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Special Article

Community Mental Health in California

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THE CALIFORNIA COMMUNITY mental health program (under the Lanterman-Petris-Short act) is now five years old. At this half decade mark, it seems appropriate to comment on the impact of the program and to review its prospects and problems.

The Lanterman-Petris-Short act (LPS) had two major goals. The first was to protect the civil rights of the mentally ill by ending indefinite involuntary commitment. The second was to shift patient care from distant state hospitals to local communities and to decrease reliance on inpatient treatment. These goals have been met and national attention has focused on California's approach to treatment of the mentally ill. Many psychiatrists view LPS as the model law to be adopted by other states. Massachusetts, New York, Pennsylvania and others have initiated steps to bring about changes in the care of the mentally ill that are closely patterned after the success of LPS.

These changes in mental health treatment in California have not occurred without concern and criticism. We have witnessed protest over the closure, or threatened closure of state mental hospitals. The roots of this protest are to be found in economics, politics, concern that the mentally ill are neglected and fears about dangerous mental patients in the community.

Economics

Several state hospitals which have been closed were located near small communities. Hospital closure meant the loss of a large payroll. Little planning was done about the impact of these changes on state hospital staff members who lost their jobs and were forced to move away or to find other work in their communities. Those who affiliated with community mental health programs were unable to transfer seniority, retirement and other accrued state benefits.

The California State Employees Association which represents state hospital employees, initiated efforts to prevent further state hospital closures. A historic first was registered when the legislature, for the first time in 27 years overrode a gubernatorial veto on a bill which requires legislative approval before additional state hospitals are closed.

Politics

Political pressure has also been apparent because of the 1974 election. Most of the changes in community mental health in California have occurred during the tenure of a strong, conservative Republican governor. Many opponents of the Administration have labeled the new approach a money-saving device aimed at reducing costs without regard for patients. The closure of state hospitals became a campaign issue rather than a question requiring scientific evaluation. The accomplishments of community programs and the problems in a state-hospital system are better evaluated by professionals than by a political debate. Those who sought to politicize these issues failed to acknowledge that the California mental health legislation was a bipartisan endeavor.

Concerns About Adequacy of Care

In addition to economic and political pressures, there has been public concern about the adequacy of care for mental patients who are treated in the

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community. It is probably the most serious question to be raised. Investigations of community care of chronic patients have revealed great variability among the various county programs. Inadequate housing, lack of professional care and insufficient attention to rehabilitation have been described in some counties.[1] Other local programs have given high priority to the treatment of chronic patients and have devised innovative and effective programs. The controversy centers around whether to reopen state hospitals to provide humane custodial care, or to improve treatment and rehabilitation in the home community. The consensus would seem to be that public care of the mentally ill has improved, and few would choose to go back to the old system of reliance on state hospitals to treat the majority of mentally ill patients.

Danger

Another public concern relates to fears that dangerous mental patients have been released from state hospitals. Several dramatic mass murders have occurred in California since the enactment of LPS and in some instances the alleged murderer was a former state hospital patient. The news media have given wide publicity to these events and have suggested that a need for protecting the public is evident. Those who take this position ignore the fact that the ex-patients were adjudged sane at the time of their release and therefore could not be detained legally under any system. Second, the overwhelming majority of murders are committed by people who were never in psychiatric treatment or in state hospitals. All studies reported to date, indicate that former mental patients are less likely or no more likely to be arrested for crimes of violence than the average citizen.[2-6] In a study of former state hospital patients in New York State, the arrest rate of a group of 5,833 patients was 6.9 per thousand. This compared with an arrest rate of 99.7 per thousand in the general adult population during that same year. In another study of 1,000 patients who had formerly been at Middletown State Hospital in New York, the average annual arrest rate among this group was 2.4 per thousand. This group was followed for 10 years. In another study of 741 patients from other New York State Hospitals, the annual arrest rate among men was seven per thousand and among women was one per thousand. This group also was followed over a 10-year period. In a report by Rappaport and Lassen, the arrest rate among men who had been state hospital patients was similar to that in the general population except for the offense of robbery. Murder, manslaughter, rape and aggravated assault were offenses committed by former mental patients less frequently or at the same rate as in the general public. In a study of women, reported a year later, those who had a history of mental illness had an arrest rate for murder, robbery and manslaughter which was less than or the same as the rate in the general population. There was a somewhat higher arrest rate in this group for aggravated assault.

