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November 22, 1961

LONG RANGE PLAN FOR MENTAL HEALTH SERVICES IN CALIFORNIA

PRELIMINARY REPORTS OF TASK COMMITTEES

Attached is a copy of each of the preliminary reports of the task committees working on the long range plan for mental health services which has been received to date. They are submitted for review and comment.

I should like to point out that these documents do not represent the completed work of the committees, but should give you a picture of the direction in which they are working.

I should appreciate your forwarding to me comments and suggestions that are elicited by this material.

The attached report of the Treatment Committee does not include the major part of its work. Additional Treatment Committee material will be available shortly and will be forwarded to you. Similarly, additional material from the Rehabilitation Committee will also be forwarded.

I again would like to thank you for your assistance in this project.

Daniel Blain, M.D.

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Director of Mental Hygiene

LONG RANGE PLAN FOR MENTAL HEALTH SERVICES

PRELIMINARY REPORT OF COMMITTEE ON ZONE I (PRENATAL ZONE)

The Committee met on October 11, 1961, in San Francisco, and on October 24, 1961, in Los Angeles. The following deliberations are a result of these sessions.

The Committee defined its task as, first, that of selecting the concepts concerning pregnancy, child birth and mental health which seem to be soundly established at the present time; secondly, to consider which of these concepts had pertinent application to the problems of the people of California; thirdly, to make recommendations about those situations in need of remedy.

The Committee feels the following statements are based on enough evidence to warrant their being used as a basis for program planning:

(1) Increased incidence of congenital defect, mental defect, and behavioral disorders is related to low birth weight of babies.

(2) The outcome of pregnancy is less favorable in the lower socioeconomic group.

(3) Lack of or reduced prenatal, natal, and postnatal care which is competent and reasonably thorough has an adverse effect on pregnancy outcome.

(4) Substandard nutrition during pregnancy significantly correlates with increased incidence of congenital defect.

(5) There is an important correlation with maternal age: very young mothers and older women have a significantly higher risk of producing mentally defective children. For example, chances of mongoloidism increase from one in 10,000 in the maternal age group of 20 to 25 years, to one in 2,000 in the age group 40 to 45 years.

(6) High parity (beyond four pregnancies) carries an increased risk of mental deficiency in the later children. This is even more so in the case of young mothers with closely spaced children.

(7) An important cause of mental defect results from toxic effect of infectious diseases during pregnancy: syphilis, brucellosis, toxoplasmosis, salivary gland virus, coxsackie virus, and polio, rubella, and herpes viruses.

(8) Specific genetic factors relating to mental defect are known. A few of these such as phenylketonuria, galactosemia can be detected early and appropriate dietary therapy can prevent significant cerebral damage.

(9) Maternal and foetal immune reactions are harmful to the foetus and newborn child. Incompatible blood types between mother and father produce erythroblastosis with high risk of cerebral damage.

(10) The emotional status of the pregnant woman has some relationship to pregnancy outcome.

There are, of course, numerous other factors relating to successful production of children. The committee did not have the time to document these completely. It did feel that the factors listed above were at this time the most important to examine in relation to the health of the population and the health practices now prevalent in California.

The Committee considers prematurity to be the number one problem in California as it relates to the incidence of congenital defect, mental defect and behavioral disorder. The California State Department of Health reports a rise in infant mortality and in prematurity in the years 1957, 1958, and 1959. Infant mortality is well accepted as a sensitive index of child health care the world over, and prematurity is a like indicator. The incidence of prematurity in California is above 7% of live births, or between twenty and twenty-five thousand of such births a year. It appears to the Committee its importance in mental health preservation and prevention is about four thousand times that of phenylketonuria which occurs about once in twenty to forty thousand births.

Factors which seem related to the increased incidence of prematurity are maternal age and maternal parity.

California residents are marrying earlier than in the past and continue to be younger when their first children are born. This increases the possibility of large families. The percentage of women who were under 20 at the time of the first marriage rose from 41.0% in 1952 to 51.7% in 1959, and decreased in all other age brackets. The number of births to women under 20 rose from 11.5% in 1950 to 14.5% in 1959.

Births to women over 35 increased from 9.25% in 1950 to 9.91% in 1959. Births to women over 40 increased from 1.80% in 1950 to 1.86% in 1959.

Parity beyond the fourth birth was at the rate of 7.6 per thousand in 1950, 12.7 in 1956, and 14.6 in 1959.

The incidence of prematurity for the Negro population has increased from 10.8% in 1949 to 13% in 1958 and 12.5% in 1959. The reasons for the undesirable trend in mortality and morbidity rates for the Negro population are not clear. One pertinent fact is that the Negro population averages lower birthrates than whites, so that more prematurity by the standard definition is to be expected.

> "It is hypothesized that Negro mothers may not receive the same quantity and quality of medical care as they formerly did. Perhaps there has been a change in the attitude of the Negro population now resident in California toward the value of prenatal care, this general change in attitude due mainly to an increase in Negro migration from areas of the country with different medical resources and a different concept of the value of preventive medical care." (Department of Public Health Family Health Bulletin, September 1961, p. 3)

As of 1955, 12.5% of births in California occurred in county hospitals, and in 1960, 14% occurred in the 48 county hospitals in the state. The prematurity rate in county hospitals is 50% higher than in private hospitals, the neonatal death rate of infants born in county hospitals is 60% higher than in private hospitals, and the maternal death rate is 200% higher than in private hospitals. Therefore, and because care is considered the most important factor relating to prematurity, the maternal care provided by county hospitals becomes a matter of specific concern to the Zone I Committee in its efforts to make realistic and feasible recommendations toward reducing mental defectiveness and retardation in this state.

There is considerable divergence in practice among county hospitals in California. Every county makes some provision for prenatal medical care of county patients. About 5% of California's mothers receive it largely from local health departments and about 5% from county hospitals. The geographic distribution of these clinics when considered in relation to city, district, and private clinics and federal hospitals is reasonably satisfactory.

County hospitals see pregnant women during the first trimester in only 21% of the cases as compared to 69.2% in private hospitals. The first visit occurring during the third trimester is 25% for county hospitals and 7.5% for private hospitals. The latest report of the Bureau of Maternal and Child Welfare of State Department of Public Health states that most county hospital staffs estimated that between 10 and 40 per cent of mothers delivered in their hospitals had not received any prenatal care. Against their recommended 10 to 12 visits per pregnancy, most clinics actually provide between 2 and 5 visits per birth. Some hospitals see mothers only during first pregnancies, some only during subsequent pregnancies; some see mothers only during the first trimester and some only during the third trimester.

> "Procedures. Of the commonly accepted procedures in prenatal care, only the tests for urinary sugar, hemoglobin (one exception), and the legally required serology for syphilis were performed at least once on all mothers in addition to weight, blood pressure, and urinary protein (one exception) which were determined on all mothers at each visit. Of the 93 clinics studied, 61 per cent did not type blood for ABO factors, 13 per cent did not type for Rh factor, 42 per cent did not examine urinary sediment,

> 35 per cent did not perform chest x-rays, 30 per cent did not measure height, 8 per cent did not measure the pelvis. Many clinics tested for urinary sugar at each visit and one clinic each reported routine Rh titers on Rh negative patients, Rh typing of husbands of Rh negative patients, tuberculin testing, cancer detection smears, pelvic x-rays. Written nursing manuals on clinic policies and procedures were available in only 15 hospitals and 7 health departments. Special nutritional advice was given in 31 hospitals and 7 health departments, usually both verbally and with supporting printed material. In one county, all pregnant women were placed on diets restricting salt and calories. In only 20 counties were there any expectant parents' classes, many of these given by the Red Cross." (Public Prenatal Care in California, Report of a Statewise Study in Quantity, Quality and Eligibility, Department of Public Health, Bur. Maternal & Child Health, Feb. 1957)

Economic and social factors are related to inadequate care.

> "Policies determining eligibility of mothers for prenatal care varied considerably. One of the most significant finds is the 40 per cent of the agencies responsible for these policies who did not have them in writing. . . In some places the three years in state, one year in county is strictly observed and in others more attention is given to the need for care and the likelihood of county hospital delivery. The factors involved in determining financial eligibility are as complex but a few were identified. A multifactorial budget standard, largely the Aid to Needy Children budget, was used by 42 per cent of agencies but 58 per cent did not obtain a medical diagnosis prior to eligibility determination so that concurrent disease or complications of pregnancy could not be considered. Most agencies were less likely to accept a mother if she carried any health insurance. She was automatically excluded in 20 if she would not waive the statute of limitations; in 13, if she would not accept a lien on her property; in 6, if she sought care too early or too late in pregnancy; in 5, if she were pregnant for the first time; in 3, if her family income was over a fixed amount; in one, if she did not provide blood for the hospital bank." (Ibid, pp. 2-3)

One important factor which affects differences in county hospitals is the concept of the Boards of Supervisors as to what constitutes minimum charity service. The prime difference seems to be in the leadership of physicians in the community.

Although there exists a definite body of factual knowledge concerning prenatal, natal, and postnatal care, there is a wide gap between knowledge and practice. A wide variety of concepts exists among physicians as to what constitutes proper maternal care. The best county hospitals are those where physicians insist on high minimum standards and where there is a real community interest and pride in the county hospital.

