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**uts and Discrimination:** It was again empha- nat the separation of psychiatric and substance ervices (carveouts) from general medical care is inatory and detrimental to the provision of qual- ical services. Carveouts marginalize and stigma- chiatric patients.

There were several additional action papers that ssed by the Assembly:

**ency Preparedness:** Each district branch should e a person responsible for preparing for disasters.

**Rights for Patients:** APA will prepare a Bill of or people with serious and persistent mental ill- s part of its advocacy mission

**n Privileging:** The assembly took a position against l care companies and other health care organiza- ting about prior treatment for mental illness and/or e abuse. Questions regarding current impairment ant. Questions regarding past history are an inva- rivacy and may be unconstitutional.

**ce Use Disorders are Mental Illness:** Substance sorders are part and parcel of mental illness di- and treatment. APA should issue a statement de- iscrimination against substance use disorders.

**tting:** It has been recommended that many of the ponent meetings be cancelled and that business cted via e-mail and teleconferencing.

**reer Psychiatrists:** Definition of Early Career Psy- ECP) changed to include psychiatrists in the first seven r becoming eligible to be a general member.

his was my first meeting as Assembly Repre- . Having been an outspoken critic of managed the erosion of the authority of physicians, I was l to see and participate in the efforts of the APA f of patients and members alike. The APA, as all stitutions, is facing a time of crisis. Medicine is With concerted effort, I believe we will prevail.

*k Guerra is a retired CPS member and is CPS Representative to the APA along with Dr. Joanne*

# ORAL HISTORY

By Don Glasco, M.D.

Several years ago, the History and Archives Committee began to tape CPS members to accumulate an oral history of psychiatry in Colorado. Today we have more than 50 hours of tape, much of it interviews with senior members who are now deceased.

Drs. James Galvin and Fred Lewis describe the renovation of the state hospital and the establishment of the Fort Logan Mental Health Center in the 1960s. Dr. Gretl Hitchman describes the Freud household and her friendship with the Freud family in prewar Vienna. Dr. Hans Marx tells how he and Dr. Lynwood Hopple brought psychiatric services to outlying rural areas of the state.

The Colorado Historical Society expressed interest in this project and offered their facilities as a repository for these tapes. Duplicate tapes are also stored with the audio service of the Department o Psychiatry at C.U. The Historical Society plans to make the tapes available on the internet.

Currently our Committee is reviewing the tapes and indexing them. We also plan to record some new tapes. The committee meets about five times a year at dinner meetings. There are always some new stories to hear and reminiscences to recall. We are always looking for new members for the Committee. All CPS members are welcome. We have more fun and less toil than any other committee. If you are interested, contact Don Glasco or notify the CPS office.

*Dr. Glasco has been the Chair of the CPS History and Archives Committee for several years. He recently retired from private practice.*

# PSYCHIATRY IN COLORADO

## Before World War I

By Donald Glasco, M.D.

The first physician in Colorado who made a recorded effort to improve the lot of psychiatric patients must have been **John Evans** of Evanston and Northwestern fame. Born in Ohio in 1804, he graduated from the medical department of Cincinnati College in 1838 and moved west, working for several years as a general practitioner in Indiana. There he championed the establishment of a state asylum for the insane, becaming its first superintendent.

In 1848, he left Indiana for Chicago, joining the faculty of Rush Medical College and starting to amass a fortune in real estate. With increasing wealth, he became a friend and political ally of Abraham Lincoln. In 1862, President Lincoln appointed Dr. Evans the second governor of Colorado Territory.

Evans left his mark on Colorado. As gover- he worked to bring in the railroad, establish Denver as the capital city, and promote Republican politics. He also worked to establish statehood for Colorado, but this early effort was not successful. He continued his philanthropy in Colorado by contributing $200,000 to establish and construct Denver University and by giving a large endowment to the university. He was a trustee and board member of the university when it opened the first medical school in Colorado in 1881. Dr. Evans died in Denver in 1897.

The earliest Colorado Physician to express continuing interest in psychiatric problems was **Jeremiah T. Eskridge**. Eskridge was born in Delaware in 1849. He attended Jefferson Medical College of Philadelphia, where he received his medical degree in 1875. For a time he was head of the Department of Nervous Diseases at Jefferson Medical College. Because of tuberculosis, he came to Colorado in 1884. A year later, he was appointed neurologist at St. Luke's and the County (Denver General) Hospitals. He was elected president of the Colo- Medical Society in 1890. The topic of his presidential address was hypnotism! In a balanced, conversational style, he cited the French research in hypnotism, chiding the doctors of Colorado that "in England and America the subject has never received the attention its importance seems to deserve."

From 1892 to 1897, Eskridge served as Dean of the Gross Medical College. He described himself as an "alienist and neurologist" in a 1900 paper, *Effects of the Climate on Sleep*. Eskridge published several papers on medical jurisprudence with suggestions to recognize hysterics and malingerers. He was said to be a valued witness in court. He died of complications of tuberculosis in 1902.

By 1890, there were four medical schools in the state. The Denver Medical College belonged to D.U. The small C.U. Medical School was legally restricted to the town of Boulder. The Gross Medical College and a homeopathic medical school were located in Denver. The *Flexner Report of Medical Education in the United States and Canada* was published in 1909 and all three of the schools in Denver had unfavorable reports! The homeopathic school soon folded, and the Denver Medical and Gross schools merged. The State Legislature relented and lifted the restriction on the location of the C.U. Medical School. C.U. negotiated with Denver University, and all three schools emerged as the University of Colorado School of Medicine in 1910.

