DEPARTMENT OF PUBLIC WELFARE

TO: Hon. Karl F. Rolvaag, Governor — Dec. 1, 1965
Hon. A. M. Keith, Lieutenant Governor
Mr. Stephen Quigley, Commissioner, Dept. of Administration
Mr. Robert Mattson, Attorney General
Mr. John Jackson, Director, Civil Service Department
Mr. Morris Hursh, Commissioner, DPW
DPW Cabinet
Mental Health Medical Policy Committee
Children's Mental Health Committee
Citizens Mental Health Review Committee
Hospital Construction Advisory Council
Mental Health Planning Council
Mental Retardation Planning Council
State Advisory Council on Community Mental Health Center Construction
State Advisory Council on Mental Retardation Facilities Construction
Legislative Building Commission
Medical and Administrative Chiefs - All Institutions
Program, Clinical Directors and Board Chairmen, Community Mental Health Centers
Mental Health Executive Council
Regional Mental Health Coordinating Committees
University of Minnesota- Dept. of Psychiatry & Neurology
Dept. of Pediatrics
Dept. of Public Health
School of Hospital Administration
Administrator, University Hospitals
Mayo Clinic, Psychiatry Section Attention: Dr. Edward Litin
Mr. Virgil Shoop, Acting Regional Program Director, Mental Health Services, 560 Westport Road, Kansas City, Missouri 64111
Veterans Administration Hospital, Minneapolis, Minnesota
Veterans Administration Hospital, St. Cloud, Minnesota

FROM: David J. Vail, M. D.
Medical Director

SUBJECT: Attached report: Scandinavia-England, 1965, Study Tour

Attached is my official report to Commissioner Morris Hursh on my recent trip abroad.

This document will form the basis of my presentation at the Study Tours Anthology meeting of December 8, 1965.

I would be glad to answer any questions which you may have.

DJV:rcj
Enclosure

DEPARTMENT OF PUBLIC WELFARE

TO: Mr. Morris Hursh Nov. 26, 1965
Commissioner

FROM: David J. Vail, M. D.
Medical Director

SUBJECT: Scandinavian-England 1965 Study Tour

This is my summary report, for your information and the official record, of my trip to Norway, Sweden, Denmark, and England, from October 10 - November 2, 1965.

Regarding the Scandinavian portion, I reported to the Minnesota Association for Mental Health at their annual meeting on November 13, 1965. I will render an official oral report at the Study Tours Anthology meeting on December 8, 1965; this will be transcribed. Finally, I will prepare later a more detailed written report, hopefully to be published in book form.

The visit to England was for the purpose of giving a lecture, visiting the programs in Essex under the administration of Dr. Russell Barton, obtaining further information about the Mental Welfare Officer, and learning about the organization of programs for the mentally retarded.

Introduction

The problem is not obtaining sufficient information in a short time: the problem is obtaining the right information, sifting through what may be an excess of information (or useless information) and weighing and balancing the impressions obtained. Further, the primary need is not to evaluate or validate facts (as these are abundantly available in statistical reports, etc.), but it is to get a clear view of a culture pattern and a set of values different from our own — which provide a matrix for understanding the facts. My trip was so brief and fragmentary that I cannot pretend to have obtained this clear view of the Scandinavian programs. Still, it is possible to learn a great deal in a short time if one's energies are properly focused.

It is very hard to keep from being misled by a view of a facility that gives a favorable or unfavorable impression, or a conversation with an individual who appears to be competent or incompetent. In other words, one is faced always with the hazards of generalizing from a small sample, in a situation where personal reactions may play an important role in what is perceived and how it is perceived.

I. Norway. Sweden and Denmark.

Note: 1. Scandinavia is here used in a purely geographical sense to denote these three countries. Culturally it is more fitting to speak of the Nordic Community, which includes also Finland and Iceland. Since I did not visit these countries, I can make no comment about them.

2. It is inappropriate and slightly offensive to Scandinavians to deal with these countries in a single, inclusive sense; as they are separate nations with individual differences, separate institutions, their own national pride, etc. The effect would be the same as reporting on three U.S. state programs as a single entity. Nonetheless in this summary I will discuss factors which the three countries seem to share in common.

The general approach is to try to discern the system features of the mental health programs in the Scandinavian countries, as a key to the organization of the services.

A. General Issues

1. Climate

2. Language, culture, form of government

3. Homogeneity of population (e.g., 98% of Denmark residents are Danish by extraction).
This means that the public will is more quickly and easily expressed in the form of a consensus, in contrast to the U.S. situation, where wide diversities of ethnic, religious, racial, sectional, economic, and other differences make consensus a more arduous process.

Size is a factor: "We all know each other."

4. Social policy

(1) Confidence in the state; respect for the government, its officials, and its actions.

(2) Social policy. Definition (Hojer): ". . . the welfare of the private citizen and private groups is the conscious aim of the state's social activity . . . Society according to this view is ordered so that social security is its objective and the whole population's feeling of solidarity is its basis."