The Committee didn't have to search far to find some verification of the vulnerability of the physical and mental health of certain groups of families in the lower socioeconomic group. Families on Aid to Needy Children (ANC) funds reflect this to a considerable degree. From the excellent 1959 report of the Senate Committee on Labor and Welfare of the California Legislature, the high incidence of impaired physical and mental health is obvious. From a study of 200 ANC families done by the Santa Clara Welfare Department come the following figures:

> "Over 60% of these families present four or more problems that affect their economic and social well-being.
>
> "Physical health problems are present in 53% of the families.
>
> "Diagnosed mental illness is involved in 22% of the cases.
>
> "Over 22% of the families have problems of physical disability, and 13% of mental deficiency.
>
> "Poor family relationships, demonstrated by homes broken by divorce, separation, and desertion are present in 52% of the cases. Severe problems of parent-child relationships or extreme friction between parents are noted in 33% of these families.
>
> "Illegitimacy and common-law relationships occur in 35% of the cases.
>
> "Delinquency of at least one member of a family exists in 26%, and crime in 31% of the cases.
>
> "Alcoholism is a serious problem in 30% of the cases."

How many of the above problems reflect a poor birth experience of the individuals involved? No figures are available, but it would seem these families make up a significant part of the pregnancy vulnerable group.

The Committee was struck with the relatively large amount of pathology in the ANC families, medical, psychological, and social. Pregnancy in these families provide for increased contact with professional workers--caseworkers, nurses and medical personnel--with usually no coordination. Increased family casework would seem to be the only effective way of support toward health and increasing the potential of the family to meet the needs of the mother and the

expected infant. Prenatal care and nutrition are highly important concomitants of good casework--especially for increasing the amount of medical care sought in the first trimester of pregnancy. The more good prenatal care delivered in the first trimester correlates with lowered incidence of congenital defect, prematurity and its increased risk of damage. Yet trained caseworkers in ANC programs are practically non-existent.

John M. Wedemeyer, Director of the State Department of Social Welfare, pointed up the shortage of professionally trained social work personnel:

> ". . . there are fewer than 100 trained people (out of 3,000 in all categories) on the working line in the public assistance programs of this State . . . ." (P. 31, July 1, 1960)

The Committee concluded on the basis of the above statistics and reports that the most vulnerable of the population is receiving the poorest quality of service. The study referred to above highlights the unsolved problems of inadequate quality of care, ineligibility for care, and unsought care, documents the deficit in prenatal care received by mothers from low income families, and indicates that much public prenatal care falls far short of criteria for good care. Public and private health agencies, medical schools, State Departments of Education, Mental Hygiene, Social Welfare, and Public Health and related local agencies who have a high stake in the outcome of this problem have a responsibility to work for solutions.

The arrangement and availability of prenatal and natal medical services to themost vulnerable segment of the California population is such as to almost ensure a relatively high incidence of prematurity and substandard care of the newborn--with a consequent higher incident of damaged or handicapped individuals.

As to the problem of unsought care, the committee felt that county hospitals will always have higher mortality and morbidity rates because a certain percentage of pregnant women will not appear for care during the first trimester. The effectiveness of an educational program is limited because of the mobility of the population. Services are not used, not only because of ignorance, but also because of fear born of bad experiences, including perhaps the basic attitude of the public and the hospital staffs toward increases in this segment of the population.

Regarding community responsibility to those who cannot afford hospital care, it was pointed out there is practically no community support for hospitals except taxes; no free beds in any non-governmental community hospital in the state, relatively few services for the semi-indigent.

The Committee concludes from the above data and the interpretation of it by its members, that prenatal care for the group of the population which produces the potentially larger number of premature births and, therefore, the larger pool of potentially handicapped persons, is near chaotic in its variety

of administrative restrictions and its quality of medical care. At present, hospitals are licensed not on practices but only on facilities. The Public Health Department had advisory control over standards for prenatal care, and only are little used and cumbersome mandatory powers. The Committee was impressed with what the advent of the Crippled Children's Services in this state had done to raise standards of medical care in all hospitals approved to deliver such services. It feels a similar approach to the problems of prenatal care for the vulnerable segment of the population be explored as a practical solution to the problem. It will cost money to save money. Pilot programs need to be started to test such a hypothesis. The Committee is also impressed with the results of the Emergency Maternity and Infant Care (EMIC) program in raising and maintaining high quality medical care of the pregnant wives of soldiers throughout the country during World War II. The principles of these two programs have been tested and put into practice. They can be applied to this special problem of California. It would take the combined approach of the Department of Public Health, Welfare and Mental Hygiene--perhaps something already envisioned in the combination of these three departments into a single state agency.

The Committee also recommends that increased attention be given to providing excellent, not merely mediocre, medical care to premature infants, especially those whose birthweight is under 1,500 grams. Of significance is the fact that there is no really top grade premature center in the state, comparable to those in existence in some cities in the eastern United States, notably New York City. Although there are facilities at a number of hospitals, well trained and experienced staff for care of premature babies is generally lacking. Enough good centers need to be established and subsidized to include service to families of all income groups and need to be geographically located within a half day's distance from the place of birth.

The Committee also recommends that the need for increased casework with ANC families be considered an important prenatal service, especially as it could be the most effective tool in getting more prenatal care for this group in the first trimester of pregnancy.

The science of genetics is coming to have a place of prominence in medicine. It is a subject which may eventually come to have as much importance as that of infection in the theory and practice of medicine. The professional person who will need to know and use the subject is primarily the physician. Of the five medical schools in California, only one has a department of genetics (Stanford); three have a geneticist on the medical staff, all in the departments of pediatrics (USC, UCLA and Stanford). The University of California at Berkeley has a world famous genetic staff and laboratory, and there is minimal relationship to the Medical School in San Francisco. Loma Linda Medical College has no geneticist on its staff.

Research in genetics is being undertaken at Sonoma and Pacific State Hospitals. A serious problem has arisen in the retention of scarce and highly skilled research workers at these laboratories because these scientists are supported on research project funds with no opportunity to establish a permanent position on hospital staffs, and obtain retirement, health insurance and other benefits. Research laboratories should be established in each State hospital since they provide the material for research. University staff people often wish affiliation with State hospitals to pursue basic research on study populations in the

hospitals but funding arrangements between State Department of Mental Hygiene and the Universities seem to be obstacles to such arrangements.

Several committee members raised the question of the need for a genetic research center such as institutes of genetics at Universities of Michigan and Minnesota. It was felt this state has several centers capable of becoming leaders in the field. The main problem is to form closer relationships with the Department of Mental Hygiene and the state hospitals. A basic requirement here is to have hospital administrators who have equal personal investment in developing programs equally in service, training, and research.

The Committee, therefore, recommends:

(1) The Department of Mental Hygiene encourage all medical school deans to give more curriculum prominence to teaching genetics.

(2) The Department of Mental Hygiene encourage medical schools to develop post-graduate courses in genetics.

(3) The Department of Mental Hygiene support the development of a basic science research and applied clinical research laboratory at each staff hospital, and involve the hospital superintendents toward this end.

(4) The Department of Mental Hygiene explore the ways and means to encourage the participation of university personnel to collaborate with state hospital personnel and use patient populations for study.

(5) The Department of Mental Hygiene should explore ways to retain skilled research scientists on project research staffs, at Sonoma and Pacific staffs.

The Committee was struck with how little opportunity is taken to identify families who might tend to produce individuals with genetic defect, but who might not be aware of the risk they run. Phenylketonuria is an example. The incidence in the general population is low, but most well baby clinics and almost all pediatricians test infants' urine as a screening test for this disorder. However, certain vulnerable groups remain unscreened. For example, all children in point 1 and point 2 programs in public school should have their urine tested for the evidence of phenylpyruvia. Alameda County Schools tested this group and found three children with the disease in these classes, and whose family had no idea about the disease and its risk of inheritance.

The Committee recommends that the Department of Education enact a policy that all children on entrance to special classes be given a screening test for phenylpyruvia. When cases are found, referral to the physicians is highly indicated so that families of afflicted children may be aware of their problem.

As to the problem of infections in the prenatal period, congenital syphilis is now a rarity, despite the increase in venereal disease in California. It is felt this is due to early casefinding, diagnosis and treatment. ("Health Care for California," p. 60) German measles is a disorder which can be prevented from occurring during pregnancy but contracting the disease in childhood. Despite its relatively lower ability to produce defect than was once thought, it is still worthwhile to encourage girls contracting the disease in childhood. So far, there is no effective method of artificial immunization. Research as to other infections that cause fetal damage is highly indicated since we have practically no knowledge as to preventing infection during pregnancy, with exception of poliomyelitis, through its vaccine.

The Committee wondered about the importance of the problem offered by the event of pregnancy in a psychotic adult.

Psychotic parents. Although the available data is insufficient to more that approximate figures and is based on the untested assumption that the hospitalized parent does not differ in fertility from the non-hospitalized, the Mental Hygiene Department estimates that of the California population under 18 years (5½ million), eight out of every thousand (i.e., 44,000) children have one parent in mental hospitals as of October, 1961. It is further estimated that 50 out of every thousand will have a parent in a mental hospital sometime during his lifetime.

Psychotic children are not likely to have psychotic parents. The primary problem centers around the inability of the psychotic mother to provide adequate care. The deprivation of maternal care results in mental disturbance, but the deprivation due to the psychosis of the mother is no more serious than the deprivation due to any other illness which interferes with mothering. Child-bearing by psychotics is not so important as child-rearing by psychotics.

The Committee recommended intensive prenatal counseling, with emphasis on preparation for motherhood, and early postnatal casework for psychotic adults who are under the care of the Department of Mental Hygiene and who have just borne a child.

The Committee was concerned by another group in the population and whether there were significant ways of helping those in it. These are the young women under 20 years of age who produce approximately 15% of the babies born each year. A considerable number of this group may be high school pupils during some part of their marriage or their pregnancy. Education for parenthood is a lifelong process, and the school is in a unique situation to contribute to this process. The group who marries while still in high school will, of course, have different needs than those who don't. The Committee also is aware how little evidence is available that health education has any significant effect on one's attitudes or habits. Research is desperately needed to clarify this point. The Committee recommends that the State Department of Education encourage local school districts to study the needs of the worried high school student, especially as to health counseling and its effectiveness.

