THE ROLE OF THE STAFF CONFERENCE IN A STATE MENTAL HOSPITAL[1]

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The purpose of this paper is to describe the functioning of diagnostic and release conferences in a state mental hospital, in order to point out areas of study that would be of interest to social-science theory as well as to practical therapeutic programs.

During the summer of 1957 the writer, together with another anthropologist, was engaged in field study at Napa State Hospital, a large mental hospital located about forty miles northeast of San Francisco, California. The patient population at the hospital numbers about 5,500, including court and voluntarily committed mentally ill, alcoholics, drug addicts, children committed for "juvenile observation," and a large number of seniles. The hospital is not intended for treatment of the mentally retarded or criminally insane, or for neurotics. Although the patient population has grown steadily since the hospital was founded in 1871, the past year has shown, for the first time, a decrease of 160 patients. This has been brought about by a combination of circumstances, including use of new, so-called "wonder drugs," as well as by important changes in the social environment within the hospital. Many of these recent developments reflect increased state expenditures for personnel, equipment, and services.

During the two months of research at Napa State Hospital the writer studied medical records of individual patients, observed behavior in wards, interviewed patients, technicians, doctors, and other personnel, and observed the proceedings of staff diagnostic and release conferences. It became clear that the staff conferences deserve close study as an important focus of hospital decision-making and as a means of expressing value orientations.

Diagnostic and Release Conferences[2]

Staff conferences are held separately in the men's, women's, and children's services (administrative divisions). The conferences take place on Mondays and Wednesdays. While there is some attempt to separate diagnostic and release conferences, most sessions handle both kinds of cases. The conferences are attended by staff psychiatrists, physicians, psychologists, social workers, the industrial therapist (at men's conference only), and various spectators such as student nurses and technicians. Of these people, all except the spectators express opinions and ask questions during the conference, but as a general rule only the psychiatrists, physicians, and occasionally the psychologists, participate in the making of recommendations.

At release conferences the major decision concerning a particular patient is nearly always whether or not he should be released. A secondary question is the advisability of the particular "plan" of release--the selection of the patient's post-hospital environment.

The selection of the post-hospital environment depends in most cases on the initiative of the patient and his relatives. Often there is an informal agreement (arranged by letter or visit) between the patient and a relative to the effect that the patient can be signed out to live with that relative. This plan is then brought to the attention of the patient's ward doctor, or perhaps to the ward social worker. At this time the ward doctor decides whether the patient has recovered enough to be considered at the staff conference. Some ward doctors make a practice of sending to conference nearly all patients who present a leave "plan," but most wards have chronic patients whose recurring "plans" for leave are only infrequently brought before conferences because the patient is obviously still mentally ill. Such chronic "leave-planners" usually succeed ultimately in getting their proposals admitted to conference, however, since this can ease tensions between doctor and patient by shifting responsibility to the staff conference.

The procedure in the release conference is usually as follows:
(1) The patient's ward doctor presents background information about the patient, including social history, evidence of mental illness presented at time of commitment, diagnosis, record of hospitalization, leave plan of patient, and statements from family members concerning the request for release (if there are any). The completeness of this preliminary report varies considerably with the predilections of the particular ward doctor and the amount of ambiguity in the case.
(2) The patient is brought into the conference room.
(3) The doctor who has presented the case usually takes the lead in questioning the patient concerning his release plans and present mental functioning. The procedure of the conference can best be described by giving some examples.

Case 1: Conference of August 12, 1957[3]

Dr. Smith (the patient's ward doctor) presented the case by reading from the medical files (quotations are approximate).

"This case is that of a 48-year old married laborer. He escaped from another state mental hospital, was working for quite a while, then was picked up and brought to this hospital. The diagnosis is schizophrenia, undifferentiated. This man says that he inhaled powder smoke and that is the cause of his symptoms. He apparently has had some delusions about spirits. Maybe his wife will take him back although she has not visited him. He drinks somewhat, has a ground-parole card, and has made a good adjustment on the ward."

(Patient is ushered into the room.)

Dr. Smith: "How long have you been here?"

Patient: (Gives correct answer.)

