Mental Health

A Discussion of Various Program Approaches Used in California and the Basic Assumptions Involved

PORTIA BELL HUME, *M.D.*, Berkeley

• **The nation's Number One health problem, mental illness, compels careful reevaluation of past and current methods of attack. It also invites consideration of the ways and means of integrating preventive measures that emphasize the conservation of mental health with prophylactic efforts that stress the avoidance of mental illnesses.**

A review of the development of both local and statewide mental health programs in California reveals that three fundamentally different approaches have been used: (1) The traditional approach which confines itself to the protection of society from the "insane" by the state, and to the treatment of those who are not legally insane through "private enterprise"; (2) the public health approach which seeks to minimize the causes and/or spread of selected types of psychiatric disorder regarded as mass phenomena; and (3) the sociological approach which stresses the importance of social factors both in the causation and in the rehabilitation of those mental conditions that are considered to be symptomatic of a "sick" society.

An approach that combines the theoretical and practical implications of all three viewpoints offers some new solutions to the problems of (1) fitting mental health programs to populations; (2) financing; and (3) balancing preventive and clinical services.

Mental illness is not a single disease-entity but a long list of distinctly different conditions. The causes and manifestations are multiple. Biological, psychological and social components in either mental health or mental illness cannot be dissociated in any attempt to understand and deal with so wide a range of illnesses and states of comparative health. Therefore, many professions and multiple public and private agencies are involved in planning, developing and administering a mental health program.

IN CALIFORNIA as in other parts of the United States, mental illness in all its manifestations constitutes the most serious public health problem. The discussion to follow is based upon experiences in this state, and is prompted by the urgent and unmet needs for preventive, therapeutic and rehabilitative services. For example, during the first quarter of last year, 44 different communities appealed to the Department of Mental Hygiene for help in establishing local mental health services. There were 30 applications for federal grant-in-aid funds totaling $322,887 needed to supplement local public or private funds for such mental health services as outpatient psychiatric departments attached to hospitals, child guidance clinics, psychiatric consultation for schools, mental health institutes, family casework services, mental health programs in health departments, day care programs for mentally retarded, brain-damaged or emotionally disturbed children and a mental health survey of a metropolitan area with a population of five and a half million. Of the 44 communities that sought help to set up local services, 30 had never before requested help or made known their local needs for services. The sizes of these communities ranged from a city of five thousand to a county or area with a population of over five hundred thousand.

One out of 200 of the population of California was in a hospital last year for mental illness or mental retardation, and it is estimated that every fifth family was affected. The state is now spending $5.60 per capita of the population to operate its mental hospitals. Only 1 per cent of the state budget however, is allocated to mental hygiene clinics and other preventive services. Growing public demands, the size and costliness of the problem of mental illness, and increasing knowledge of methods of attack all compel a reevaluation of mental health programs and the basic assumptions involved.

DIFFERENT APPROACHES USED IN CALIFORNIA

The traditional approach in California has meant a public, institutional type of custodial care for patients so greatly retarded or so severely mentally ill they could no longer stay in the community. General hospitals refused to take these patients at any stage of illness, partly because of the high costs of treatment. In northern California, 14 years ago, only one general hospital, a university teaching

Read at the annual meeting of the American Psychiatric Association at Chicago on May 4, 1956.

Deputy Medical Director for Community Services, California State Department of Mental Hygiene.

Submitted May 6, 1956.

hospital, accepted psychiatric patients for treatment. Cost of psychiatric treatment, unlike that for other therapies, is not covered, or is barely covered in a few instances, by prepaid hospital and medical care insurance plans. A survey in 1952 showed that a fourth of Blue Cross and fewer of Blue Shield plans allowed a few days' psychiatric care "in the life of the patient." County hospitals have for the most part served as detention quarters for psychiatric patients until they could be committed; often jails had to perform the service. Even now, only two county hospitals offer psychiatric treatment.