This report is respectfully submitted: Kent A. Zimmerman, M. D., Chairman. Members: Mrs. Jeanada Nolan, M. A.; George Tarjan, M. D.; Leslie Corsa, M. D.; Henry H. Work, M. D.; Charles Graham, M. D.; Eli Bower, Ph.D.; Mrs. Robert Fitzmaurice, M.A. Professor Norman Kretchmar, M. D.; Professor John Milner.

LONG RANGE PLAN FOR MENTAL HEALTH SERVICES

PRELIMINARY REPORT OF COMMITTEE ON ZONE III, THE NON-PSYCHIATRIC TROUBLE ZONE

Focus and Intent

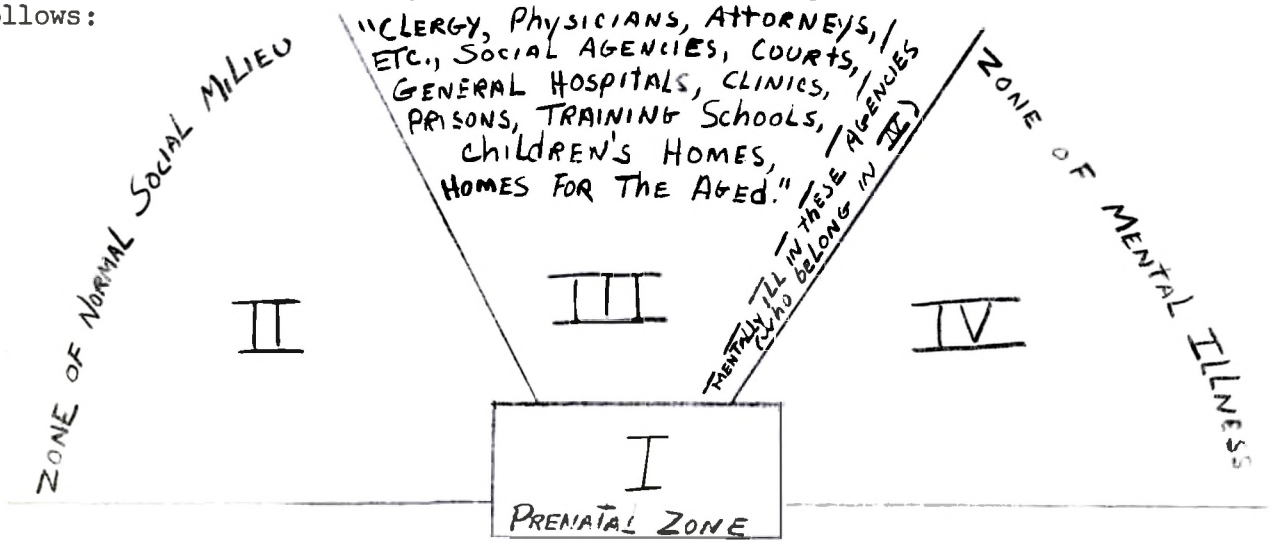
The assigned definition of Zone III, as given to the Task Force, was: "Trouble Area - This encompasses people in special need, who turn to the non-psychiatric trouble-shooting agencies set up by society for its protection and adjustment. In this zone, we find people under stress with corollary emotional problems which may remain secondary to the stress if their non-psychiatric need can be met. The stress having been relieved, they may return to Zone II."

The Task Force also discovered in its examination of Zone III that there is a large load of Zone IV people (mental ill requiring specialized psychiatric treatment) in the work loads of organizations defined as in Zone III. This is true in part because of legal definitions and in part due to insufficient facilities for caring for these mentally ill by hospitals and clinics.

There is also a large load of persons in the work load of Zone III organizations and professions who are on the way to Zone IV (serious mental illness) unless there are interventions of diagnosis and early treatment. This is the population of greatest risk.

In addition, and of primary importance, there is need for mental health services by the non-psychiatric agencies working with people in Zone III, if they are to do the maximum prevention job: consultation service and training, both informal and formal. The Task Force believes that it is not its function to identify ways by which all the various services encompassed in Zone III can be improved. Rather, to look at Zone III from the viewpoint of prevention of mental illness and the needs for mental health services for this purpose.

In the light of the discovered volume of mentally ill in Zone III organizations, the Task Force suggests that the Zone concept needs an additional band as follows:



This preliminary report seeks to:

1. Indicate some evidence of the size of the Zone III problems:

   a. From the other state agencies; and
   b. Acknowledgement of other data;

2. Identify the non-psychiatric professions and their general needs for mental health services in making their professions and their agencies more effective.

3. Suggest some guidelines of responsibility in helping these trouble-dealing services to be more effective.

This material does not attempt any projections of growing need with rising population. The need here described is current and we know it will be larger in five years. However, the Task Force recognizes that to catch up with current need as outlined in this report will be difficult, if not impossible, within five years.

One more assumption of the Task Force: Not all people who need mental health service are reachable and not all who need such service, even if identified, are amenable to mental health service.

I. EVIDENCE OF THE SIZE AND NATURE OF ZONE III PROBLEMS

To develop a plan for Zone III, it was recognized by the committee that the Departments of Social Welfare, Corrections, Youth Authority, Education, and Public Health should be contacted to determine the scope of services needed and provided by each of these departments. At the outset it was recognized that some of the needs of some of the departments would fall into the responsibility of Zone IV. This determination was necessary to bring the Zone III committee into focus so that we could determine the role of the Department of Mental Hygiene in carrying out a program for the citizens of the State of California, who fall into the Zone III area, more particularly described as the troubled area, or persons who turn to the non-psychotic agencies for services. The state departments contacted had little time to prepare the information requested by the committee. The Department of Corrections and the Department of Youth Authority provide direct services to persons committed to their care. Thus, fairly accurate information was available from these departments. However, information on the needs for persons in the community who are under the jurisdiction and supervision of adult and juvenile probation officers, or who are in county jails, adult camps, as well as those who are in juvenile halls and juvenile camps, are mere estimates. Time would not permit the canvassing of the 58 counties to secure an estimate from the persons who are most familiar with the case loads being served by the probation departments or county institutions. Since the Departments of Social Welfare, Education, and Public Health do not provide direct services to persons, but supervise county departments or agencies providing these services to individuals, their problem was far more complicated than that of the Youth

Authority or Corrections. This preliminary report cannot include information from Education or the Public Health Department because they have been unable to secure the information requested within the very limited time allocated. The Department of Social Welfare was in a position to provide some valuable data. The information provided by this department will be contained in this report.

It is evident from the information secured thus far by the committee that some of the state laws present serious problems to the courts, the Departments of Corrections, Youth Authority, and Mental Hygiene and, particularly, to the community. Some of these troubled areas are the result of a difference in interpretation of the present laws by the various state departments involved. Other problems result from dual responsibility provided in the law. Still other problems center around the fact that the Department of Mental Hygiene may release a person when he can no longer benefit from treatment. This does not imply that the person is capable of being returned to the community and functioning on a satisfactory level, yet the community is unable to care for the individual upon his release as the community has less facilities and program than the Department of Mental Hygiene. The courts may, in many cases, commit either to the Departments of the Youth Authority or Corrections or to the Department of Mental Hygiene. This results in duplication of programs and, at times, no program for some of the citizens for whom the state must assume responsibility. The sex offender is a good example. Some are committed to the Department of Mental Hygiene - approximately 600 now at Atascadero. Others are committed to the Department of Corrections and a few are committed to the Department of the Youth Authority. Commitments to Corrections and the Youth Authority depend upon the age of the person at the time he appears in court. This is cited as only one example of a problem that involves acting out persons who have psychotic episodes, the mentally deficient, who cannot function within the programs of the Youth Authority or Corrections, but still are not accepted by Mental Hygiene because of the problem of management of these persons. It, therefore, appears to the committee that laws should be clarified, fixing responsibility, and that the state should provide an adequate program for the department or departments who are required to assume responsibility for the persons who do not adjust to a hospital-type program within the Department of Mental Hygiene.

The Department of Corrections has identified several problem areas and has estimated the extent of these problems. Falling within the Zone IV area, the Department of Corrections has within its institutional population:

A. Psychotics
B. Sex Offenders
C. Mentally Deficient
D. Narcotic Addicts

These four areas represent approximately 18% of the prison population. Some services are provided, but they are totally inadequate and the department is not in a position to proceed with planning until the responsibility for this class of prisoner is definitely fixed. It is evident that the responsibility is one for the Department of Mental Hygiene or for the Department of Corrections. This is the question that should be resolved by the Zone IV committee.. In addition to the above, the Department of Corrections has on adult parole persons in all the

above areas. At present, they provide some services to these people through an out-patient clinic in Los Angeles and in San Francisco. These services are not sufficient to provide for the needs of approximately 7% of the men and women in parole who fall within these categories.

The Zone III committee suggests that the Department of Corrections provice consultive services to the personnel of the institutions and parole to assist them in dealing with these problem areas. Also, that consultive services be provided to the county jails and camp personnel to assist them in identifying and understanding persons placed under their supervision who are psychotic, mentally deficient, alcoholic, or addicted to drugs.

There was considerable discussion regarding the responsibility of the departments for the alcoholic, because he is a particular problem in the county jails of the state. No definite conclusion was reached except that this is an area that cannot be overlooked or lost in this study.