Dr. Smith: "What is the date today?"

Patient: "August 12th."

Dr. Smith: "Why are you here?"

Patient: (He tells somewhat involved story about being picked up by the immigration officers because he is an alien.)

Dr. Smith: "Were you mentally ill?"

Patient: "Yes." (He goes on to tell about the noise of wagon wheels making him nervous.)

Dr. Smith: "What do you want to do now?"

Patient: (Explains that he wishes to go home to his wife and eight children.)

Dr. Smith: "Would she take you back?"

Patient: "Well, yes." (He admits that she has not written or visited him in the past year and a half.)

Chairman: "Does anyone else wish to question the patient?" (Pause) "OK, that's all, Mr. C. You may go now."

(Patient leaves the room.)

Dr. Smith: "I recommend indefinite leave of absence to the wife if she will take him. No overt evidence of psychosis."

Since there were no dissenting opinions, the recommendation was adopted and the case was referred to the social worker, who wrote to the patient's wife. As the wife has not yet replied (3 weeks later), the patient is still in the hospital. If no word is received from the patient's wife, his release may be considerably postponed even though he is well enough to leave the hospital. The family can thus indefinitely defer the release process by their inaction or hostility.

Case 2: Conference of July 24, 1957

The patient in this case was an attractive young divorced woman of about 25. She had been in the hospital for about eight months, with a diagnosis of manic-depressive, manic reaction, and had received electro-shock therapy, a course of drugs, and other treatment. In the later phases of her hospitalization she had been re-diagnosed as schizophrenic, paranoid reaction. The commitment papers state that the patient had walked down the street of a nearby suburb in her negligee, saying that she was the angel Mary. At the time of the conference she appeared to be in good contact with reality, and had no hallucinations or delusions.

In response to questions from several members of the staff the patient stated that she wanted to get a job in dress designing, at which she has had some training; she would like to live alone, and would take care of her two small children. She denied any memory of the events that brought about her commitment. (Such real or simulated amnesia is common among patients who have had electro-shock therapy.) The patient said that her mother, who was caring for the patient's children, would soon be going back to her home in Denver. Some of the staff members felt that this would be for the best, because the patient had frequent emotional conflicts with her mother.

The staff denied the patient's request for release because she did not appear to be realistic about how much work and responsibility she could undertake at the present time, and also because there would be no responsible person at her home to aid and supervise her and help in caring for the children.

Staff Conference Decisions

The decisions of the staff conference concerning release of patients appear to hinge on at least four major criteria: (1) Is the patient well enough to be at large in the community without being a threat or nuisance to society? (2) Will the patient receive adequate care and supervision in the community? (3) Will the outside community be of more therapeutic benefit to the patient than is the present hospitalization? (4) What are the wishes of the patient and his family?

From our observations of the staff conference procedure it appears that the chief question to be decided in the release process is almost always whether or not the patient should be released, rather than what particular leave "plan" should be adopted. The plan offered by the patient, with or without the coöperation of his relatives, is considered (see note 2). If the staff conference rejects the proposed plan, however, the social workers may be instructed to aid in the working out of a new suggestion. In cases where the patient has children, the staff must also decide whether the patient is well enough to resume responsibility for their care.

The importance of the negative or "no action" decision as an exercise of the formal power of the hospital can be seen from the following table, in which almost one-fourth of the requests for leave were denied or deferred for further planning.

Table 1

Results of 24 Conferences During July-August, 1957[4]

	Cases	Per Cent
Discharged outright	25	10
Referred for Family Care planning[5]	16	7
Granted leave of absence[6]	145	59
Referred for further planning	24	10
Release denied	35	14
Total	245	100

Theoretical Problems in the Release Process

The release process at an eastern state mental hospital has been described by Simmons, Davis, and Spencer (1956) as a "classic triangular" situation. The authors felt that the seeking for consensus among the patient, the patient's family, and the hospital involved "structured strain" (the presence of incompatible goals among actors in a social structure),

which would be of importance in the patient's adjustment to the post-hospital environment. The authors state that: (1) In cases of disagreements among the three actors, the patient's desires in the matter are usually granted. (2) If the patient and the family are allied against the recommendations of the hospital staff, the hospital recommendation is usually not followed. (3) The hospital commands the most formal power and the patient commands the least, yet the "latter's wishes are the best predictor of what the outcome will be." (Simmons and others, 1956:27). (4) ". . . the patient has a great deal of informal power in that the hospital personnel, acting in his interest, will seldom advocate a plan that he strongly resists. . ." (p. 27).

