the least defensible part of the regulations for CO's: there is no provision as yet, despite repeated pleas, for allotments to dependents of CO's, who do not necessarily have the views of CO's, and yet have to suffer for them. The strain is even more acute in the work camps, where the CO gets only $2.50 per month, and, if financially able, is asked to contribute $30 per month toward his own maintainence.

Schedule of work. Most of the men work on one of the three regular shifts: the "day shift", 7 A.M. to 4:30 P.M.; the "afternoon shift", 2 P.M. to 11 P.M.; and the "night shift", 11P.M. to 7 A.M. Day shift men get one day off a week, and, in addition, are permitted to leave duty the day before their day off at 1:30 P.M. Men on the other two shifts get one day off a week. Thus the working time is about 9 hours a day, including a ½ hour meal allowance, or 54 hours per week; it is slightly less for the night shift. (In addition, each man gets 7 legal holidays per year, and 30 days' furlough. A reasonable amount of sick leave is also allowed. The furlough and sick leave privileges are more liberal than those of the regular employees, who get 2 weeks' vacation per year and the same amount of sick leave.)

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Types of work. Although the unit was brought here primarily to work on the wards, we have now branched out into many departments. About 25 are working on maintainence: as cooks, power house men, or leaders of gangs of patients on the farm or repair crews. A few are scattered in special work: offices, X-ray labaratory, medical laboratory, occupational therapy, music therapy. There are 4 men on "CPS overhead": the assistant director, his clerk, the educational secretary, and the personnel secretary. The bulk of the men, however, 51, are ward attendants.

Control of patients. Violence has no place in the handling of mental cases, according to the generally accepted theory of psychologists. CPSmen, of course, concur fully in this theory, because of their non-violent approach to life. On the practical level, however, CPSmen, both in this hospital, and, so far as I have heard, in other mental hospitals, have learned two things. One is that a good many attendants do in fact use violence on the patients, that the hospital staff is aware of this and tries in a general way to discourage it, but that it has not taken, and perhaps cannot take in these times of labor shortage firm steps to eliminate it. The second is that non-violent methods of handling patients are difficult to put into practice in poorly planned, overcrowded buildings, with depleted staffs of attendants, entirely untrained in the naturee of mental disorders, and therefore possessing neither the facilities, the confidence, nor the patient understanding required. Nearly all of us, however, have made a sincere and generally successful effort to avoid resorting to violence ourselves, and by example and attitude as well as verbally to reduce the use of violence by other attendants and worker patients.

Restraining and guiding force have their uses, correctly applied. Overactive and violent patients are put in "restraints", so that they may not injure themselves or others. The restraints consist of padded leather cuffs for hands and feet, by which patients are strapped to their beds, with more or less freedom of movement, asthe case requires. Of course, restraints do not usually help the patient involved; but they protect him and others and are a necessary device when the attendant has so many patients to care for that he cannot afford to "special" a violent one. Theorestically, restraints can be applied and removed only upon a doctor's order; practically, attendantsare permitted to use their own judgment in applying them, particularly in emergency cases. They are more lax, however, in taking them off; the doctor does not check up often on those in restraints, and sometimes a man who is safely over his "spell" stays in until the cuffs and straps are needed for someone else. We of the unit, on the other hand, have been criticized with some justice for letting patients out of restraints too soon.

I cite a case of a somewhat overactive patient in my ward. He entered the ward in full restraints, with a doctor's order that he be kept in them 24 hours a day. My two colleagues on the other shifts (both CPSmen) and I, however, soon discovered that the man's feet could be freed and that one hand could be released during meal time so that he might feed himself. The patient proved obedient when let up to go to shower and toilet. Finally, w e tried the experiment of letting him out during the day, and, later, during the night also. Although somewhat confusedin conversation and direction, and a great talker, he did not assault anyone, and generally he did not resist even when restraints were put on him at night. On the few occasions when he did resist, however, it took 3 men to hold him down while another arranged the cuffs and straps. All this was done without the doctor's orders: he kept signing the restraint slips routinely without, to my knowledge, inquiring about the patient's behavior or coming to see him. At times, indeed, he was left free of necessity and on approval of the building supervisor, because the cuffs and straps were in demand for more serious cases.

But thesequel, in fairness, must be added. After about 2 weeks of freedom the patient discovered that it was fun to poke or slap another man once in a while -- rather gently, and perhaps once or twice a day. Potential danger, nevertheless, was there, as the other patients were weak old men, for whom even a light blow or a fall might be serious. Since this playfulness occurred mainly at night, I began putting him into restraints again at bedtime. After ten days of this, he took a couple of hard punches at an old man in the dayroom while I was busy, as usual, in the bed ward.