From 1895 to 1910, there were several neuropsychiatrists who taught medical students and practiced in the state. One of these, a student of Dr. Eskridge, was **Edward Delehanty**. Delehanty was born in New York State in 1868 and came to Colorado in 1890. He graduated from C.U. in 1895, the same year as the photo on the next page shows him and his classmates with Dr. Eskridge and the surgeon attending a patient with a brain tumor. This picture is thought to represent the first occurrence of the use of sterile, white surgical gowns. Note the absence of head and beard coverings! Dr. Delehanty pursued general practice for several years, went to the Vanderbilt Clinic in New York, and then went on to Vienna, where he took special instructions in neuropsychiatry. Back in Colorado in 1905, he related how one could apprentice himself to a renowned neurologist in Vienna and obtain virtually independent instruction in a Socratic manner for a fee of $4 per day.

Dr. Delehanty was appointed Professor of Neurology and Mental Diseases at C.U. His son, **Edward Delehanty, Jr.**, was born in 1908, graduating from the C.U. Medical School in 1932, the same year his father served as President of CMS. Dr. Delehanty, Sr. was Professor Emeritus when he died in 1950.

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Dr. Delehanty, Jr. became a prominent Denver psychiatrist and founder of the infamous "Lunacy Commission" in 1947. This Commission of psychiatrists met weekly at the Colorado Psychopathic Hospital to adjudicate psychotic patients to the Colorado State Hospital in Pueblo for long-term care.

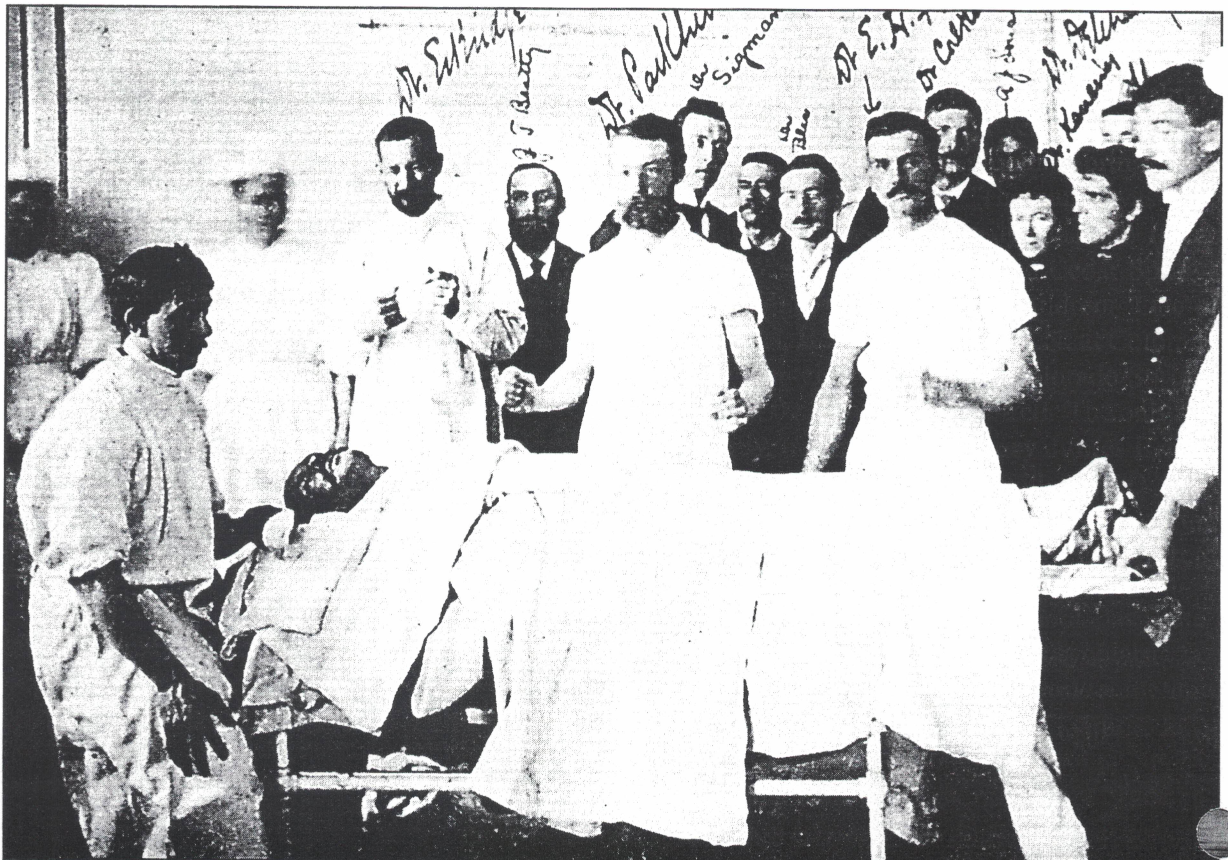
**Emory John Brady** was born in Missouri in 1874. As a young man he left the farm and went to Michigan to work as an attendant at the Michigan State Hospital in Kalamazoo. He entered the medical school of the University of Michigan and graduated from there in 1901. He practiced as a generalist in Constantine for one year and then moved to Newburg to become superintendent of the Michigan State Hospital.

In 1916, Brady brought his family to Colorado Springs, becoming superintendent of the Myron Stratton Home. This facility had been built and funded with gold from Cripple Creek. The home offered residence and care to old people and dependent children of El Paso County.