The Department of the Youth Authority has estimated the following areas of need and the extent of this need. The Zone III committee suggests that the Zone IV committee give serious consideration to fixing responsibility as to who should provide these services. The Department of the Youth Authority reported that on September 1, 1961 the institutional population was 5,513 and on the same date there were 10,400 on parole, for a grand total of 15,913 under the care of the department. Within this population it is estimated that 510, or 3.2% of the population, were in need of specialized hospital care. It should also be noted that this is also considered to be a very conservative figure. This 510 represents the following areas:

A. Approximately 15% of this group are mentally deficient to such a degree that they are beyond the scope of training offered with Youth Authority Institutions;

B. Approximately 20% are wards primarily disturbed in the sexual sphere and have a high potential for further acting out through the commission of aggressive sexual offenses; and

C. 65% of the wards are acutely or chronically psychotic and are in need of specialized care of the type or kind provided only in a mental hospital, yet because of their acting out characteristics are held in Youth Authority Institutions.

This group definitely falls within the responsibility of the Zone IV committee and, like Corrections, is a portion of the population with the institution or on parole for whom little or no services are provided. Within the Youth Authority, no services are provided for these individuals, either on parole or in the institutions, except such services as may be secured, for wards who are on parole, from private clinics, and, occasionally, from state clinics. However, since these clinics only accept persons who accept treatment for practical purposes, the services are practically non-existent.

These 510 persons can only be properly cared for by the provision of bed space for them within the existing framework of the Department of Mental Hygiene in an appropriate hospital dealing with sex deviates, mental defectives, or psychotics. If the Department of Mental Hygiene cannot provide these services for these persons, it would appear that the only alternative would be for the Department of the Youth Authority to create its own services by reproducing the facilities and staffing patterns of a mental hospital designed for the care of these wards.

There is within the Department of the Youth Authority a large group of wards consisting of 30 to 35%, who require psychiatric services. This group is partially provided for through the Psychiatric Treatment Program which was instituted several years ago. Original staff allocation provided by the Legislature was based upon a population that existed at that time. The allocations are insufficient for the present population and some of the positions have been deleted by the Legislature. The number of beds provided within the institutions of the department have increased by 1,500. The services now provided or budgeted for cannot provide for all the wards who would clearly benefit and profit from this type of treatment. This program has been subject to research and re-evaluation. The early reports by Research indicate that the success of wards in this program more than justifies the program, both socially and economically.

In the case load of the Parole Division, there are 10,400 wards, and it is estimated that 20 to 25% of these wards could benefit from a specialized Psychiatric Treatment Program. No services are provided by the Parole Division beyond the fairly minimal case work services that are acceptable for wards that function in a normal range. Whether the Parole Division should continue to rely upon community resources is a policy question which has not been resolved by the department. It is evident, however, that the 20 to 25% of the wards who would profit from psychiatric services, who are on parole, fall clearly within the area of Zone III, and it is quite probable that if they do not receive psychiatric services, they will become institutionalized cases in the future, or move into the Zone IV area.

The Zone III committee recommends or suggests to the Department of the Youth Authority that consultive services be provided to personnel in the institutions or in parole who have face-to-face contact with wards or supervised personnel who have direct supervision of staff or wards. In providing this service or training, staff would readily recognize danger signals, become more effective in their personal contacts with wards, resulting in the fewest possible number of wards becoming serious psychiatric problems, and with the greatest possible number of them moving into a normal social milieu.

The State Department of Social Welfare supervises welfare programs served by the 58 county welfare departments. These 58 county welfare departments carry a case load of almost 685,000 persons, almost all of whom are living under stress and at times need psychiatric services. The adult programs include Old Age Security, Aid to the Blind, Aid to the Disabled, and General Relief. The family and children programs include Aid to Needy Children, General Relief, Family Case Work, Adoptions, services to children in their own homes, protective services, parental counseling and guidance. There is no reliable data with respect to the portion of the total population who are faced with critical or serious mental defects and are in need

of planned preventive psychiatric services. The circumstances, however, which brought these people to the public welfare departments gives assurance that they have been subjected to a higher degree of stress than is true of the general population. It should be noted that with the development of O. A. S. D. I. and unemployment insurance programs, an ever-increasing portion of the total case load are persons facing serious physical or mental health problems. Important to the Welfare Department and the State of California is the fact that on January 1, 1962, changes in the law go into effect to grant aid to persons disabled by psychoses, as well as those disabled by mental deficiencies. Within a year, this case load will exceed 2,100 persons.

In view of the above information, it is reasonable to believe that special psychiatric services should be provided to persons who are served under programs supervised by the State Department of Social Welfare, and administered by the various county welfare departments. Certainly this clientele represents a high proportion of persons falling within Zone III, who can logically and reasonably be expected to be subject to stress and pressures which could cause them to move into the Zone IV area. It is generally believed that persons who are recipients of these programs would be more cooperative than persons who are subject to commitment to a correctional institution. It, therefore, could be assumed that a reasonable proportion of persons served by the county welfare departments could receive their services from a local clinic operated either by the state or by the community.

The private or voluntary agencies.

Information from social agencies in the voluntary or private social work fields indicates that in the course of their services in the areas of family counseling, child welfare, care of the older citizen, group work and recreation programs, hospital out-patient clinics, and so on, these organizations deal with children and adults who manifest disturbed behavior which is not yet serious enough to characterize as mental illness. Nevertheless, the personnel of these organizations should be trained both to help these people to deal constructively with the underlying stresses and be sufficiently informed to make referral to an appropriate mental health resource.

Statistics regarding the number of persons in the state who are in current need of such services and known to the private agencies are difficult to estimate. A sub-committee of the Zone III Task Force has examined some sampling studies which later may supplement this section of the report. That they number in the thousands and that their early treatment will save much human suffering and later more expensive treatment is obvious.

II. THE NON-PSYCHIATRIC PROFESSIONS AND THEIR GENERAL NEEDS FOR HELP IN MAKING THEIR PROFESSIONS AND THEIR AGENCIES MORE EFFECTIVE IN PREVENTING MENTAL ILLNESS

The kind of help needed by people in the various "trouble area" services are four: referral information and resources; mental health consultation; mental health education on the job; and inclusion of mental health content in their

professional education. This kind of help is deemed essential if the non-psychiatric workers are to deal effectively with stressful situations and with people who show difficulty in coping with them. Effectiveness in the handling of the highly charged emotional situations with which they are often faced can made the difference in whether those whom they serve remain in Zone III, move back into Zone II, or move into Zone IV during the course of their lives.

Listed below are examples of some of the non-psychiatric workers in Zone III needing the four kinds of help of a specific nature from mental health professions:

Ministers
Physicians
Social Welfare
Police Officers
Para-Medical
Homemaker
Recreation Worker
Vocational and Employment Counselors
Counselors
Teachers
Probation-Parole
Institutional Workers
Psychologists
Administrators of Staffs
Personnel Industry
Non-Professional Groups

1. Referral information and resources.

People working in the "trouble area", with many who have, or are on the way to having, serious mental health problems, should know what they are prepared to deal with and where to refer, within or outside the agency. Since early diagnosis and early treatment are the powerful preventive measures, referral of clients to more skilled resources is frequently needed. Workers in Zone III need to know what resources exist within and outside the agency in the community, what these people do, be acquainted with the referral persons and know how to make an effective referral to them. This implies not only being given the information, but visits and introductions to the mental health resources available for referral and some training and supervision in their referral practices.

2. Mental health consultation of two sorts: case consultation and program consultation.

   (a) Case consultation for non-psychiatric workers should be geared toward helping the consultee to identify problem situations in individual cases to understand and deal more effectively with

the problems presented. The psychiatric consultant should be able to interpret to the non-psychiatric worker the impact the patient's symptoms have upon the family, schools and other community relationships. Through case consultation, the non-psychiatric personnel may acquire a better understanding of emotional problems and how to deal with them more effectively.

(b) Program consultation provides an opportunity to incorporate known psychiatric and mental health principles into the program planning of various agencies. This is one way of making economic use of the limited psychiatric resources in the community. The consultant working in program consultation should be available to personnel at all levels with responsibility for the formation and carrying out of policy: executives, supervisors and practitioners. The consultant in his work with non-psychiatric agencies should keep in mind the specific needs of each agency and its responsibility to the people it serves, as well as its reason for existing.

3. Mental health education.

Mental health education for the non-psychiatric professionals and other workers in Zone III agencies should be focused upon the mental health concepts that are applicable to the work of the agency. Emphasis should be placed upon understanding of mental health concepts, of their application to their kind of "trouble area" or service and of cultural, ethnic and age differences and of special stresses faced by such groups as they encounter them.

The responsibility for seeking out such mental health education should be the primary responsibility of those individuals, groups, and institutions dealing with troubled people. It is also a primary responsibility of every individual in a given profession to secure the necessary mental health education to discharge his job effectively. The mental health professions have a responsibility to make such education available, to stimulate interest and awareness of need, and to be selectively applicable in the education to the people seeking mental health education.

This can be accomplished in several ways: lectures in a university; institutes, seminars or workshops; in-service training, staff meetings and internships; and site visits to mental hygiene facilities under the auspices of the psychiatric professional related to the facility.

Periodic evaluation of mental health education programs should be undertaken with both mental health personnel and non-psychiatric agencies participating in the common and continuing search for guiding principles and effective methods.

4. Professional preparation for workers in Zone III services should include basic mental health concepts and knowledge of resources. Both the universities and the professions involved in Zone III have a responsibility to build into curricula for their professional preparation the necessary mental health concepts needed to do a good job.

5. Resources available for help in referrals, consultation and education. There are many. Following is an illustrative list of potential resources:

State Department of Mental Health
Mental Health Association
Local clinics
-- community
-- proprietary
Private practitioners
-- psychiatrists
-- psychologists
-- psychiatric social workers
Professional Associations
-- County Medical Association
-- NASW, Welfare Council
-- Information and Referral Service
-- Intra-agency, psychiatric specialists
-- University and professional schools
-- Voluntary Citizen Associations
-- Union Welfare Services
-- Voluntary Social Work Agencies

III. SOME GUIDELINES FOR CLARIFYING RESPONSIBILITIES AND HELPING THE NON-PSYCHIATRIC RESOURCES TO BE MORE EFFECTIVE

The obvious goal of work with persons in non-psychiatric trouble is to be so effective that the fewest possible number of them move into the zone of psychiatric trouble and the largest possible number of them move into the zone of normal social milieu.