As a result, patients in the acute or earlier stages had no chance for active treatment, and the more hopeless cases jammed the state mental hospitals. Twelve years ago, California's seven mental hospitals had 25,000 resident patients, and the number discharged as recovered or improved was far less than the number of total new admissions. Only 2 per cent of the newly admitted patients were self-committed. The state had no more than six privately supported psychiatric outpatient clinics and only four child guidance centers. There was only one state hospital for the mentally retarded, and it was used for severe cases; patients on the outside had no special training or supervision.

The traditional approach now provides for public mental hospital care of 91 per cent of the mentally ill and retarded in severe or advanced cases, often when improvement is unlikely; but private hospitalization is available for only 9 per cent of such patients, due to the high costs involved, the general unavailability of sickness insurance for psychiatric disorders and the prejudice against psychiatric facilities in general hospitals. There is still consequent widespread neglect of mental illnesses in the earlier, more treatable stages. This approach essentially provides methods of dealing with large aggregations of advanced cases, and it is based on the following assumptions: (1) The state is responsible principally for the care of the "insane" and for the protection of society; (2) there is federal responsibility for the care of service-connected psychiatric disorders in war veterans; and (3) it is the responsibility of "private enterprise" to supply all other mental health services to individual patients.

State and local public health programs have largely focused on preventing certain psychiatric disorders for which definite causes could be found and which lent themselves to mass handling. Inoculation against diseases with brain-damaging sequelae, maternal and child care programs, health education and many other public health measures have reduced the incidence and spread of both congenital and acquired mental illnesses and deficiencies. For the most part, these efforts have not been adopted with the conscious purpose of preventing psychiatric disorders, by either public health officials or the medical profession. The consequent lengthening of life has in fact resulted in an increased incidence of the senile psychoses.

The public health approach comprises prevention of mental illnesses and deficiencies through reduction or elimination of the causes, through intervention in the spread of psychiatric disorders and through measures aimed at increasing the resistance of subjects to mental and emotional hazards. This approach essentially provides methods and techniques applicable to mass phenomena, and it makes the following assumptions: (1) Equality of opportunity for all citizens to enjoy the benefits of preventive services that include the protection of mental health; and (2) the ancient principle of *mens sana in corpore sano.*

In the sociological approach to mental health programs, the individual is emphasized as a member of the family and of larger social groups. Social work, stemming largely from the child guidance movement, first developed casework with children and families. Behavior disorders in children were linked with parental care and with other social situations, including poor economic situations. Social service spread to work with adults whose maladjustments could be ascribed to social and cultural factors. Various kinds of public assistance, job placement and occupational and recreational therapy were among the social means of attack. As a broad result of this experience, many social scientists now advocate a nationwide program of preparation for marriage and family living as the royal road to mental health.

Other sociologists have made ecologic and epidemiologic studies of mental illness and have noted that mental disorders are so distributed within a city that high rates are highly concentrated around the central business district. For example, schizophrenia follows this pattern, whereas manic-depressive rates show much wider scatter. Persons of ethnic or racial minority groups living outside their group have had much higher rates of mental illness than those of the numerically dominant group. Other investigators have found that the lowest socio-economic classes contained a disproportionately large number of serious psychiatric cases, as compared with higher classes; that schizophrenia especially was linked with the lowest class structure; and that the type of psychiatric treatment received is associated with the patient's class position. In the lowest socio-economic groups, physical treatment is sought and obtained for personal malfunctions; in

the higher classes, patients tend to seek and get psychological therapies. These studies, supplementing those of public health workers, point up the distribution and degree of mental illness in a population, along with the social factors in causation and correction.