Dr. Brady and a medical school classmate, **C.W. Thompson**, bought a private psychiatric facility in Pueblo from Dr. Hubert Work sometime between 1918 and 1922. Brady and Thompson later sold this property, the Woodcroft Hospital, and it became an annex to the Colorado State Hospital. Dr. Thompson subsequently moved to California.

Dr. Brady built the Colorado Springs Psychopathic Hospital in 1923. The name was later changed to the Emory John Brady Hospital. It was sold in 1979 and is now called the Cedar Springs Hospital. The Bradys had four children. One of the three girls, Helen, earned her R.N. at Colorado General Hospital and married a Colorado Springs psychiatrist, **Dr. Francis O'Donnell**. The only son of Dr. Brady, his namesake **Emory James Brady, Jr.**, was born in 1914, graduated with an M.D. from C.U. in 1940, and, after serving in the Navy during WWII, received his certificate of psychiatry, from the CPH Ebaugh Program in 1950.

*Dr. Glasco is a CPS member retired from private practice and is Chair of the History & Archives Committee.*



*C.U. medical students at St. Luke's Hospital about 1895. Dr. Eskridge is standing just above the patient's head. Dr. Delehanty stands at the extreme right. (Denver Medical Society Library)*

# In Memoriam
## Harold David Locketz, M.D.
**March 30, 1925 – July 30, 2002**

By John Lightburn, M.D.

On October 11, 2002, friends, family, and colleagues celebrated the life of Harold Locketz at the Grant-Humphreys Mansion in Denver. It was a wonderful occasion providing an opportunity for each of us to recall how Harold had touched each of our lives. Among the many who told of their experiences with Harold, his daughter Leslie's eulogy was especially moving. She told of his kindness and generosity, his love of jazz, his dislike of blueberries and PTA meetings, his pleasure in cooking, and his great sense of humor.

Harold was born in Fergus Falls, MN, the youngest son of Russian immigrant parents. He graduated from the University of Minnesota School of Medicine in 1948, interned in Minneapolis, and completed one year of residency in Internal Medicine in Duluth; moving to Denver to complete his psychiatric training at the University of Colorado in 1953. During his residency, Ewald Busse was the mentor who stimulated his interest in electroence-phalography, a subspecialty he practiced in numerous hospitals in Colorado and as far away as Boise, ID.

His psychiatric career in Denver was interrupted for two years when he was Chief of Psychiatry at the USAF Hospital at Maxwell Airforce Base in Alabama, 1957 – 1959. Returning to Denver, he joined the Staff of the Denver VA Hospital where for forty years he ran the day treatment program. With his colleague Leonard Krause, they designed an innovative program which addressed the isolation and estrangement of chronic psychotic patients. One device they used was "community singing": men who had been essentially non-verbal for years heard their own voices. They began to talk to each other.

He had a private practice in an office on East 17th Avenue where he practiced with his wife, Jan Temple. Other professional activities included working as a consultant at the Colorado State Hospital and being Director of the Spanish Peaks Community Mental Health Center, both in Pueblo. A Life Fellow of the APA, he was also a Lt. Colonel in the US Air Force Reserves, and President of Friends of Contemporary Art.

In 1984, he learned that he had Parkinson's disease. In 1997, he retired to become a volunteer. In July 2001, he had a stroke. He had been to the Botanic Gardens the day before to enjoy the birdhouse exhibit. On July 30, 2002, he died in hospice. The feeder was full of birds.

## Committee Seeks Nominees for Distinguished Fellowship

By Cynthia Rose, M.D.

The CPS Distinguished Fellowship Committee meets annually to invite qualified CPS members to apply for APA Distinguished Fellowship. If you think that you, or a colleague, would qualify and wish to have your or the colleague's name brought before the Committee, please contact the CPS office at 303-692-8783 and inform us.

A Distinguished Fellow should be an outstanding psychiatrist who has been an APA General Member for **not less than eight years** and who has made and continues to make signiuficant contributions **in at least five of the following areas**:

1. Certified by the American Board of Psychiatry and Neurology or the Royal College of Physicians and Surgeons or Canada or equilvalent certifying Board.
2. Involved in the work of the District Branch or other components of the APA.
3. Involvement in other medical and professional organizations.
4. Participation in non-compensated mental health and medical activtities of social significance.
5. Participation in community activities unrelated to income-producing activities.
6. Clinical contributions.
7. Administrative contributions.
8. Teaching contributions.
9. Scientific and scholarly publications.

We look forward to hearing from you before January 31, 2003.

*Dr. Rose is Chair of the CPS Distinguished Fellowship Committee.*

# CPH: Historical Perspective

By Steven L. Dubovsky, M.D.

The Department of Psychiatry of the University of Colorado School of Medicine (UCSM) has played a crucial role in the professional lives of many of the 497 members of CPS. If you did not graduate from its residency, you are likely to teach its residents or students or to encounter its faculty in clinical, educational, research and political activities throughout the state. Even though Colorado Psychiatric Hospital (CPH) has since its inception been a separate entity, for many of us it has been indistinguishable from the Department of Psychiatry and we remember it fondly (or not so fondly) as the cornerstone of our professional education. In this issue of the Newsletter, I will review how CPH came to be, how it has been an integral part of the life of the Department over the years, where it has gone, and where it is headed.