Ekblom, in a book published in 1970,[2] states that in Sweden, the risk of injury from mental patients was less than the risk of injury from employment in a factory or other industrial situation. Macdonald made a study of 100 patients who had made homicidal threats. Twenty-one months later (when all of the patients had been released) there had been only one person of that group of 100 who had actually committed murder. The idea of incarcerating 99 to keep one from homicide is a high price. The fact is that psychiatrists have great difficulty in predicting dangerous behavior. The only satisfactory predictor of violent behavior is a history of repeated violent acts. The law already provides for involuntary detention of a person who presents a clear threat to others. The roots of criminal behavior are to be found in social conditions of poverty, ghetto life and powerlessness. Psychiatric treatment does not prevent crime or cure its major causes.

Community Treatment Versus State Hospitals

The debate about whether community treatment or state hospital treatment is more effective is not easily settled. Matters of treatment philosophy, economics, public attitudes and politics all enter into the discussion. It is unlikely that one system or the other can manage all of the problems of mental illness. It is more likely that a balanced system of care is needed in which state hospitals and community treatment programs each have some role. As the law is currently structured, all admissions to state hospitals must be authorized by the County Mental Health Director. The need for state hospitals is clearly related to the number of admissions from each county. The reduction of referrals for admission has brought about the declining census in state hospitals rather than any wholesale discharge of resident patients. These rates of admission to state hospitals have varied greatly from county to county although the net

effect statewide has been a significant reduction in rates of admission to state hospitals.

Table 1 shows the admission rates to state hospitals from the medium and large (in population) California counties over the past five years. These data are derived from a report of the California Department of Health. The data reports *rates per hundred thousand population,* and not raw numbers of admissions. During 1973-74, the estimated rate ranged from 0 (Fresno) to 175 (Los Angeles). In the preceding year (1972-73) the rate ranged from two (Santa Barbara) to 240 (Alameda). It should be noted that all counties except Los Angeles and Orange show a significant reduction over the five-year period. The entire state shows a 39.5 percent reduction in state hospital admission rates over the same five year period.

It is reasonable to ask why there is such variation in reduction of state hospital admission rates. The major factor is the ability of the community program to provide a full range of treatment programs. Urban versus rural settings may also be a factor reflecting differences in the type and extent of mental disorder. The state of development of the community program is another factor since there were some community mental health programs which were well-established when LPS was enacted, and others were just beginning at that time. Finally, the preference of the local community and the program director may be the most important determinants of admission rates to state hospitals.

The relationship of change in state hospital admission rates to the development of community programs is shown in Table 2. This table compares the change in state hospital admission rates with changes in services rendered by community programs. Total community services (outpatient, inpatient and partial day in hospital services) are presented along with figures for change in outpatient services only. Data are presented for the years 1969-70 and 1972-73. These data are chosen because they are the most recent data from the Department of Health. If one were to go back farther or to have data for 1973-74, the picture might be somewhat different in magnitude, but would probably show the same direction. The change for Sacramento County is shown as a reduction of 95 percent in state hospital admissions and an increase of 176.6 percent in outpatient visits in the community mental health program. If we were to compare the years 1967-68 with 1973-74, it would show a reduction of state hospital admissions of 98.6 percent and an increase in outpatient visits of approximately 1,614.3 percent. However, data for all counties are not available for those years and for this reason we restrict ourselves to the 1969-70 and 1972-73 years.

In most of the counties a major reduction in admissions to state hospitals is accompanied by an increase in local treatment programs. In Contra Costa County there is a large decrease in state hospital admissions but a small decrease in community services (especially outpatient visits). Actually there was an increase in outpatient visits in Contra Costa County between 1969-70 and 1970-71, but then a decline in 1971-72 and 1972-73. The latter may reflect local preferences, special problems in the community program or simply a lack of available community mental health serv-

TABLE 1.—*Admissions to State Hospitals in Heavily Populated California Counties (Rate per 100,000)*

County	*Population* (1970)	1969-70	1970-71	1971-72	1972-73	1973-74*
Alameda	1,073,184	305	433	246	240	172
Contra Costa	555,805	330	297	102	40	27
Fresno	413,329	32	45	20	2	0
Los Angeles	7,036,987	139	187	183	187	175
Marin	206,758	207	348	65	41	39
Orange	1,420,248	119	203	157	157	141
Riverside	459,074	185	217	189	155	131
Sacramento	634,190	60	44	23	3	2
San Bernardino	681,535	299	193	66	101	103
San Diego	1,357,854	45	46	39	12	3
San Francisco	715,674	598	218	122	108	92
San Mateo	556,601	245	210	112	40	36
Santa Barbara	264,324	44	19	3	2	6
Santa Clara	1,066,421	250	229	87	22	16
Total State	19,953,134	185	198	146	129	112

*Estimate.

ices. In Orange County there has been a large increase in community mental health services, especially in outpatient visits. At the same time there has been an increase in state hospital admissions. This probably reflects the fact that Orange County started its community program somewhat later than some of the medium and large size counties. In the early stages of any community program there may be an increase in the use of hospital services (locally or in state hospitals) while alternatives to admitting patients to hospital are developed. Although Orange County increased its admission rate during the years cited, it reduced its state hospital inpatient days by 27.1 percent reflecting diminished use of state hospitals for long-term treatment. Los Angeles also shows increased admission rates, but a decrease in number of state hospital inpatient days (also reflecting the fact that Los Angeles County uses a local state hospital for acute inpatient treatment).