Now if I were able to keep my eye on him pretty constantly, I could allow him to be up and around. But there is too much work to do which takes me out of the dayroom and sometimes out of the ward. Am I to neglect this other work, mostly for the 25 bed patients, to watch him; or am I to keep him in straps constantly, where he can do no harm? The answer is obvious. No less obvious is the fact that perpetual restraint is not leading him into a better mental state, but may, on the contrary, be hindering his recovery.

Care of Patients. Any one who comes to Byberry must be prepared to find conditions far from ideal, as this is a state institution, inadequately supported, not free from politics, the more poorly supplied owing to wartime shortages; and it was taken over by the state only a few years ago on the grounds that the corrupt city government of Philadelphia was allowing intolerable conditions to exist there. It is decidedly not a situation for realizing an ideal mental hospital: progress is very slow, with many irritations and disappointments. Dr. Zeller and some of the administrative staff seem sincere in their desire to improve it; others don't care.

The complicated and inefficient system of procuring supplies results in many deficiencies. Some of the buildings do not have enough pants and shirts to clothe their patients, and some of the clothing that is usedis ragged. The shoe situation is fairly tight. There are not enough blankets to ensure that every patient gets one. The supply of sheets is desperately low, and no relief seems to be in sight, because few companies can handle orders as large as ours, and those that try to do so are blocked by priorities. And the rules for state institutions do not allow the hospital to purchase materials on the open market. Meanwhile, one building with ambulatory incontinent patients can afford only bottom sheets, with blankets serving for a top covering. I work in a ward for incontinent bed patients, who have frequently to lie in their own urine for 2 to 5 hours, and can be changed then only if the dirty sheets can be rinsed out on the ward and dried on the radiators. This acute stage occurs nearly every weekend, since the laundry does not operate on Sundays.

Owing to the small number of doctors, it is impossible for them to give personal attention to all the patients, or even to all who are physically ill. Besides, they have clerical and administrative duties, such as inspecting buildings, deciding which patients should be paroled and which should be trusted to roam freely about the grounds. The impossibility of their task seems to have made them careless and unconcerned; it does not seem to me that they are working as hard as they could. Similar statements can be made about the nurses: most of them have so much to do that they have let their nursing standards slide out of self-defense.

About all that most ward attendants have time and energy to do is to see that the building is kept clean, the meals well served, and the patients treated for serious physical ailments. Very little treatment for their mental ills is given, unless the hospital routine and the visitors' days are called treatment. A considerable number of the patients do maintainence work in or outside of the buildings: this work is absolutely essential to the running of the institution and keeps the patients occupied, but it is not planned from a therapeutic angle. Electric shock treatments are given, with mediocre results. A little hydrotherapy is practiced on the female side; the equipment stands unused on the male side. Shortage of manpower and materials are largely responsible for this condition, but poor administration is also a factor.

There is one ray of sunshine in this gloom: a recreational program is getting under way, largely through the effortsof the unit. The new workers' building has a library and a game room, equipped with bowling alleys. By supervising these rooms onour own free time, a few of us have made it possible for the patients to use these facilities more often than otherwise. More significant, some of us have organized simple game parties (checkers, bingo, etc.), reading circles, especially for the blind men, and medicine ball, which has caught on well in the violent ward. We are making checker boards out of scrap materials, or painting them on old tables, cutting checkers out of old broom handles, collecting old magazines such as Life and National Geographic, and maintaining a small fund for prizes and other expenses of this recreational program. Yet these efforts are partial and spasmodic, circumscribed as they are by facilities, time, and varying abilities and interest in recreational leadership.

Lest the reader gain a falsely discouraging impression of mental hospitals in general, I ought to add that observers and attendants of other state hospitals where CPS units are established would place Philadelphia State Hospital near the bottom of the list in care of patients, and in most other respects. One visitor, after working on the wards for a week with the men of the unit, submitted his impressions in writing to the superintendent, who, he reports, accepted them as onthe whole reasonable and accurate observations. He later submitted the same report, anonymously, to the superintendent of another state hospital where he also worked; this superintendent replied that he could not believe a state hospital existed which had such conditions.

On-the-job Instruction. This hospital has set a good precedent in arranging training courses for attendants, mostly on work time. These courses are arranged primarily for the men's and women's units, but a few other attendants come. Classes meet four days a week, 2 hours a day. The first course, on General Nursing, runs for 30 hours and includes such topics as Bed Making, TPR (temperature-pulse-respiration), visits to the laundry and disposal plant, and ward housekeeping. The standard nursing techniques demonstrated are so out of line with actual practice, to be sure, that some of the lessons are of little value. But we feel that the principle of instruction for new attendants is an important one to establish, and that the lessons can be made more significant.

The second course, of about 35 hours, is an introduction to Abnormal Psychology. It is taught mostly by the doctors. Representative topics are Organic Mental Disorders and their Care, Schizophrenia, Manic-Depressive Disorders, and Psychoneuroses.

The AFSC is trying to get other state mental hospitals with CPS units to offer similar instruction, and hopesthat this practice will eventually spread to institutions with which it has no official connection.