UCSM was founded in 1883, just 7 years after Colorado attained statehood. At its inception, the medical school was located in Boulder; it had 2 professors, 2 instructors and 2 students. A 50 bed university hospital was constructed in Boulder for $6000.

The medical school business quickly grew. By the end of the 19th century, the University of Denver College of Medicine, Gross Medical School, and the Denver Homeopathic College of Medicine had joined UCSM. Abraham Flexner visited American medical schools and wrote a comprehensive report on their educational methods in 1910, however, the curricula of these schools were found to be deficient in some areas and redundant in others. In response to the Flexner report, the Homeopathic College closed and the University of Denver and Gross schools were amalgamated with UCSM, whose curriculum was increased to 4 years, a duration of undergraduate medical education that has survived for more than 90 years.

To accommodate the need for clinical teaching that was made possible by the increase in the length of the curriculum, the medical school had to find a bigger clinical service. In 1911, the medical school was split. Basic science teaching still took place on the Boulder campus, while the clinical years moved to Denver General Hospital. Almost 100 years later, the same thing is happening as the medical school slowly moves to the Fitzsimons campus one piece at a time.

Clinical education required clinical departments, which were brought into existence in Colorado in 1924, the year that CU medical students first came to Denver. The first professor in a clinical department was Franklin Ebaugh, who also became Director (later Superintendent) of Colorado Psychopathic Hospital the following year. Dr. Ebaugh, who was a student of Adolph Meyer, personified principles of psychobiology to which modern psychiatrists still adhere. He moved to Colorado from Baltimore by train and never left. His grandson told me that Dr. Ebaugh was "a real Coloradoan." He loved the mountains and was a skilled fisherman.

The University now needed its own Denver hospital, and in 1925 it built Colorado General Hospital (CGH). This 150 bed hospital was considered a modern miracle and was the model for Columbia Presbyterian Hospital in New York which, unlike Colorado General, has yet to be renovated. The University of Colorado Medical Center (later the Health Sciences Center or UCHSC) was dedicated in the same year. UCHSC consisted of the Schools of Medicine and Nursing, CGH, and Colorado Psychopathic Hospital, whose name was changed in the 1960s to Colorado Psychiatric Hospital.

CPH, which was established by legislative statute in 1923 (CRS-23-22-107) and opened in 1925, was as much a modern wonder as CGH. According to the statute,

> The Hospital shall be primarily and principally conducted...for care and treatment of legal residents of Colorado who are afflicted with a mental disease or disorder or abnormal mental condition which can probably be corrected by observation, treatment, and hospital care. Said Hospital shall also be utilized for such instruction and for such scientific research as in the opinion of the board of regents will promote the welfare of the patients committed to its care and assist in the application of science to the prevention and care of mental disease...The superintendent...shall have had at least five years actual experience as a neuro-pathologist...[and] shall reside at the hospital.

CPH was placed in a location that would minimize exposure to strong winds and "to secure a maximum of sunshine." The hospital opened with 80 beds and three floors. The first floor contained

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the same administrative offices that are still there today (most of them not yet repainted). Men's wards were on the second floor and women's wards on the third floor. Disturbed patients were placed on wards on the south wing of each floor so that they would be farthest from CGH, while patients who were quieter were on the west wings, which were closest to CGH. An entire wing was dedicated to the treatment of the most common psychiatric illness of the day — general paresis. The requirement that the superintendent live in the hospital may eventually be fulfilled indirectly: a plan is underway to convert the venerable building to condominiums.

The first CPH patient ("guest #1"- a concept later adopted by Target Stores) stayed in the hospital less than a day before being transferred to the state hospital. For a while, lengths of stay continued to be a day or less as patients who were severely ill were rapidly transferred to a more secure environment. However, the hospital soon got its feet on the ground and began applying modern techniques such as hydrotherapy. Shortly after ECT was introduced by Cerletti and Bini in 1938, CPH adopted this treatment as well.

Dr. Ebaugh had a strong interest in community psychiatry and involved CPH and the Department of Psychiatry in community clinics. Child psychiatry emerged from this partnership. In 1932, a grant was obtained from the Rockefeller Foundation to establish one of the first 5 psychiatric liaison divisions in the United States. Ed Billings was recruited to head the division. Dr. Billings published a study in the early 1940s demonstrating that consultation to medical floors reduced lengths of stay significantly and saved more than $40 per patient — a sum no managed care company has been able to match given the $35 daily bed cost at the time. John Benjamin was recruited in 1936 to add a psychoanalytic dimension to psychiatric treatment and education.

It wasn't long before a town-gown split began to emerge. During the 1930s, community practitioners began to complain that CPH and CGH, which were supported by state taxes, were competing for private patients. When patients who could afford a psychiatrist became plentiful and more Colorado practitioners were educated in CPH, this kind of antagonism receded. It re-emerged, however, in the early 1990s when one of the private hospitals was taken over by a national chain that complained to the legislature that CPH was competing unfairly for insured and managed care patients because some of its operations were supported by state funds. The complaint was rejected, giving CPH the opportunity to compete vigorously for below-cost contracts that could expand its deficit.

Another recurrent theme in CPH, as in CGH and the entire School of Medicine, has been the need to improve clinical teaching. In a history of the medical school, Henry Swan, a renowned surgeon and chair of the Department of Surgery, said that in 1945.

> The Colorado General and the Colorado Psychopathic Hospital provided a bare minimum of patients for teaching...Rapport with the practicing physician was at a low ebb.