Therefore, high priority attention should be given to helping the professional workers and agencies now dealing with people in non-psychiatric trouble to be of maximum effectiveness.

The following suggested guidelines are intended both to clarify responsibilities of various units of society related to mental health and to focus and enhance their efforts:

A. General Guidelines

1. The effectiveness of the various professional workers who provide sources to persons in non-psychiatric trouble can be enhanced in at least several important ways:

a. by improving their professional preparation;

b. by improving their ability to make effective referrals and by increasing the number of referrals to appropriate resources;

2. The use of local or regional resources for consultation and training is usually preferred because of the advantages of more intimate knowledge of local area needs and the possibility of continuing relationship.

3. Mutual feedback for correction of both the workers in Zone III services and psychiatric personnel in the Department of Mental Hygiene can occur in everyday exchange. Whether this occurs or not depends upon the attitude of inquiry in all collaborative situations.

B. Guidelines related to local community agencies.

1. Every community agency intending to help persons in non-psychiatric trouble has the responsibility to acquire through purchase or contribution the necessary and available resources for the improvement of its referral, consultation and staff training programs;

2. The more an organization is focused upon non-psychiatric trouble (Zone III), the less it is appropriate for the organization to have psychiatric sources within it; and the more an organization aims to serve persons close to or headed for psychiatric trouble, (Zone IV), the more appropriate it is for that organization to provide its own psychiatric services.

3. Many agencies whose purpose and program are geared to help persons in non-psychiatric trouble (Zone III) are so loaded with persons in psychiatric trouble (Zone IV) that they are unable to satisfactorily accomplish their primary aim. Both the large number and the seriousness of the condition of those clients in psychiatric trouble, frequently uses so much agency energy, time and money that there is insufficient remaining to serve sufficiently or competently the large number of persons in non-psychiatric trouble. As a result, many persons with non-psychiatric trouble are not being prevented from becoming more seriously ill and, thus, are become prospects for, if not patients in, the psychiatric trouble zone.

4. Whether or not an agency provides its own psychiatric sources is, or should be, dependent upon the volume of its caseload and its ability to use the psychiatric resources economically. There are various aspects of economic use of psychiatric sources, among them:

a. Judgment as to whether the limited psychiatric services which are available to Zone III agencies and professionals can be most productively used for treating clients or for consulting with or training staff and what proportion of both. (Too frequently limited psychiatric resources are

loaded with direct treatment caseload which precludes consultation and training of staff.);

b. Consideration of under what conditions it is best to build in psychiatric consultation and training services on the agency's own staff or secure part-time services from a psychiatric agency. Fragmentation of services by splitting them up in small administrative units may not be the most economical way of utilizing the limited psychiatric resources.

C. Guidelines related to universities and professional schools

1. There is urgent necessity to educate some professional workers in each of the mental health professions so that they are prepared to educate and train others and to provide consultation. The community agencies should then be encouraged to use those who are especially prepared to provide training and consultation.

D. Guidelines related to California Department of Mental Hygiene

1. One of the major functions of the Department of Mental Hygiene in relation to the zone of non-psychiatric trouble is to cooperate with local governmental and voluntary agencies, and professional groups, in efforts to develop general public understanding on mental health problems and programs.

2. Another major function of the Department of Mental Hygiene is to recognize community readiness for working on its mental health problems and for developing mental health programs. This community readiness must be matched by the Department's own readiness to assist on those matters in which assistance is needed.

3. The Department routinely should make known its services to local communities. When its representatives come into a community upon community invitation or departmental initiative, the representatives should make themselves known to community officials and leaders.

4. Function of the Department is to stimulate the more effective use of existing local and regional resources, and to provide direct services to agencies and professionals working with non-psychiatric trouble only when there are no other resources available.

5. Function of the Department is to gather and disseminate experience of local or regional services so that agency and professional workers as well as citizen groups may be able to benefit from the accumulated and evaluated experience of all agencies and professional workers.

6. Function of the Department is to assess the distribution of mental health personnel throughout the state, to encourage and motivate personnel from the various mental health professions to work in non-metropolitan as well as metropolitan areas, and to take whatever action is appropriate and necessary to assure adequate mental health personnel for non-urban areas of the state.

E. Guidelines related to local citizens

1. The responsibility for identification of local community mental health needs and for developing appropriate and adequate resources to meet these needs, rests upon local citizens.

2. Local citizens have a further responsibility to use whatever local organizational machinery, talents and assets are available to assess the need objectively, to strengthen existing services where possible, to develop new services where necessary, to use appropriate outside sources where desirable, and to assure that all services are working together efficiently and effectively.

3. Professional mental health workers have a special citizen responsibility by virtue of their special knowledge to help keep lay citizen leaders alert to the possibilities of newly emerging problems and to the potentialities of using newly emerging insights and newly available resources to meet local problems.

CONCLUSION

Zone III Task Force, in its exploration of the "trouble area", found, first, that there is a considerable number of persons in the care of Zone III agencies who are mentally ill and who belong in Zone IV. This is both because of law and because of lack of sufficient resources in Zone IV agencies to which to transfer them. This involves legal questions, inter-departmental agreements and financial resources to care for them. Section 1 of this report identifies some of the types of cases and indicates the extent of the problem in Corrections and Youth Authority. The material from the State Department of Welfare also bears upon this problem.

The Task Force also identified the kind of mental health services the professions and workers in Zone III agencies need to become more effective in preventing mental illness. These are defined in Section II. Some Guidelines were suggested in Section III.

Exact figures could not be obtained from the state departments and from local voluntary agencies. Additional data may come from the Department of Education and the Department of Public Health. Some sample data may come from voluntary studies. It is clear, however, that by virtue of the pressures which are exerted to treat those who have actually become mentally ill, comparatively little (with notable exceptions) is being done to reduce appreciably the great reservoir of those who do not yet require psychiatric care, either in state or county hospitals

or in equivalent highly expensive facilities. The road to prevention is the way indicated in Sections II and III. In this the Department of Mental Hygiene has a responsibility along with the many people who work in Zone III and mental health resources wherever they are.

Statements from the State Departments of Corrections, Youth Authority, and Social Welfare are appended. Figures supplied by the State Department of Mental Hygiene on the community services offered through California's Mental Hygiene Clinics for the year ending June 30, 1960 are also included in the Appendix. (The Appendix is omitted from this preliminary report.)

LONG RANGE PLAN ON MENTAL HEALTH SERVICES

PRELIMINARY REPORT OF COMMITTEE ON ZONE IV, DIAGNOSIS AND EVALUATION

Your task committee has considered the problem of estimating the resources that will be required for diagnosis and evaluation in the Mental Hygiene field in the State of California by 1971. We have delimited our task, at the outset, to a consideration of present resources, trends, and 1971 goals.

Present services we have categorized. We will pursue the study of these various categories as best we can. It is already apparent, however, that this task committee cannot analyze these resources quantitatively. Such accounting, if it is deemed advisable, will have to be conducted by a staff of skilled statisticians, devoting many hours of critical study, not only to the figures available, to the gathering of new data, to the consolidation and projection of these figures but, most important of all, to the correlation of such figures to determine that categories and figures gathered from different sources are comparable. Tour task committee is aware that figures expressing such services as the number of diagnoses or the number of treatments are not always comparable between two elements of the same agency. To try to compare such figures between different agencies, without critical professional and statistical study, will lead to more error than enlightenment. Without such an accounting of present resources, this task committee will be able to estimate future needs quantitatively only be recommending the multiplication of existing facilities by some, as yet, undetermined factor.

Your task committee has considered recent trends in the field of diagnosis and evaluation. We believe that diagnostic procedures within our already existing institutions and facilities will remain as important, and the need will expand in direct proportion to the expansion of these institutions. The need for evaluation of people before they become typical Zone IV candidates should be increased in far greater proportion than now exists. We believe that at the outset it is more important to determine whether or not a candidate needs assistance than it is to determine whether or not he belongs in some particular nosological category. We would, therefore, broaden the base of the initial evaluating group to include teachers, recreational technicians, social workers, public health nurses, and others. There will be a need for a broad program of training for these people who are to do the initial screening. More refined diagnosis can await the reaction to initial assistance. Your task committee sees diagnosis and evaluation as being a continuous process, concurrent with treatment, extending from the initial indication that help is needed throughout the full period of inpatient and outpatient care.

We believe that the most refined type of diagnosis should embrace a complete historical, physical, and mental evaluation of the patient, and that this can best be provided in coordinating diagnostic centers. We envisage the centers as providing a broad program of diagnosis and treatment for all types of cases: general medical and surgical, neurological, neuropsychiatric -- both inpatient and outpatient. We believe that it is of primary importance that diagnosis and treatment be conducted within the living radius of the recipient. The coordinating diagnostic centers must be dedicated first to service but, in the interest of enrichment of service, should conduct

training and research in collaboration with academic institutions. Further definition of this type of center will be developed in Phase II.

Your task committee supports the three Zone IV definitions of Diagnosis and Evaluation:

1. Gross assessment of a person's mental and emotional health, taking into account the pre-morbid and morbid environment of the person, with special consideration of his immediate family relationships and his physical health, to determine whether psychiatric or other services are required.

2. More intensive assessment of a person's mental and emotional health, with a view toward developing an hypothesis on which treatment and rehabilitation can be based. Again, the assessment should take into account the pre-morbid and morbid environment of the person, with special consideration of his immediate family relationships and his physical health.