Simmons and his collaborators stated that they got their data by collecting the names of patients who had been released from a hospital in an eastern metropolitan area. "The chief of each service was asked, after reviewing his case records, to tell us for each patient: his social or family setting on admission, his social or family setting on release, the disposition plan favored by the patient, the plan favored by the hospital, and the plan favored by the patient's family." (They did not get independent data from the patient or the family, since, they felt, the psychiatrist would be in the best position to have the full information.) (p. 22).

It is important to note that the conclusions derived were based only on cases in which the patient had been released; cases in which the hospital had denied release were not included in the study.

In the release process at Napa State Hospital, as we have described it above, it appears that study of the "structured strain" must include analysis of all the cases considered at staff conferences, and not just those that are passed on favorably, for it appears that in denial of release the hospital's formal power is most clearly expressed. Any case in which the hospital staff approved the patient's release would, it seems likely, involve a specific "plan" which was at least minimally acceptable to the hospital.

The Concept of Triangularity

The release process at Napa State Hospital is difficult to describe in terms of a triangular relationship. In the first place, the patient's family as "actor" often consists of more than one set of relatives, perhaps in conflict with each other. This was quite apparent in a recent case where the mother was violently opposed to continued hospitalization of the patient (a possibly suicidal depressed case), whereas the husband agreed with the hospital staff that further treatment in the hospital was very necessary. On the other hand, in many cases the patient's relatives are entirely neutral or uninvolved in the decision-making process itself. (Relatives of patients seldom appear at the staff conferences.) In the men's staff conference of August 26, 1957, for example, mention of the relatives' attitudes was made in only 4 of the 12 cases considered for release, and in only one of these cases was the family actively seeking the patient's release. From this it appears that the release process is most often structured as a relationship between the patient and the hospital

staff, with the attitude of family members serving only as additional information for the primary decision-makers.

The hospital, too, is not always describable as a single "actor" in the sense apparently intended by Simmons. Members of the psychiatric staff may disagree concerning a patient, and the opinions and activities of the psychologists and social workers add still more complexity to the position of the hospital regarding the patient's leave planning. It can also happen that a leave plan approved by the therapeutic staff is vetoed by the administrative heads. This action is most likely to occur in the case of a patient who has a record of violent anti-social behavior.

Staff Conference and Socio-cultural Norms

An important aspect of the staff conference procedure is the judgment of "normal" or acceptable behavior. In their diagnoses and in decisions concerning release of patients, the hospital staff members assess whether the patient has engaged in psychiatrically "abnormal" behavior, and attempt to gauge whether or not the patient is likely to engage in future behavior contrary to the social and psychiatric norms. In these cases the staff must also estimate the amount of tolerance for "abnormal" behavior in the patient's prospective home community. Thus, some patients may be released from the hospital while they are still considered psychotic, provided the staff feels that they are not dangerous and that family and community will tolerate their behavior. Some members of the staff have expressed the opinion that Negro communities are particularly tolerant toward behavioral aberrations. An important question for investigation would be whether such tolerance, if it exists, is due to "open-mindedness" toward mental illness or simply an expectancy of "ornery," "contrary," or unpredictable behavior as part of "healthy" and natural human action.

Staff Conference as a Hub of Communications

In the study of hospital social structure a great deal of attention has been paid to problems of communications. (See, for example, Stanton and Schwartz, 1954.) So far, however, not much attention has been paid to the staff diagnostic and release conferences as communication processes. We have noted above that these sessions bring together physicians, psychiatrists, residents, psychologists, social workers, and other hospital personnel for decision-making which is crucial for the purpose of the institution.