As a result of such criticisms, another series of educational reforms began in the 1940s that has continued to this day. By 1949, the entire medical school curriculum had been revised with an eye toward better integration of clinical and basic science teaching. The Department of Psychiatry and CPH were leaders in educational reform. As Ed Billings remarked,

> Frank Ebaugh...developed...a medical student curriculum... and a three year resident training program that was exemplary and with one or two exceptions, had no peer in the country.

In the 1960s, the medical school curriculum was revised in the opposite direction, but a series of faculty retreats in the mid-1980s returned the curriculum to its previous organization. After a scathing review by the accrediting body for medical schools, the curriculum is now being revised again. This time, an interesting twist has been added: a tuition surcharge is being added on the grounds that it will cost more to actually teach medical students.

A change of leadership for the Department of Psychiatry and CPH came in 1951, when Herb Gaskill became the second chairman and superintendent. Gaskill, like Sigmund Freud, was both a neurologist and a psychoanalyst. Building on Ebaugh's foundation of psychobiology and community psychiatry, Gaskill integrated psychoanalytic teaching and treatment into the lifeblood of the department. Psychoanalytic theory flourished in Colorado at a time when somatic therapies were limited and the Department became known as a center for psychodynamic psychotherapy. At the same time, an amalgamation of an ever expanding involvement with community psychiatry gradually changed the

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orientation of treatment in CPH. Milieu therapy, which was growing at Fort Logan and elsewhere, became an increasingly important component of inpatient treatment at CPH. As treatment was increasingly focused on solving the conflicts that led not only to hospitalization but to the illness itself, lengths of stay increased from less than a day to up to a year. The goal of inpatient care evolved from quieting the patient and arranging transfer for patients who needed ongoing care, which was likely to be custodial, to reconstructive therapies.

Patients who could tolerate and benefit from this approach were naturally not as ill or regressed as most of today's inpatients. On the other hand, therapists were braver then than they are now in working intensively psychologically with psychotic individuals, and no wonder. Without a rapidly rotating revolving door and limits on duration of hospitalization, patients could be kept in the hospital a few days or weeks longer if they were improving slowly or reacted adversely to an interpretation. Inpatient psychiatrists did not have to worry that patients would be discharged before they were safe, let alone significantly better.

The medical school grew during Gaskill's chairmanship, and CPH and the Department of Psychiatry grew with it. The VA Medical Center was built in the year that Gaskill began his tenure. By 1960, CPH had 80 beds. In the same year, the medical school class was increased from 80 to 125. The size of the psychiatry residency also grew, reaching 21 per class by the 1960s, when the inpatient year was moved from PGY-2 (first year residency) to PGY-3 to give residents a chance to develop psychotherapy skills before treating the sicker inpatients. During this era, CGH built a new hospital and later changed its name to University Hospital (UH).

Growth of CPH soon outpaced the support available from state sources, and the hospital had not yet attracted many private patients. Poor billing and collection and high write-offs limited income, while a rudimentary billing system limited the hospital's ability even to know how much money was in the bank. Unpredictable financial shortfalls led to abrupt ward closures and staff layoffs that undermined morale and interfered with therapeutic optimism. As an era of less restricted health care funding emerged, the financial health of the institution improved even though its ability to bill and collect did not.

In 1973, Gaskill retired and Herb Pardes was recruited from SUNY-Downstate Medical Center to become the department's third chair and CPH superintendent. Pardes had gone from the rank of assistant professor to professor and chair in just a couple of years, and it was clear that he was on his way up. Sure enough, he only remained in Colorado for about 2 ° years, but in that brief time he recruited 12 new faculty members, many of whom formed the core of new directions that would end up carrying psychiatry in Colorado into the next century. It was a mark of Pardes' foresight that he attracted triple-threat faculty with expertise in such areas as psychoanalysis (Dick Simons and Ruth Fuller), medical student education (Dick Simons), community psychiatry (Ruth Fuller) sociology (Emily Mumford) and biological psychiatry (Bob Freedman), and that faculty members who were known as specialists in one area had remarkable knowledge and skill in other dimensions of psychiatry. Pardes not only aimed the department and its hospital toward the future, but he enhanced relationships with other departments. By the end of his brief tenure, psychiatry had begun to play a major role in the school of medicine, especially in research and education. His faculty went on to leadership positions in the Dean's office, the Clinical Research Center, faculty governance and the medical board of University Hospital.

During the era of heavy emphasis on psychological treatments CPH, like many other psychiatric institutions, had drifted away from the medical model, seeming to adopt Freud's philosophy that "psychoanalysis is not a branch of medicine but of psychology". The advantages of being a separate institution from CGH may have begun to be outweighed by alienation from other medical specialties, and the camaraderie of an egalitarian model of interdisciplinary care may have come at the cost of conceptual separation from the rest of medicine. As new somatic treatments were integrated into the CPH armamentarium, however, both the hospital and the department were drawn back into the medical field.

After Pardes departed to become head of NIMH in 1976, CPH had a series of acting chairs/ superintendents. During this time, CPH had its ups and downs. Lengths of stay decreased from months to weeks. The billing system improved a little too much: along with charges through the medical school practice plan, CPH physician charges started going out automatically, generating accusations of Medicaid fraud against the practice plan. A settlement resulted in total over-

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haul of the practice plan. The overhaul was so effective that when the practice plan was audited years later by the U. S. Inspector General as part of a general move to find Medicare billing improprieties in university practice plans that generated fines of $30 million against a number of prominent medical schools, the total bill to UCSM was about $175.