3. Development of a plan of intervention which takes into account the assessment of mental and emotional health, as well as the pre-morbid and morbid environment of the patient, with special consideration of his immediate family relationships, and his physical health, and which is acceptable to the person, his family, and the community, and makes appropriate use of psychiatric and other resources.

To the above this task committee would like to add that special attention should be paid to the impression that diagnostic and evaluative procedures make upon the patient, his family, and the community.

Your task committee sees diagnosis and evaluation extending into the family and community, and involving family counselors, sociologists, anthropologists, and others, as well as psychiatrists, psychologists, nurses, social workers, and others who now constitute the mental health team.

Our consideration of trends points the way to 1971 goals. The resources required to attain these goals will have to be based on the analysis of present resources and their projection ten years into the future.

We recommend that a statistical group be employed by the State of California to analyze present resources and, with the professional support of your task committee, to plan for the future.

Your task committee has further considered the type of centers needed to perform the role of diagnosis and evaluation for the future Mental Hygiene Program for the State of California. We believe such centers should develop complete diagnostic resources -- general medical and surgical, as well as neuropsychiatric. They should be designed to meet local community needs and operated at the community level but integrated into a coordinated statewide plan and supported as need be by state and federal resources. Existing local resources should be encouraged, expanded, enriched, supported, or otherwise modified to meet needs but should not be duplicated. The State should set the

standard of performance of these centers and should provide coordination between centers. These centers should provide a broad program in which diagnosis and evaluation is combined with treatment, rehabilitation, education and research.

We believe that by appointing coordinators somewhat comparable to the State coordinators fostering the Short-Doyle program, the State of California could make a significant contribution to the establishment of these centers. Such a coordinator would analyze local resources and encourage their development in consonance with local needs and opportunities and would recruit staff and develop responsibilities for the center as local conditions demanded. Your committee would encourage these centers in the collection, analysis and interpretation of data, diagnostic and other, from all mental hygiene resources in the community. For this purpose electronic equipment is indispensable.

Your task committee sees these centers as being the focal point of all mental hygiene resources. So far as our particular assignment goes, we see it as the center from which diagnosis and training in diagnosis extends throughout Zone IV and particularly into Zone III. We would stress especially the need for enriching resources in Zone III since if early diagnosis and treatment is anywhere to be effective, it must be effective before the subject gets into Zone IV.

Training for specific tasks within both Zone IV and Zone III need to be carried out to provide for a high standard of diagnostic and evaluation services in both areas. To maintain a high level of education with the staff, your task committee would propose some program of credit such as is now given to teachers in the State of California for continuing postgraduate education. Training for psychiatry, social work and psychology should stress the community aspect of mental health practice. The commensurate improvement in quality of service, teaching and research will tend to draw private psychiatrists, at least part-time, away from their private practices and into community psychiatry. Whereas a high level of service and opportunity will be major attractions for community psychiatry, the importance of good public relations and a favorable image based upon service and opportunity should not be overlooked.

Your task committee would stress the importance of quality and breadth of service in recruitment. We believe that the opportunity to provide a high quality of service in a center dedicated to a high standa rd of health service of all kinds would do much to invite a high quality of staff. If such an opportunity for superior service be combined with a rich opportunity for education, teaching and research, the best people in the field will be attracted. To make those attracted stick, salaries will need to be adequate and competitive, and will have to be adjusted from time to time to keep pace with competition and inflation.

Your task committee cannot emphasize too strongly the need for recruiting of personnel from people with a broad and rich educational background and with the type of intellect and training that not only welcomes but invites change and is hungry for new endeavor. In the rapidly changing program we envisage for mental hygiene, only people of vigorous intellect and lusty intellectual appetite will be able to keep pace. Those trained only for limited tasks will soon find themselves frustrated and outstripped.

To encourage an integrated plan and to discourage wasting scarce resources, the Department of Mental Hygiene should develop and encourage legislation which would enable it to control to a considerable extent the establishment of mental hygiene

institutions throughout the state in conformity with a master plan subject to periodic revision. This it should do by its exercise of control over state and federal funds. Private and local resources must be left free to pursue their independent goals. Hopefully, the coordinating function of the Department would, in most instances, be able to persuade these private and local resources that a high degree of integration would be mutually beneficial.

Your task committee finds itself in general accord with the recommendations of the Joint Commission on Mental Illness and Health. We believe that the cost formula set by this Commission is a modest one. We do not anticipate that the expansion of diagnostic and evaluation services will be one of the more expensive elements in the development of a total mental hygiene program. We anticipate that the cost of hospital psychiatric care will decline whereas that of outpatient mental hygiene care will increase, with the cost of diagnostic services playing a lesser part in this increase.

To two parts of the Joint Commission's Report we take exception. First, we believe that mental hygiene care must be a part of the general health program of the state and not separated from it as would seem to be implicit in the Commission's report.

Second, we believe that outlying hospitals should be converted into general hospitals rather than into institutions specializing in the care of chronic illness. A high standard of care requires that a hospital be equipped and staffed to take care of all kinds of illness -- general medical and surgical, neuropsychiatric, acute and chronic. Experience has demonstrated that one cannot provide high quality of staff in a hospital dedicated to chronic care. We further believe that whereas it is probably disadvantageous to permit a hospital to grow to more than 1,000 beds, other factors such as location, research, teaching, staff-patient ratio and hospital goals are more important than mere size.

Your task committee considered the geographical and ethnic problems of the state. We recognize that many resources that can be provided readily in metropolitan communities are not available in remote communities. We firmly believe that to the greatest extent possible patients should be found, diagnosed, evaluated, treated, and rehabilitated in their own communities. The extent to which this can be done will depend first upon the extent to which Zone III resources can be encouraged and supported. These resources in Zone III should have top priority. Second, this will depend upon the extent to which those resources can be developed, even in isolated communities. We think particularly of social service, foster homes, half-way houses, public health nursing services, and volunteer agencies supporting all these activities. Third, this will depend upon the extent to which the richer center resources can be spread out into the more remote communities. We must recognize, however, that in spite of all effort, some patients are going to have to be cared for at some distance from their homes. This should be done only where careful evaluation demonstrates that the patient's removal from his home community is necessary to provide the best possible care and that, as a consequence, this care is provided at the cost of considerable disadvantage to the patient.

Your task committee recognizes that certain groups, social and ethnic, present special problems. As the plans for your program develop, and soon, representatives of these groups and those especially equipped to understand and handle their problems -- sociologists, anthropologists, and others -- should be drawn into the planning process.

The support of all interested professional groups is of great importance to the development of the state's mental hygiene program. The recently expressed support of the California Medical Association is most encouraging . The Department of Mental Hygiene should encourage the support of this parent organization in bringing county and local groups into line.

Your task committee is aware that certain groups in the community will continue to resist the development of a richer mental hygiene program. We are optimistic enough to believe that superior performance, developed where and when it can be, will continue to win a favorable consensus. If all who strive to extend the program continue to work where their services are most needed, and if their work is well integrated by the Department of Mental Hygiene, we believe that most dissident elements will be gradually engulfed.

C. H. FRANCIS, M. D., Chairman
Zone IV
Diagnosis and Evaluation

LONG RANGE PLAN FOR MENTAL HEALTH SERVICES

PRELIMINARY REPORT OF COMMITTEE ON ZONE IV (TREATMENT SERVICES)

INTRODUCTION

This report is the result of one month of study by the Task Force and is presented in answer to the Department of Mental Hygiene's request that a report be made at this time.

This is an extremely brief summary of the main points stressed in the subcommittee work and the general Task Force meetings. The first subcommittee reports are also submitted as attachments to this summary. At this time it must be stressed that the Task Force does not endorse all of the details suggested by the subcommittees. Many of the details have not had the opportunity for adequate discussion and study; we, therefore, request that the material be held as tentative and confidential. Shortness of time prevents us from adequate study and refinement of details. We hope there will be time for this in the coming months.

GENERAL RECOMMENDATIONS

Our studies have shown a remarkable amount of agreement on certain basic approaches and principles for provision of adequate mental health services to communities in California.

1. Regionalization. The planning of mental health services is most effectively carried out in a "service area" or regional basis. The question of financing and administration should be secondary. Patients should be treated as close to their homes as possible. Larger institutions could be located on a state-wide basis, such such as in the 9-area plan suggested on page 15 thru 20 of the report by the subcommittee on Mental Retardation. Smaller facilities, such as community mental health centers and all-purpose clinics, could be located in population centers similar to the "general hospital service area." The tendency for hospitals and clinics to cluster in certain large parts of a city should be discouraged unless cooperative planning has led to such a decision. It is probably not necessary for every general hospital to have a psychiatric service, even though they all accept psychiatric patients. A psychiatric service could be developed depending on the needs of that portion of a city or county.

2. Coordination and continuity of planning and treatment. This point is probably the one stressed with most frequency. The present fractional approach to the treatment of individual patients is harmful and should be reduced or eliminated. The ideal is that all patients be treated by the same person he starts with and in the same center; if this is not possible, then a minimum number of relationship changes should be sought. Intake should be brief or combined with

other treatment. Out-patient facilities and personnel can do both pre- and post-hospital care of a patient, if hospitalization is required. The original therapist should maintain contact with his patient during the period of hospitalization, if possible.

Coordinated community planning and integration of resources should be done under the leadership of a particular guiding body. Administrative control in this instance is not needed. The total resources of a community or region, however, should be viewed together as a program. Delineation of roles and intercommunication can then be done through on-going joint discussion; this may be the first priority of action.