Since the formal power of the hospital vis-à-vis both patient and community is most clearly exercised in the conference setting, the competition for prestige among factions in the hospital, if such exists, might be profitably studied at the staff conferences. The introduction of large-scale use of psychiatric drugs, of concepts of the "therapeutic community," and other innovations have made the hospital the scene of very rapid change, and the cleavages that occur between "progressives" and "conservatives," or other kinds of factions, may be expressed rather clearly in consideration of particular cases. For example, in a recent release conference a lively discussion took place over whether a certain rather "poor risk" should be

released, since she had promised that she would seek private psychiatric care at home. After the patient had been interviewed the chairman informed the conference that the administration (the Superintendent, Assistant Superintendent, and the Director of Clinical Services) would be very sceptical about letting this patient go home, since the community had been so upset by her previous relapses, which involved near-riots with the neighbors. At this point two doctors stated that they felt she should stay in the hospital. The discussion continued as follows:

Dr. Carter: "But her point is; what are we doing for her?"

Dr. Means and others: "We may not be doing anything for her, but we are doing something for the community in keeping her here."

Dr. Day: "I think we should let her go."

Dr. Yates: "I think she should go out--but we must make sure she gets treatment" (as she had promised).

Dr. Carter: "We must remember that she was a successful businesswoman for twelve years."

The staff recommended release, and referred the decision to the administrative officers for approval. The administrators approved. In this case it appears that there was conflict between the concept of the hospital as "patient-centered" and the older attitude of the primary responsibility of the hospital being for the protection and convenience of the outside community.

Summary

(1) The release process involves conflicts between "actors"; these conflicts have been described by one research group as triangular situations producing "structured strain." In our Napa State Hospital material, however, it appears more feasible to describe the action as involving a superordinate-subordinate relationship between hospital and patient, with the patient's family playing an important role in only a minority of cases.

(2) In staff conferences, estimates must be made about norms of behavior and thresholds of tolerance to deviant behavior in various communities. Differences in attitudes among sub-cultures and perceptions of these cultural differences by staff members could be an important area of study.

(3) The staff conferences are an important center of interdepartmental communication, concerned with transmission of opinions that are made the basis for immediate action in concrete cases. Intra-staff differences of opinion and resolution of these differences may be more apparent in the release conferences than in communication not as immediately involved with disposition of patients. It should be noted also that staff conferences may be an important means of communication with the patient.

The research possibilities that have been suggested here would naturally involve investigation of many other phases of hospital operation besides the release and diagnostic procedure, but a well-rounded study of modern mental hospital functioning should certainly include consideration of these staff conferences.

ENDNOTES

(1) The writer wishes to thank the administrative staff of Napa State Hospital for financial support and cooperation in this research project. Thanks are also extended to the staff members at all levels, and to the patients, for their assistance.

(2) The important changes taking place in state mental hospitals may also directly affect the structure and functioning of the staff conferences. This is borne out by the following excerpts from a letter (Sept. 3, 1957) written by the administrative heads of Napa State Hospital when they were asked to comment on this paper.

> ". . . we would not like you to take away the impression that we think the present conference procedure is an ideal one. Much of this procedure arises from the fact that physicians, social workers, and other professional personnel have very large case loads. Even though the professional staff is growing rapidly, we still have physicians with case loads of 200 and 300. The point of this is simply that if a psychiatrist has a small number of patients he can be more intimately aware of each patient's individual problems and more of the planning for release would originate with the physician himself.
>
> The second point is that in state hospitals in general there is an increasing tendency to do away with the formal conference procedure, with more and more problems of this type being handled in individual wards by consultation between the ward personnel and the chief of service. . . ."

A transition from staff conference to less formal handling of the release process would be an important area for future research.

(3) Fictitious names have been used for all persons referred to in this study.

(4) We excluded such cases as alcohol and narcotic addictions, in which the discharge process is usually automatic at the end of a 60- or 90-day commitment.

(5) Family Care homes are private homes inspected, licensed and paid by the state to provide a temporary home for released mental patients.

(6) Leave of Absence is the most common type of release for patients who have been diagnosed as psychotic cases. The patient is allowed to go home, but remains in the hospital records. If further hospitalization is indicated the patient may be re-admitted without formal commitment procedure.

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