After several abortive searches, UCSM recruited Jim Shore in 1984. Shore brought with him Spero Manson, who established the National Center for American Indian and Alaskan Native Mental Health. He oversaw the first revision in the structure of the residency since the inpatient year was moved to PGY-3 and among other things moved the inpatient rotation back to PGY-2, making the Colorado residency consistent with other residencies. At the same time a neuroscience training program was established with representation from basic sciences, neurology and psychiatry, reflecting a move toward integration of the neurosciences that has resulted in an explosion of knowledge in psychiatry; a Ph.D. in neuroscience was formally established in 1992. In 1987, Bob Freedman established the Schizophrenia Center, one of the first four NIMH Sylvia Conte centers.

Through a complicated series of trades, the University acquired Mt. Airy Hospital. A private CPH service was moved into this building from the Davis Pavilion, and the regular CPH inpatient service was moved into the same building from the space it had occupied in University Hospital since the CPH building was condemned for inpatients in the 1970s. The outpatient clinic remained in the CPH building until the late 1990s, when it was moved to the Mt Airy building (now called University North Pavilion or UNP) to consolidate the services.

During Shore's stewardship, medicine and in particular psychiatry underwent dramatic changes not only in the way clinical skills are acquired but also how they are funded. On the positive side, new technology was leading to new treatments for major psychiatric illnesses, and the conceptual pendulum, which had swung from brainless to mindless psychiatry, was beginning to find a middle ground that integrated both approaches. But as psychiatric treatments became more precise and effective, third party carriers were less willing to pay for them. Many hospitals were finding it increasingly difficult to meet their expenses as managed care groups ratcheted down reimbursement and increased bureaucratic obstacles to obtaining whatever payment might be available. Many psychiatric hospitals closed, and some of the others were bought by national chains, leaving CPH as one of the few independent psychiatric hospitals that was not a cog in a national wheel. CPH was able to establish contracts with many managed care groups, but at rates that were below its costs. At the same time, no one was entirely sure what those costs were since the accounting system was still inadequate. Nevertheless, a loan from the university to fund a deficit was finally retired.

In an attempt to rectify repeated problems with billing and collecting, CPH bought a $250,000 computerized billing and collection system. Like many things in medicine, the system looked good on paper but did not work in actual practice. A new service that was established to provide post-hospital care and medication management for managed care patients had to be closed abruptly when it was found to be losing large sums of money. The service should have been self-supporting, but since the new system was unable to send out any bills, it quickly went into the red. In moves reminiscent of the abrupt closures of the 1960s, inpatient units were consolidated and closed. The number of beds occupied, which had fluctuated between 40 and 80 since 1960, decreased to 30. A deficit equal to the one that had finally been corrected necessitated another multi-million dollar University loan.

Finding it increasingly difficult to compete or even function effectively in the world of modern medicine, University Hospital was able to divest itself from the University and become a hospital authority separate from the state system in 1991. This move allowed UH to get out of the state personnel and purchasing systems, which had hamstrung its ability to develop new initiatives and respond to market pressures. Following the change, which required legislative approval, UH became profitable for the first time and has remained one of the few general hospitals in the country to maintain a positive margin in an era of cost containment. After a long debate, CPH faculty decided not to join UH in the divestiture from the state system because, despite the potential advantage of greater administrative flexibility, psychiatry was likely to take the same back seat to larger and more profitable services and the overall financial mission of the hospital that it does in other general hospitals. And despite its repeated fiscal shortfalls, CPH retained

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its ability to make its own decisions and to integrate clinical, financial and research initiatives in the Department of Psychiatry and CPH. And UH was just as happy to let psychiatry, whose services are organized differently from other departments and whose patients still make noise, go its own way.

Just one detail had escaped the planning process. When UH established an administration separate from the University and the Health Sciences Center, the shared line of reporting with CPH was eliminated. This worked well for the two hospitals, but it eliminated the grounds for CPH sharing a Medicare license with UH. When it became clear that CPH could not realistically get a license of its own, especially given its existing deficit, a decision was made to join UH. CPH inpatient and outpatient services remained in UNP, but the administration and finances of the hospital were taken over by UH and CPH ceased to exist as a separate entity.

One of the first duties of Bob Freedman, the fifth chair of the Department of Psychiatry, was to oversee this transition. Despite dire predictions of loss of fiscal flexibility for the Department and inability to develop new programs, the move to UH has gone smoothly. Psychiatry remains in the same quarters, and the reorganization has not produced drastic financial shortfalls, although the Department has been forced to back up the University loan to CPH. Rather than robbing psychiatry of its creativity, turning fiscal administration over to hospital administrators turns out to have left departmental faculty free to focus on clinical and academic initiatives.

In addition to his well-known academic leadership, Freedman is providing an ideal balance between the clinical, teaching and research missions of the Department of Psychiatry. Lacking preconceptions about the best way to run CPH services, he has been able to work exceptionally well with UH administrators to maintain the forward direction of the Department's inpatient and outpatient programs. At the same time, he is ensuring that psychiatry remains a major force in the School of Medicine and that modern concepts of psychiatric education are integrated into all teaching programs. The department's practice plan is flourishing, free of any further audit concerns, and he has already arranged two endowed chairs—two more than the other chairs combined. Freedman's greatest challenge will be to move psychiatry with its current programs and future directions intact as UCHSC moves to the Fitzsimons campus. Protecting and enhancing psychiatry's resources will be no small task during this complex, multibillion dollar project.