3. Small group units. Psychiatric patients should be handled in relatively small groups, and if institutionalization is necessary, this principle also applies to the dormitories, wards, and other facilities. Increase in size of groups and facilities also increases problems of communication and of personal attention and interaction.

4. Financing. Public financing will continue to be necessary to a large extent, even with increase in private facilities. The expense of high-standard psychiatric care is beyond the means of most families. Programs can be jointly financed by private, local, state, or federal sources. The facilities may also be jointly staffed from different organizational entities.

5. Increased use of non-psychiatric resources. The hidden mental health resources of a community should be greatly developed. These are such agencies and personnel as clergymen, medical general practitioners, public welfare workers, the courts, the police, medical clinics, and other agencies where social help and counseling are given, whether public or private. Such people are in immediate contact with thousands of mentally troubled persons in their community. Many people accept such help more quickly than specialized psychiatric help. Shortage of trained mental health personnel makes the development of this resource a necessity; ease of communication with the mentally troubled makes it a great advantage.

6. Recruitment and training. Necessary expansion of services in the state requires the recruitment and training of many more professional and non-professional personnel. Intensive specialized courses could meet the need in many instances.

7. Treatment emphasis. Services should develop a primary therapeutic orientation as opposed to a primary diagnostic or dispositional function. Diagnostic sophistication is reasonably wide-spread, but treatment services are not. There is a tendency throughout the state toward repetitive diagnosis and referral being applied to the same case by different agencies. Frequently no one accepts responsibility for treatment.

8. Emergency programs. Provision of immediate psychiatric aid which is available to all persons in a community is of great importance in preventing serious personal and social disruption. This is particularly needed on an out-patient basis and should be part of the regional plan.

9. Broad eligibility criteria. Restrictive financial and residence requirements should be discontinued so that the program may focus on what the patient needs rather than administrative and clerical issues.

10. Mental Health Centers. The basic facility of a community (or service area within a community) should be a mental health center. This is a functional and physical unit combining both in- and out-patient facilities. It would treat mentally troubled and mentally ill persons as well as mentally retarded, alcoholics, senile, mental conditions, persons on parole from correctional institutions, and function as a focal point for the mental health resources of its area.

    This center would consist of an immediate aid, evaluation and referral service (24-hour) for adults and children, a day-hospital, a state hospital pre-admission service, and perhaps 250 in-patient beds. Consultation services would be provided from the center; satellite all-purpose clinics as well as district psychiatric teams would be administratively related to the center.

    Regular working relationships would be maintained with private therapists in institutions, occupational rehabilitation agencies, foster family care, half-way houses, correction agencies, welfare agencies, youth guidance programs, and the courts. In-service training for personnel of non-psychiatric agencies would be one of the important services rendered from the center. Training, research, and community education programs should also be included.

    A formal working relationship would also be maintained with the larger, regional, long-term hospitals. The mental health center could be private, public, or jointly operated.

    (Note: "Beds" is felt to be an out-moded unit of measurement in a psychiatric center, since patients are ambulatory, and since many other important facilities must be associated with the bed space. A different unit of measurement should be used; this could be in terms of square foot per patient or any other suitable reference which includes out-patient, recreational, and other considerations.)

11. Intensive treatment for "chronic" cases. The knowledge that many people become chronic cases because of insufficient treatment facilities leads us to the belief that "long-term institutions" are warranted only for a small number of people, and will become gradually less so. All facilities provided should have a treatment emphasis suitable to the type of case being handled. Various proposals

are under discussion regarding the practical handling of the long-term case. There is agreement that the large institution of over 600 or 800 beds makes personalized attention difficult and administrative complexities numerous.

12. Out-patient emphasis. Out-patient approaches should be used to the maximum and 24-hour care to the minimum extent.

13. Dignity and comfort. Both patients and staff should be treated with dignity, respect, kindness, and comfort. Staff should be of highest quality and physical facilities for patients and personnel should be adequate, well-equipped, comfortable, and attractive.

14. Local responsibility. Cities and/or counties should be helped to gradually assume increased administrative responsibility for planning and operation of mental health programs with the State concomitantly reducing its role in the operation of direct services to patients. The State should remain active and strong in setting and review of standards, and in training, research, and financing.

SUBCOMMITTEE WORK

Each subcommittee has presented a preliminary statement. Since there are many points still at issue and details to be changed or expanded, these committee reports are attached only for purposes of reference and general direction.

1. Subcommittee on Basic Principles. This statement will be considerably refined and combined with the statement of principles developed by the Department of Mental Hygiene. The Task Force generally agreed with this report and the "restorative program" aims. Number 6 of the restorative program is under considerable question and study as is the last sentence of the first paragraph on page 2. The Task Force feels that many psychiatric jobs have been well accomplished, but that others have not. Alteration of the environment as well as the individual needs to be considered in basic principles and goals of psychiatric treatment.

2. Subcommittee on Treatment of Emotionally Disturbed Children. This excellent preliminary statement stresses many of the general principles noticed for all categories. Coordination and continuity of services as a major program aim is brought out, as well as treatment close to home without disruption of social relationships. Collaboration with school programs is mentioned but deserves more stress and evaluation. The critical needs for training and recruitment are well stated; specialized program needs and broad eligibility policies are discussed. It should be noted that children in this report are defined as persons under the age of 18.

   The report makes certain recommendations beginning on page 7. References to state or local administration do not yet represent the thinking of the Task Force. On page 13, the statement is made "in addition to special children's units, all community hospitals should be encouraged to have psychiatric units which could offer at least

several months of hospitalization to a few children and adolescents." The Task Force does not agree with this statement and feels that local planning in the service area concept may indicate such units for some hospitals and not for others. Number IV, on page 15, is at issue in view of the principle of continuity of service and a minimum of changes in therapists.

3. Subcommittee on Adult Psychiatric Disorders. Only general principles are covered in this report and details are to be submitted in the final report of the subcommittee. Coordination and continuity are again stressed, and the "treatment" approach is recommended rather than the diagnostic and dispositional approach. Services to mentally troubled people as well as those with severe psychiatric disorders is held to be deserving of major attention. The use of non-psychiatric personnel is recommended with the definite caution that training and supervision of such service is a necessity.

   The mental health center is recommended as the basic hub of the psychiatric program for a community or the subdivision of a community. On page 3, the phrase "custodial cases" should read "long-term" in view of the attempt to get away from the custodial concept.

4. Subcommittee on Adult Anti-Social Reactions. This report was generally well received, but time prevented study of the many details of ratios and administrative matters. The need for extension of programs, both in the present facilities and into jails and courts for early treatment, was definite. There is some disagreement within the subcommittee as to the extent to which adult criminal behavior should be considered a psychiatric area of concern. Their suggestions as to possible joint use and financing of clinics should be noted.

5. Subcommittee on Mental Retardation. This report recommends mental retardation programs as being a specialized entity within the mental health center. References to the Department of Mental Hygiene and its part in administration of services do not yet represent a recommendation of the Task Force.

   Although larger institutions still remain a part of the state plan, the use of small "hospital-clinics" is stressed as the main facility. Their suggestions for regionalization and administration are quite interesting.

6. Subcommittee on Alcoholism and Drug Addiction. The concept of continuity and coordination is again strong in this study. Their recommendation for a central evaluation, referral and follow-up clinic is generally supported and should be incorporated in similar services rendered in the mental health center. Regular contact and consultation with non-medical facilities handling alcoholics should be further explored.

Their report on narcotics addiction is to be extended with particular reference to non-institutional treatment programs. Nalline clinics could also have counseling services built in.

7. Subcommittee on Psychiatric Problems of the Aged. This report states that the present fragmentation of services is economically wasteful and detrimental to the patient, and that continuity and flexibility of services are a necessity. The goal of restoring the patient to effective social functioning is mentioned. Incorporation of programs for this age group into the mental health center program is a basic recommendation here. Early intensive treatment is viewed as a way of decreasing the number of patients requiring long-term, inpatient care. The present large number of patients over 65 years of age is noted as a problem which is inadequately dealt with and needing immediate attention.

   The care of the long-term case who does not respond to intensive treatment is approached in several ways, but it should be noted that custodial, geriatric hospitals are not recommended.

ROBERT A. KIMMICH, M.D.
Chairman
California Psychiatric Treatment
Master Plan Task Force

REHABILITATION TASK COMMITTEE

GENERAL PRINCIPLES IN THE PLANNING OF REHABILITATION SERVICES FOR THE MENTALLY ILL

1. Planning for rehabilitation services should be part of, and not separated from, planning for treatment services.

2. Treatment and rehabilitation services and facilities should make every attempt to help the patient maintain a level of functioning which keeps him in his usual environment. Only those services which are necessary to return the patient to adequate function should be applied.

3. Treatment procedures, including all forms of hospitalization, should create only that degree of dependency absolutely necessary to the situation and should seek to maintain all functions of the individual at the highest possible level, as far as practical.

4. Hospitalization should be as brief as necessary to restore function.

5. Institutions should be centrally located to population needs and readily accessible to patients requiring their services.

6. Institutions should make a maximum effort to maintain contact between family and patient during the period of hospitalization.

7. Many rehabilitation services required by patients while hospitalized may be available in the community. Such services should be used where feasible. Services should be created by the community rather than the institution if these are services which are required in the rehabilitation of the non-hospitalized mentally ill patient as well as other groups of handicapped.

8. Admission procedures to institutions should be on the same basis as admission to a general hospital, that is, with consent of patient or parent, or guardian and without court proceedings except as a last resort.

9. Regular medical and dental examinations with prompt institution of needed treatment are essential for adequate rehabilitation of all individuals with psychiatric problems.

10. Some one person should have primary responsibility for follow-up services after hospitalization and should assume responsibility for the immediate return to the hospital should this become necessary. He should take part in the planning process within the hospital or institution prior to the patient's leaving.

