few states at the present time.


11. I am indebted to Dr. Harold Pepinsky, Professor of Psychology, The Ohio State University, for this felicitous phrase. I do not know if it is "original" with him.


14. This extremely graphic expression was brought to our attention in an unpublished paper by Irwin Deutscher. "The Gatekeeper in Public Housing," read at the annual meeting of the Eastern Sociological Society, April 1, 1961.


17. Lindeman and McIntyre, op. cit., passim.


24. Ibid., p. 21.

25. Ibid., p. 7.

27. This marginal group of paid help givers has been largely unexplored in the social science literature. In a speculative way one might guess that some of these practitioners might be in a sense highly skilled "help givers." They might also be "bunco artists."


31. Muth, op. cit., p. 63. It should be of interest to the student of small group behavior, how it is that the ex-mental patient clubs have not become widespread, compared to "cholostomy clubs," "the lost cords," etc.


33. All of the statistics for the above discussion have been taken from the source cited in footnote 32. It is well to remember that these data include "marginal" facilities to the mental illness system. That is, special hospitals for addiction problems, alcohol and narcotics, and hospitals which serve the mentally retarded are also included. Thus the system seems larger in scope than it may in fact be, yet the "marginal" facilities probably do enter into the ebb and flow of the system and thus it seems wise to count them in.


38. In a newspaper item in the *Columbus Citizen-Journal* of Sept. 19, 1968, a psychiatrist speaking to a group of clergymen is quoted as saying, "... ministers could be helpful in 'propagandizing' the principles governing normal interaction among families. By acquainting people with the norms it would be easier for them to recognize departures and thus recognize problems early before they become serious." p. 11.


41. John Seeley, et al. *Crestwood Heights*, New York: Basic Books, 1956. "All those means, circumstances and life-ways in terms of whose absence we habitually account for 'pathology' are there ... and yet no forcing of the data can lead us to conclude that the mental health of the community is sensibly better than elsewhere ..." p. 410.


43. E. Goffman. *Stigma*, Englewood Cliffs, New Jersey: Prentice-Hall, 1963. It is well to note here Goffman's point about how comfortable the social sciences have become in using the term, "deviant." He infers that it may be serving social science as the iatrogenic disorders serve medicine, to give social scientists more work to do.


48. All of these studies cannot be cited; however, for example, see Srole, et al. *Mental Health in the Metropolis*, New York: Basic Books, 1959; Marjorie F. Lowenthal, "Social Isolation and Mental Illness in Old Age," *American Sociological Review, 29*, Feb. 1964, pp. 54-70. Tangentially, though they deal with pathways out of the system, the work of Dinitz, et al., "Psychiatric and Social Attributes as Predictors of Case Outcome in Mental Hospitalization," *Social Problems, 8*, Spring 1961, pp. 322-328, is relevant for this formulation, inasmuch as the process of staying out of the hospital is likely to be influenced by the same variables as those which determine how the patient got in in the first place.


52. Dennis Wenger. "A Confrontation of Professions: The Medical-Legal Debate, and the Effect of Legal Counsel on the Commitment Decision," *Sociologies*, 3, No. 1, pp. 23-35. (Published by Alpha Kappa Delta, Department of Sociology, The Ohio State University.)


58. Here the writer is reminded of a hospital superintendent who always bargained (unofficially) with the county home. The county home superintendent would be seeking admission to the state hospital for one of his patients, the hospital superintendent would refuse on the ostensible basis of lack of beds, and offer to take the patient only if the county home would agree to take a patient from the hospital; strictly speaking none of this was "legal" but it did move out of the hospital persons who probably would never get out otherwise.

59. The source for the information around the 1845 period is obtained from the *Reports of Lunatic Asylum of Central Ohio*, 1-10, 1839-1845. These reports prepared by William Awl, M.D., the superintendent for the asylum throughout this period are illuminating in many respects. The "moral era" of treatment was in vogue during this time and as Dr. Awl's comments are read they
sound similar to those written today about therapeutic milieu, etc. The influence of the superintendent on public policy appears to be considerable, and suggests the medical view prevailed during this period.

60. The writer is indebted to T. H. Sills, M.D., for this concise summary of the Revised Code of the State of Ohio, and for permission to use it here.


62. Robert A. Scott comments on the rehabilitation services for the blind and the explicit use of a "loss" model as used in some rehabilitation centers. The "mark" is taught that he must accept the loss and compensate for it. Thus precluding a host of other ways "the mark" might re-establish himself. In "Rehabilitation As An Interpersonal Process," in Marvin B. Sussman, (ed.), Sociology and Rehabilitation, American Sociological Association, 1965.

63. In this connection see Appendix C, pp. 380-382 in Srole, et al., op. cit., for an excellent discussion of the meaningfulness of such statistical data.


66. This pattern is best known through the literature in criminology especially in regard to juvenile delinquents, women criminals, white collar criminals, etc. See Reckless' discussion of "categorical risks in crime" in Walter Reckless, The Crime Problem, New York: Appleton-Century-Crofts, 1961, pp. 31-48.

67. Wanklin, et al., op. cit.

68. Srole, et al., op. cit.

69. Multiple problems exist in the use of hospital admission data. An excellent discussion of this can be found in a report by B. Locke, M. Kramer, C. Timberlake, B. Passamanick, and D. Smeltzer, "Problems in Interpretation of Patterns of First Admissions to Ohio State Public Mental Hospitals for Patients with Schizophrenic Reactions," Psychiatric Research Reports, 10, Dec. 1958, pp. 172-196.

70. See especially, Muriel Hammer, "Influence of Small Social Networks as Factors on Mental Hospital Admission," Human Organization, 22, 1963-64, pp. 243-251. While the sample for this study was


75. In phone conversation with Dr. Ishiyama. To the best of his knowledge and mine, Cleveland was the first beneficiary of the expanded grants program of the Federal government and none of the other hospitals in this category were funded in any supplementary way. Incidentally, as of four years later, July 1968, Cleveland State has reduced the in-patient census from 2,052 to 1,420.

76. Dr. Henry Brill quoted this to the Midtown Manhattan investigators. See Srole, op. cit.


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