(3) State planning. Definition (Hojer): "A general endeavor to create an effective, planned society . . . and to wipe out differences of property and class."

From this effect and factors like homogeneity one result is a general evenness of affluence and opportunity, at a generally high living standard.

(4) Protective intervention. This is a basic concept, but difficult to interpret or translate. It appears to be related to the parens patriae or guardianship concept of English common law, but (as in the case of local Temperance Boards, stringent driving laws, etc.) it shades over at times into

a kind of police power. Social instruments are not only available but readily functional to intervene in need situations. For example, note the Norwegian concept of sosial omsorg, the principle that every person in need of help shall get it; need is defined on the basis of a majority consensus according to terms that are, in the eyes of the majority, self-evident. By the individual-rights oriented traditions of English law and the rough and ready values of the American frontier the quality of protection might be viewed as over-protection or even invasion of individual privacy and rights.

5. Social medicine and the disease model

The prevailing outlook on mental disorder seems to be the disease model. Psychiatry is psychosis-oriented. Mental disorder is seen as a relatively fixed, established process that has its roots in the hereditary constitution of the individual; once it is set in motion it is relatively difficult to arrest or reverse. Thus, one gets the impression of an inherent pessimism about mental disorder that is implied in the classical — as it were, Germanic — concept of dementia praecox, or its more modern counterpart process schizophrenia. There is compared to American psychiatry, a relatively greater effort to find and ascribe some tissue change as an explanation for the behavior manifestations.

There is, conversely, relatively less emphasis on the idea of mental disorder in terms of psychosocial dysfunction or as a total systems response pattern, as expounded in Menninger's The Vital Balance.

Thus the approach is more "organic" than "psychodynamic." It is classically medical in the sense that the disease is named (diagnosed) and the status of patient thereby conferred. The measures taken are also classically medical: the patient is put to bed in a hospital and specific medical treatments instituted. This model, together with the strong tradition of protective intervention, seems to produce, by our standards, an overloading of hospitals and a prolongation of the mental patient career.

The picture is here painted in overly strong primary colors for purposes of emphasis and should not be seen as critical or derisive. By Scandinavian standards, our practices of early hospital release might well be seen as medically irresponsible; our efforts to thrust the patient on his own cognizance as cruel; our emphasis on psycho-social maladaption as admission of defeat in making adequate medical diagnoses.

Furthermore, the picture would not be complete without noting the dimension of Social Medicine, which is far better developed in Scandinavia than in the U.S. Separate departments of Social Medicine exist in the University of Oslo and the five Swedish medical schools. A way to formulate this concept is not so much in terms of the social causes of disease, or disease as a product of numerous intrapsychic and extrapsychic forces; but of the social consequences of disease. Thus the medical student is systematically exposed to the multiple ramifications of illness. Taking the simple example of a man breaking a leg at work: the student learns to inquire into what this will mean for the patient's economic situation, for his family, for his fellow workers, for his employers, for the social agencies that may have to intervene with home helps, for the sickness insurance office, for the board that may have to hear a compensation claim, etc. The roots for this social mobilization process probably lie deep in Scandinavian village life, where the physician from very early times was seen first and foremost as public health officer or physician for the whole community.

In the mental field the result appears to be a mixture of what we would regard as a relatively somatic concept of mental disorder coupled with an efficient system of social organization which sets into motion a wide variety of protective and supportive measures in which the physician participates. The hospital is the nerve center of the health care system, including mental health.

6. Legal structure

I defer this discussion to more competent observers, principally Douglas Head, who has made his own study tour of the Scandinavian forensic psychiatry systems. Main points are:

(1) Rejection of the McNaughton rule in favor of the product test of criminal responsibility.

(2) Reliance on the expert medical witness as amicus curiae, employed before the establishment of fact.

(3) Rejection of the adversary system.

(4) Use of mental hospitals as the disposition locus of those persons exculpated from responsibility because of psychosis, conditions on a par with psychosis, or mental deficiency.

(5) Use of the indeterminate sentence, in detention centers, in appropriiate (e.g., sociopathic) cases.

7. Design

The world-famous Scandinavian flair for design is abundantly manifest in the architecture and furnishings of the mental health and mental retardation facilities in Scandinavia. Words fail to convey the sometimes sheer beauty of the

facilities. Noteworthy are the skillful manipulation of space and light, and the use of wood, glass, and metal in standing and mobile structures.

B. Organization

Probably best developed in Norway.

C. Specific programs.

1. Alcoholism

Seen traditionally as a social problem; this is changing.

2. Mental retardation

Organized variously: Norway: psychiatric
Sweden: rehabilitation
Denmark: social

The protective intervention concept comes to the fore in relation to the mental retardation programs. By U.S. standards, both in regard to staffing, programs of all kinds (educational, vocational, nursing, medical, etc.), and facilities, the mental retardation programs could only be described as magnificent.

3. Mental illness

The general picture is one of expansion of institutional spaces, overcrowding, waiting lists, periodic closing of voluntary admissions in favor of more urgent cases, etc. The commitment of criminals to mental hospitals no doubt contributes to this picture.