The statewide trends point to a reduction of state hospital admissions and use of state hospital inpatient days throughout the system. Concomitantly there is generally an increase in community mental health services, especially in outpatient visits. We suggest that the largest decrease in state hospital utilization has been in those counties which have shown the largest increase in community services, especially in those counties that have developed community services for the chronically mentally ill—former state hospital patients. Perhaps the point might be more poignantly illustrated by a case example—the changes that have taken place in Sacramento County. We will pay special attention to programs of aftercare (or continuing community care) of the chronically mentally ill.

Before 1968, Sacramento County had a two-tiered system of mental health care which encouraged reliance on the state hospital system for long-term care and the State Bureau of Social Work for aftercare services. Community treatment was relatively unavailable. In 1968, with the leadership of the new School of Medicine at the University of California, Davis, and the mandate of LPS, a community mental health program began. As local treatment services expanded, state hospital admissions declined significantly. Chart 1 shows the decrease in admissions to state hospitals during the period 1968-73 through 1973-74. This reduction of state hospital admissions was made possible by a pronounced increase in local treatment programs. Outpatient services were approximately 7,000 visits in 1967-68 and approximately 120,000 for 1973-74 (the estimates made when the chart was drawn have been exceeded). Equally important has been the diversification of community mental health services to include day in hospital, crisis intervention, aftercare enrichment and specialized programs for children, families, drug and alcohol abusers and other categories of people needing help.

The special challenge has been former state hospital patients. In some communities in Cali-

TABLE 2.—*Changes in State Hospital Services and in Community Mental Health Services 1969-70 to 1972-73*

	State Hospital Admissions (Percent)	*State Hospital Inpatient Days (Percent)*	*Community Mental Health Services* (Percent)*	*Change in Outpatient Visits Only (Percent)*
Alameda	−21.2	−45.1	+ 4.6	+ 2.3
Contra Costa	−88.0	−54.5	− 3.8	− 10.6
Fresno	−94.8	−97.5	+118.0	+143.7
Los Angeles	+33.9	−30.9	+ 12.2	+ 30.6
Marin	−80.4	−60.2	+ 57.3	+ 40.5
Orange	+32.0	−27.1	+ 83.0	+173.2
Riverside	−15.8	−19.4	+977.0	+793.8
Sacramento	−95.0	−82.8	+ 95.6	+176.6
San Bernardino	−66.1	−62.4	+439.2	+782.9
San Diego	−74.0	−63.5	+ 29.6	+ 57.8
San Francisco	−81.9	−64.4	+ 40.0	+ 43.1
San Mateo	−83.8	−54.5	+ 51.5	+ 29.9
Santa Barbara	−95.7	−82.4	+120.8	+197.4
Santa Clara	−91.1	−70.4	+109.6	+122.2
Total State	−30.0	−52.2	+ 55.3	+ 79.9

*Includes outpatient visits, inpatient days, partial hospital days and residential treatment days.

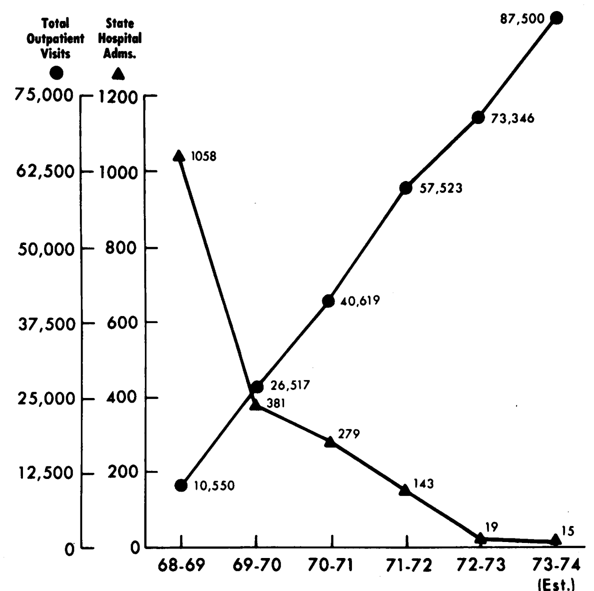

Chart 1.—Admissions to state hospitals and community mental health outpatient visits in Sacramento county.

fornia there has been inadequate attention to this group. They have generally been excluded by families because of long periods spent in hospitals. They are frequently housed in board-and-care homes which may provide food, clothing and shelter, but lack the resources to offer rehabilitation and treatment. Those with chronic illness frequently come to the attention of police, who feel frustrated by an inability to deal effectively with their problems. In such cases the patient may be returned to the state hospital, or kept in the community without adequate treatment.