11. Hospital procedures should be such as to permit readmission with the least delay or traumatic effect on the patient.

12. The objectives of long-term hospitalization should aim for treatment to enable the patient to return to family and community rather than be symptom-free or conflict-free in the "pathologic" environment of the hospital or institution. An adequate, even extensive program in psychiatric rehabilitation properly staffed and amply financed, can fail of its purpose if the unconscious aim of the program is not the return of the patients to full functioning on their own outside of hospitals and institutions.

13. Legislation and programming should keep the special needs of the adolescent in mind, particularly when at times they need services suitable for children while at the same time needing services and consideration due an adult.

14. The successful application of rehabilitation procedures to the aged requires the acceptance of certain principles:

    A. The aged have the capacity for rehabilitation.

    B. The aged are valuable contributors to our culture.

    C. Economic support in old age should be regarded as a right given by society because of the contribution made throughout a productive lifetime. This support should be adequate so that the individual may enjoy economic independence.

    D. In the aged, physiologic adequacy has an important bearing on psychologic adequacy of functioning. Sufficient activity and stress to maintain physiologic functioning on a high performance level are necessary to prevent cerebral deterioration. Adequate physical rehabilitation is important for psychiatric rehabilitation with this age group.

LONG RANGE PLAN FOR MENTAL HEALTH SERVICES

PRELIMINARY REPORT OF COMMITTEE ON RESEARCH

The Task Force Committee on Research met Wednesday, October 18, at Langley Porter Neuropsychiatric Institute. The members present included:

Leon J. Epstein, M.D., Chairman; Associate Medical Director, Langley Porter Neuropsychiatric Institute
Joseph M. Bobbitt, M. D., Assistant Director, National Institute of Mental Health
Robert M. Featherstone, Ph.D., Professor and Chairman, Department of Pharmacology, University of California
David Hamburg, M.D., Professor and Chairman, Department of Psychiatry, School of Medicine, Stanford University
Robt. T. Ross, Ph.D., Acting Chief of Research, Department of Mental Hygiene
M. Brewster Smith, Ph.D., Professor of Psychology, University of California
Ralph Littlestone (ex officio), Chairman, Master Plan Committee.

Absent:

John E. Bell, Ph.D., Acting Chief, Mental Health Services, San Francisco Regional Office, National Institute of Mental Health

The meeting was initiated with a discussion of the purpose of the Master Plan and the role of the Research Committee within the Master Plan Task Force. This was followed by a review of the history of the Research Section within the Department of Mental Hygiene. It was pointed out that, at its inception, the purpose of the Research Section was to develop and maintain a progressive research program in the Department of Mental Hygiene which would expedite both basic and applied research concerning mental illness and mental retardation. It was pointed out that from the beginning of the development of the Department's research program there was the general conviction that there should be a broad view of a program which would include both basic and operational research, the latter involving continuing evaluation of both the over-all program as well as specific programs within the Department.

In order to accomplish these goals, the research program was geared with two primary mechanisms. One involved the support of individual research projects with funds allotted by the Legislature or secured by means of research grants obtained from outside sources. The other involved long-term continuing research program efforts which were not tied to specific projects or limited terms, which would be carried out by career research personnel. These investigators were conceived as members of hospital research teams whose function was both to carry out such long-range projects and to serve as consultants to other hospital personnel who might be pursuing their own investigations.

It was recognized by the Department of Mental Hygiene that it has great responsibilities as well as investment in supporting and maintaining a forward-looking program in research. Its vast expenditures currently approximate $130,000,000 for the care and treatment of mental illness and mental retardation and its recognition that sufficient space and support over and above that supplied by university teaching centers is mandatory if progress is to be made toward improve-

ment in treatment methods. Furthermore, the investment in operational problems would likely not be found outside of the Department to any great extent. In addition, it was believed that many members of the professional staff of the Department of Mental Hygiene were able to carry out, with varying amounts of consultation, significant investigations. These factors combined to reach the conclusion that the Department of Mental Hygiene was the logical place for the development and maintenance of a sound research program. The Legislature initially allocated the sum of $200,000 in 1957-58. This was increased in 1958-59 to $540,000; in 1959-60 to $802,000; in 1960-61 to $1,002,000; and in 1961-62 to $1,107,000. There are currently eight research teams and 135 separate projects.

The committee next discussed the recent report of the Joint Commission on Menta Health. This report contained certain proposals for a general strategy for expanding and strengthening the research effort expended on mental health programs. These proposals include: (1) There should be support for flexible and experimental programs of stimulating research in many different areas and settings. (2) Efforts should be made to increase contacts between researchers and practitioners so as to increase mutual understanding of each other's problems and approaches. (3) There is a general need for long-term research support. (4) There is an urgent need to expand and intensify basic research in mental health fields.

The meeting, from this point, centered largely about status of Departmental programs with respect to these four proposals and comments, and also critiques of current program conceptualization. It was apparent at the outset that the proposals in the Joint Commission were aimed at essentially areas wherein research programs had only recently been initiated or were yet to be sponsored in thoughtful, invested fashion. It was evident that the Department of Mental Hygiene had been cognizant of and had already taken action on each of the factors cited. For example, the program from its inception has been adapted to the support of flexible and experimental programs; it has a specific program for publication of results and currently disseminates research reports to all centers within a few days of their receipt; it has, since its inception, provided for long-term research report, and has expended a sizable share of its resources in the area of basic research. Certain very provocative questions were specifically discussed. One related to the concept of over-all "research needs." Questions were raised as to where society might get the greatest return, where progress was most likely to be made, the need for operational research in the areas of treatment and rehabilitation. There was some discussion about the difference between problems which had immediate relevance or possibly delayed relevance, the latter referring to the fact that certain problems which had scarcely any immediate relevance may have tremendously important ultimate yield. The point was made that there is, in many quarters, some trend to ignore present patients and the problems that they present in that there is great pressure to carry on so-called "basic research" to the extent that applied research may be considered less "legitimate." The committee agreed unanimously that it is entirely proper to place emphasis on the patient of the present generation and in the broad area of applied research. The point was also made that the current bulk of biochemical research may have little immediate yield but carries the promise of tremendously important long-range possibility. The suggestion was made that those responsible for programming research attempt to address themselves to what was "hot" and what was "cold" in research so as to insure that certain very important areas which might not be receiving well-deserved attention would not be subjected to real neglect. The example was cited that currently social problems, as related to mental illness, tend to be a somewhat neglected area in the current emphasis

on biochemical and physiological research. Mention was made of the fact that this is being approached in the Department's research program with its recent emphasis in sociological research as exemplified by the creation of five positions for trained research social scientists.

With respect to the question of need, it was suggested that there be consistent awareness of the importance of projects of a pilot nature which aim to evaluate current techniques of care and treatment or to develop additional research techniques. The team practice was viewed as having many meanings, certain of which are not readily observable. The cogent statement was made that "Nothing was so practical as a tenable theory." There was unanimous agreement that basic research should continue to have its current emphasis in that there was a "moral obligation to replace capital" in the sense that the exploitation of current knowledge will inevitably result in the wearing out of the area explored to the point of exhaustion and little return. The committee pointed out that the Department must consistently and continually examine the field carefully to determine current needs. There are ways available for doing this; for example, the examination of important academic and research appointments which are being made and surveys of articles in leading journals which provide clear indications of areas of emphasis as well as of neglect.

The committee considered seriously the relationship between the State and Federal support in research, the areas where these investments meet as well as where they may diverge. The State of California was viewed as a large progressive state which should assume increasing responsibility for long-term, well-conceived research. It was pointed out that without such investment the quality of the research product tends to decline. The concept of support with greater risk in terms of product potential was also discussed. The conclusion was that Federal funds by the very nature of their distribution may impose a certain conservatism which can be avoided with support on State or local level which is to be encouraged in view of the history of many important findings which have been made through such risk support. Furthermore, support may initially be given to projects wherein the standards may not reach the level needed for outside support, however lead to the polishing of research techniques at subsequent outside support. State support also in its career aspects promotes the capacity but not the necessity of 100 per cent research careers which fills a definite need in research programming.

The committee concluded that the State should continue to support research. In doing so, it accepts a share of the larger responsibility for advances in this field. In this fashion it is able also to approach problems which may be more particular to the specific state and which could scarcely be funded by a national body. Problems might also be approached which are not approached by the larger body but, nonetheless, of importance. It affords also the opportunity of initiating investigations which may subsequently grown beyond the capability of the individual state to support. This did not imply an indescriminate sowing of seeds but rather a careful and selective seeding to plant zise of those problems which have a certain amount of promise. It was pointed out, however, that the research program of the Department of Mental Hygiene is not to be considered in an isolated fashion from the remainder of the departmental program. This was to be considered also in the frame of reference of the individual hospital wherein research was conceived not only in terms of its possible findings but also in terms of its meaning to the hospital. It pointed to the importance of correlating, insofar as possible, the research efforts with the total hospital program which would be, assuredly, to the interests of each.

In terms of support, the committee saw no problem between combined State and Federal support of research programs. There was, for example, no question of the concept of initiating projects of greater risk and subsequently seeking larger amounts of support elsewhere. It was recommended that additional support be sought also from local communities; for example, from those with Short-Doyle operations. Support of research from Short-Doyle operations, it was believed, might well proceed with their treatment programs which might serve to generate both interest and support at the local level. It was also pointed out that additional emphasis might be placed in collaborative studies and problems of joint interest; for example, in setting up nationwide recordkeeping systems, in providing sampling which would be of both local and national interest and in long-term studies, federally supported, of very widespread interest.

In view of tremendous scheduling problems, subsequent meetings and discussions have been held by the sub-groups of the Task Force Committee on Research, and a final report with additional detail will be forthcoming.