3.1 Child psychiatry

This is relatively advanced by U. S. standards, especially in Sweden.

4. Community psychiatry

Here we find a different pattern from that in the U.S., with emphasis mainly on in-patient general hospital services, hospital out-patient clinics, etc.

5. Aftercare

Organized as an adjunct of in-patient mental hospital services. Much aftercare is provided in psychiatric nursing homes.

6. Forensics

The detention center model could be usefully adapted for our purposes.

D. Places visited

Norway:

Directorate of Health, Psychiatric Division
Institute of Child Psychiatry, Oslo
Oslo University: Gaustad Mental Hospital
Oslo University: Psychiatric Clinic
Oslo Health Board, Psychiatric Division
Psychiatric Clinic and aftercare-home for alcoholics, Oslo
Oslo Observation Center for the Mentally Retarded

Sweden:

National Board of Health — Mental Health Division
Mental Retardation Division
Child Psychiatry Division
Southern Hospital, Stockholm
Clinic for Forensic Medicine (Langholmen Prison), Stockholm
Swedish Mental Health Association
Ulleraker Mental Hospital, Uppsala
Akademic Hospital, Uppsala — Department of Social Medicine
Child Psychiatry Clinic
Karolinska Hospital, Stockholm
Mr. Gosta Nordfors, Director, Care of Mentally Deficient, Stockholm County

Denmark:

The National Health Service of Denmark
Detention Center for Criminal Psychopaths, Herstedvester
State Mental Hospital, Glostrup
Lillemosegaard Institution for the Mentally Retarded, Soborg

E. Recommendations for visiting

I would be glad to consult with anyone to give any recommendations on persons to consult and places to visit. Such arrangements can most profitably be made on the basis of personal contact.

II. England

A. Mental Welfare Officer

These are employed by the local authorities, that is the local governments of counties, county boroughs, and cities. They work out of the local health departments and are responsible to the medical officer of health. Their function has changed historically from that of "body snatchers" — sent out to pick up mentally ill persons and bring them into the hospital — to a professional status of public mental health social worker. They play an important role in assisting in the admission of patients and in helping with aftercare plans.

The mental welfare officers have an important role in placing mentally ill and mentally retarded former patients (and, especially in the case of the mentally retarded), those who have never been patients, in hostels of various kinds. These are also run by the local authorities. The Mental Welfare Officers may carry out counseling and casework services on clients who are now residing in hostels.

The local authorities also run the community educational and "Day Training Centres" for the mentally retarded and may provide for housing accommodations nearby in connection with these. Mental Welfare Officers often have coordinative and casework duties in connection with these programs.

The concept of case-control, as we envision the role of county welfare departments in Minnesota, exists in theory in regard to the Mental Welfare Officer; it is weakly developed with regard to the mentally ill, where the mental hospitals maintain the control, and somewhat better developed with regard to the mentally retarded.

B. The National program for mental retardation

The mental retardation programs are organiized in the Ministry of Health, under the terms of the Mental Health Act of 1959.

A booklet published by the National Association for Mental Health has these descriptive paragraphs:

> "Under the general term of 'mental disorder' the Mental Health Act. 1959 (England and Wales) includes provision for the mentally subnormal who under earlier legislation were termed 'mental defectives'. It classifies them in two groups:
>
> (a) subnormal (including the majority of those formerly known as feeble-minded), and
>
> (b) severely subnormal (including those formerly termed 'idiots' and 'imbeciles' together with the lower grades of the 'feeble-minded').
>
> Local Authority Services
>
> The Act puts considerable emphasis on the desirability of the mentally subnormal person remaining in the community, and lays upon the Local Authority the duty of providing comprehensive free services for their support and training. These include:
>
> 1. The provision of Day Training centres or other facilities for the training and occupation of both children and adults, with the power:
>
> (a) to compel attendance in the case of a child of school age, and

(b) to provide residential accommodation at or near the training centre for those unable to attend daily by reason of distance or lack of available transport.

2. The appointment of Mental Welfare Officers to carry out aftercare and such other duties as may be assigned to them by their Authorities.

3. The provision of such Welfare Services as may be required by the mentally subnormal person and by his family.

Hospital Services

Hospital care is available for those requiring treatment or care not readily available in the home, and for children and adults who, for a variety of reasons, are best cared for either temporarily or permanently in a residential environment. The Act emphasises that, wherever possible, entry to and discharge from hospital shall be on an informal basis, thus bringing this more into line with other form of hospital care. In the rare cases when for the protection of the patient or to safeguard society he has to enter hospital against his will, two doctors are required to recommend this course, of whom one must have special experience of the disability. Both the patient, and his 'nearest relative', as defined under the Mental Health Act, 1959. have appeal rights against compulsory detention.[11]

Institutional care is organized under the hospital branch of the National Health Service, through the Regional Hospital Boards and the Hospital Management Committees. Community care is organized through the local health departments. The role of the Minister of Health is encouragement, consultation, support, and rarely pressure to and on the local authorities.

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