Sacramento County planned special programs for those with chronic mental illness. In a series of services called Community Alternatives to State Hospitalization (the acronym CASH was created to emphasize the need for funding), the Sacramento program included:

- Comprehensive mental health services in each catchment area (thus identifying the agency responsible for all of the mentally ill).
- Crisis responsiveness including mobile crisis intervention.
- Patient follow-up care system.
- Rehabilitation-resocialization programs.
- Intermediate care facilities.
- Volunteer programs.
- Information-education programs.

The first requirement of a program for treatment of the chronically ill involves a commitment and responsibility to the total population. Sacramento County has a mental health team (50 to 80 staff members) for each of its five catchment areas—each team committed to meet the total mental health needs of its entire catchment area. That system identifies the professional group responsible for treatment of acute and chronic illness in adults and children and for prevention and early identification of illness. Patients who have been treated in a state hospital are discharged after treatment planning with the catchment area team. That team also works closely with a group of professional social workers in the Community Services Section (CSS) of the State Department of Health. These social workers are involved in visting board-and-care homes and families in order to provide continued care and follow-up treatment. Patients, families and board-and-care home operators are all in contact with the catchment area team and the CSS worker.

Crisis intervention has been the priority of the Sacramento County program. Crisis responsiveness means that patients, family members and board-and-care home operators can obtain immediate help from a 24-hour crisis intervention team staffed by mental health professionals. Where appropriate, members of the mobile crisis team will travel to the patient. The catchment area teams provide regular contact with residential-care home operators including consultative visits and mutual treatment planning. Patients are transported to special aftercare clinics operated by the catchment area teams. They are maintained on medication where appropriate. The aftercare program includes individual and group psychotherapy and the availability of any appropriate mental health treatment. When indicated, intensive inpatient, partial day in hospital and outpatient treatment is available.

The patient follow-up care system includes accurate clinical records of all phases of treatment. It allows a mental health team to contact those patients who do not keep appointments. Close contact with the public guardian (the conservator of some patients) and the availability of inpatient crisis treatment with a minimum of red tape insures that such patients can be helped through critical situations promptly.

A rehabilitation-resocialization program operated under contract by the Community Services Section is aimed at rehabilitation of former state hospital patients. Such patients are either transported or taught to take the bus from a board-and-care home to a daytime treatment program. The rehabilitation staff includes social workers, recreational therapists, paraprofessionals and mental health volunteers from the catchment area Volunteer Unit. Three such resocialization-rehabilitation centers work closely with the catchment area teams. Patients are not permitted to sit in front of a television set day after day.

Intermediate levels of 24-hour care have been developed to offer more professional staff and direct treatment than is possible in a board-and-care home. This type of facility is useful for patients who do not require the most intensive (and costly) hospital services, but who require active inpatient treatment. Special contracts have been developed with two "L" facilities which augment the available staff with mental health professionals. This type of intermediate facility allows greater flexibility and community treatment of patients who might otherwise be readmitted to a state hospital.

The use of mental health volunteers is exten-

sive. There is a volunteer program in each of the five catchment areas. Each Volunteer Unit has a half time salaried staff coordinator provided by the Sacramento Area Mental Health Association (under a contract with the County Mental Health Service). The Mental Health Association and staff coordinators recruit and train volunteers, and operate a program which is closely coordinated with the catchment area team. Volunteers make visits to board-and-care homes, participate in the rehabilitation centers and are active in treatment programs at each of the five catchment area mental health centers.

Finally, information-education has a high priority. Public information is a major focus with efforts being directed through the media and personal presentations in service organizations and educational groups. The education of human service professionals and of laypersons are equally important. Special attention is paid to primary care physicians, ministers, probation officers and social agencies of all types. The education program has communicated information about program and resources (as well as results) to the general public and to health professionals.

The Sacramento experience has convinced us that a comprehensive community program can treat chronic patients, as well as those with acute illness. It is this former group which is most likely to require readmission to state hospitals, or to suffer from lack of treatment without special attention. We are aware that the Fresno and Santa Barbara County programs have also developed specialized programs for former state hospital patients. These three county programs are those which have had the largest decrease in state hospital inpatient days and the largest increases in outpatient visits among the community programs. A combination of community mental health programs and special attention to the needs of the chronically ill demonstrate that community programs can minimize the use of state hospitals and still provide quality care to all patients.

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