This history of CPH recapitulates the history of psychiatry during the last century. As CPH and the Department of Psychiatry moved from the Ebaugh years to the Freedman years, the emphasis of psychiatric treatment moved from observation and cataloguing, to somatic therapies, to psychosocial therapies, to somatic therapies, and is now on the way to integrating these approaches. When education in CPH began, clinical teaching followed an apprenticeship model. After the introduction of multidisciplinary teams, the inpatient milieu was characterized by a kind of egalitarianism that in the context of a conceptual separation of psychiatry and other medical specialties ended up in role diffusion. During this time, residents were collaborators as much as they were students, with residents serving as ward chiefs on one CPH unit. With further specialization of knowledge and recognition that supervisors cannot always tell exactly what is going on with a patient without ever examining the patient personally, direct faculty participation in patient care was reinstituted and education in CPH and other academic programs moved back toward a new kind of apprenticeship model. Cycles of educational and clinical innovation have been paralleled by cycles of funding boom and bust that will probably continue to plague us.

The CPH story tells us that just as administrators are not capable of running clinical services, clinicians in any specialty are usually not qualified as hospital administrators or CPAs. The evolution of the relationship between clinical leadership in psychiatry and administrators in UH will determine whether it is possible to develop a true partnership that fosters not only clinical initiatives but teaching and research in the new milieu of medicine. Hopefully, another 100 years of history of CPH will not be necessary to answer this question.

*Dr. Steven Dubovsky, in addition to being a CPS member, is Vice-Chair for Clinical & Academic Affairs, Professor of Psychiatry and Medicine, Department of Psychiatry, School of Medicine, University of Colorado Health Sciences Center, Denver, Colorado. Dr. Dubovsky is a native of Pueblo.*

# Deinstitutionalization and Decentralization

By Joseph Jensen, M.D.
and Anne Courtright, M.D.

## *Observations from Denver by Joe Jensen*

In the early '60s there was much optimism about the care of the mentally ill. All across the country, the patients were being discharged into the community with the feeling that the new antipsychotic medications would allow new freedom for patients. This process was called Deinstitutionalization. In Colorado, the Fort Logan Mental Health Center had opened near Denver. No longer was a Denver area patient sent to Pueblo. Families could now stay in contact with patients in treatment. Mental health funding from the Legislature was generous.

Decentralization was also instituted at this time. This meant developing Mental Health Centers closer to where patients lived. Programs were started in Grand Junction, Fort Collins, Fort Morgan, etc. This became an era where for years psychiatrists who were airplane pilots, such as Drs. Hans Marx and Lynwood Hopple, would fly to outlying clinics to provide psychiatric consultation. This process of making treatment available closer to where patients lived was very beneficial.

It was in this context that I went to Pueblo a day a week for five years to consult with the staff about treatment and selecting patients to discharge to their new freedom. One of the people I consulted with was Dr. Anne Courtright. By the middle 1960s, the Department of Psychiatry had begun the career programs for residents at the University of Colorado. They would receive an increase in pay and in return they would spend a year in Pueblo. This was helpful increasing psychiatric staff at the hospital.

In retrospect, we were overly optimistic about this new adventure of releasing patients into the community with the hope that mental health centers would be there to provide care. We expected that there would be more success in continuing treatment as outpatients. No doubt, many patients adjusted to their independence, but for many patients, maintaining treatment proved to be difficult. We did not foresee that funding from the legislature would become increasingly limited and that payments by HMOs would result in lower payments for mental illness. One result of the latter was the closing of two great private psychiatric hospitals in our community, Mount Airy and Bethesda. The fact that 20 – 30% of persons in prisons have mental illness speaks to the inadequacy of our present mental health programs. It seems easier to get funds for more prisons than to keep adequate funding for mental health facilities. Treating the mentally ill in the first place might have prevented many crimes from being committed by this population.

For the past seven years, I have spent half a day a week at the Stout Street Clinic for the homeless. This is where a number of the mentally ill, who have fallen through the cracks of our present programs, end up. Many were at one time treated in a mental health center, but have discontinued their treatment. Returning them to the care of the mental health center is frequently a challenge. Former patients are rejected because of problems with alcohol, or because they do not have Medicaid insurance. At times, they are denied treatment because they are viewed as not sufficiently ill by the intake worker at the mental health center. We frequently continue to treat these patients for years because of the difficulty of access to a mental health center.

There continue to be patients who are too ill to be cared for by Mental Health Centers, in spite of all the medications available at present, for whom hospitalization is very important. Despite this reality, the Colorado legislature may consider closing Fort Logan for budgetary reasons. If this happens, it will be disastrous for psychiatry in Colorado. Hospitalization continues to be important for that segment of the populations which is too ill to function in the outpatient setting. An important mental health institute would be removed from the major population center of Colorado. Once again, the majority of patients would be isolated from their families whose participation in the treatment process can be crucial.

## *Observations from Pueblo by Anne Courtright*

Decentralization, as I experienced it at the Colorado State Hospital in the early 1960s, involved the step-wise reorganization of a 6,000 bed custodially oriented hospital into smaller geographically oriented treatment divisions with a continuum of care.

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This may sound fairly simple and logical, but it was a gigantic undertaking. While the physical logistics were daunting, they were much more easily implemented than the necessary change of orientation and "mind set" of the staff. The new superintendent, Dr. Willis Bower, with his patience, vision, wise, but unswerving leadership, organized and educated the staff into an effective, focused organization. Prior to the actual "decentralization" of the hospital, several new units were created and received all admissions in rotation. They treated the patients until they were ready to return home. This created the necessity for both patients and staff to unlearn the old habits of transferring a patient to another ward when his or her behavior improved or deteriorated and focused staff on working toward discharge from the time of admission. The other areas in the hospital that were no longer getting new patients were focused on helping people who had been hospitalized for years to begin to get reacquainted with "the outside world." They were relearning the necessary social skills to adjust in a less structured and sheltered environment to be ready for return to the community.

The next step was the reorganization of the hospital into six geographically oriented divisions. After much study and planning, on the appointed day, there was a mass movement of patients and staff to physically establish these new units. Each division was challenged to: 1) accept all inpatients and new admissions from its geographical area and treat them to the point of return to the community and 2) work closely with the local departments of public welfare, public health nurses, and mental health centers to facilitate appropriate admissions and discourage inappropriate ones and to facilitate the timely discharge of patients back to their county of admission to appropriate situations with adequate supervision.

While these changes were going on within the hospital, the community mental health centers were being developed and strengthened, preparing to provide and coordinate more and more effective treatment in the communities. These changes led to the process of "deinstitu-tionalization" which was reflected in a steady decrease in census of the Colorado State Hospital from 6,100 in July 1962, 4,487 in 1963, 3,000 in 1965, 800 in 1983, and 419 on March 6, 2003.

Was this a good idea or a bad idea? Ideally, it was an excellent idea whose time had come. The new psychotropic medications were changing chronically psychotic and combative patients into rational, cooperative people, many of whom could again become functional members of the community. Many, however, had long since lost contact with discouraged and weary families and had no place to go. Many of the elderly were placed effectively in nursing homes. Many became better with medications, but were not really well enough to become self-sufficient. A variety of sheltered living situations were developed in the communities, under the supervision of the local welfare and/or public health departments and the mental health centers. Where the fit between the person and the placement situation was good and the supervision allowed the working out of problems as they arose, good long-term adjustment was established. Most of the people placed seemed quite pleased with their new situations. Some missed the activities they had enjoyed in the hospital setting, but were able to adjust comfortably. Some returned to the hospital for a period of re-stabilization and treatment. When releases were done hastily, were inappropriate, or adequate follow-up was not available, the individual either returned to the hospital or was simply lost from view and was either able to make an adequate adjustment on his/her own, or drifted about on the streets or ended up in jail.

For the newly admitted patients, the new system seemed to work very well. Both the hospital staff and the community staff worked with the family from the beginning with the expectation of a prompt return home. The hospital staff worked with the patient and the family together to build healthier relationships. Both were reassured to know that help would be available in the community after release.

Today, many have voiced a concern that the number of "homeless" and the proportion of inmates with profound psychiatric problems in jails and with the Department of Corrections has risen and is continuing to increase. That these increases have occurred as the population of the state mental hospitals has de-

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creased, suggests that the system has not operated as planned. I am not in a position to prove "what went wrong." I would suspect that a number of factors are involved. At times I fear that the importance of reduction in census became more important than that of the welfare of the individuals involved. Poor judgment and poor planning undoubtedly occurred occasionally both in the hospitals and in the community. More importantly however, it seems that the communities were asked to do more and more, but were not given adequate funding to expand their programs to meet the growing need. Funding of the mental health institutes has been steadily cut to the point that there are no longer enough beds available there to accept the patients who are too difficult to be handled in the community setting. These persons may end up in jails, either for safekeeping or because inappropriate behavior leads to arrest. Mental health laws have been changed so that it is more difficult to get unwilling patients hospitalized or into adequate treatment. Inadequate insurance for the treatment of mental illness and the growing number of uninsured have created havoc with both public and private treatment of the mentally ill. The decrease in the number of private hospital beds available for the treatment of psychiatric illnesses is appalling. Perhaps policymakers think that with the advent of psychotropic medications, hospitalization is no longer necessary. Sadly, this is far from reality.

It is my impression that there are more people today who are not getting the available psychiatric treatment that they need than there were in the 1960s. This is not necessarily directly because of "decentralization" and "deinstitutionalization," but due to the combined factors listed previously. More people are "falling through the cracks" into homelessness and/or the correctional system, even as families try frantically to get needed treatment for their ill relatives.

From discussions I have heard, it is less expensive to maintain a person in jail and the correctional system than in the mental health institutes. Given Colorado's current financial status, this is an important issue. In the long run, this seems to be a false economy. It is my impression that the mental health system is more effective in treating people with profound psychiatric problems and returning them to a functional and productive status, than is the correctional system. By maintaining them in jails and prisons, we are losing human potential, productivity and dignity, and criminalizing the mentally ill.

As so often happens in the course of human affairs, a good idea has been taken past its point of maximum benefit. It is time to reverse the process a bit to find a balance where treatment is given in the community when that is appropriate, and where the mental health institutes have sufficient beds to provide care that cannot effectively be provided in the community settings. It is my hope that as the economy improves, a way will be found to provide adequate funding for the treatment of both physical and psychiatric illnesses.

*Dr. Jensen is a CPS past president, retired, but still donating much of his time to CPS and to the mental health field. He lives in Denver. After a thirty-year career at the Colorado Institute for Mental Health, Dr. Courtright is now retired, but still living in Pueblo.*

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