In California the sociological approach has been valuable. For example, since 1938 the Department of Mental Hygiene's bureaus of social work have increasingly worked with patients on convalescent leave from state hospitals. All types of former state hospital patients may now be placed in licensed private homes for rehabilitation. Since 1945, the family care program has been extended to the mentally retarded. Two information centers, staffed by psychiatric social workers, devote full time to parents' groups and social agencies with special programs for the mentally retarded outside of hospitals. A law passed in 1945 enables mentally retarded children to be trained in public schools, thereby helping to keep these children in the community.

The sociological approach places emphasis upon the individual as a member of society or of the family, and upon the social and cultural determinants of mental illness and health. This approach stresses the importance of social factors both in the causation and in the rehabilitation of psychiatric disorders, which are here regarded as essentially symptomatic of a "sick" society. The sociological approach assumes that: (1) Social and family conditions are not merely the results of individual psychobiological adaptive mechanisms but are, more importantly, prominent as etiologic factors in psychiatric disorders; (2) criteria for healthy and pathological patterns of social organization, and for social action with respect to individual and communal mental health are applicable to the problem of mental illness; and (3) correctional measures, applied to both social conditions and (through education) to individuals, promote mental health.

A combined approach to mental health programming that includes the traditional, public health and sociological viewpoints and principles, has been applied in California and has achieved modest results. By early 1956, the state population had risen to more than 13 million, with the population in some cities and counties having doubled or trebled since World War II. The Department of Mental Hygiene, with its caseload of 56,500 patients under treatment, had 36,500 resident patients in the ten mental hospitals, 8,700 in hospitals for the mentally retarded and 8,300 on convalescent leave, under the supervision of the bureaus of social work. Each of the state's 58 counties had at least one psychiatric social worker assigned to it, with field offices in 18 of the larger cities. The state mental hygiene clinics had over 2,200 patients in treatment at any given time and were seeing over 6,000 patients per year for an annual total of 38,000 treatment hours. By June 30 of 1955, the seven state mental hygiene clinics, of varying ages, had admitted in less than a decade a grand total of 18,400 different patients. These were patients who could not afford psychiatric care on a private basis; indeed, 85 to 90 per cent were financially dependent or in marginal economic circumstances, and most of them were referred by the medical profession. The outpatient departments of the Langley Porter Clinic and other state hospitals bring the total number of outpatients to about 50,000 treated since 1943. The staffs of these state-operated clinics have been steadily increasing the amount of time devoted to work with children and youth. During the past five years, furthermore, about 17 per cent of staff time has been spent in community mental health services, such as consultation to schools and other social agencies, mental health education and community organization.

Despite the shortages of psychiatric personnel in most states, California has managed to recruit a steady increase. The Department of Mental Hygiene now has about 300 psychiatrists and physicians, 100 clinical psychologists, more than 300 psychiatric social workers, over 700 graduate nurses and 6,700 psychiatric technicians.

It is noteworthy that the state has 11 per cent of the membership of the American Psychiatric Association. Most of these psychiatrists, however, serve the metropolitan areas, and most of them confine themselves to private practice and volunteered services.

The 267 privately operated hospitals and sanitoria that are under licensure and minimal supervision by the Department of Mental Hygiene, in 1955 had over 6,000 inpatients. A small but growing number of nonprofit, private, general hospitals treat short-term, acutely ill mental patients in psychiatric units; again, these are mostly located in the larger urban areas.

Several indices point to increased efficiency in the over-all picture. The state mental hospitals now admit 20,000 patients per year, but they discharge patients as recovered or improved so fast that the past fiscal year's increase was only 750 patients. The index of release rate shows that mental patients now have a 25 per cent better chance to leave the hospital than did patients in 1947. Improvement or recovery rates run as high as 85 per cent of discharged patients. All clinic patients are voluntary admissions, and, with the modernization of the state's commitment laws, an increasing number of state hospital patients now enter voluntarily, at a stage of their illness when optimal results can be

expected. However, the main factors accounting for the striking improvement in the release rate are the steadily increasing medical, nursing, rehabilitative, and social services during the past decade. Although the protection of society from the insane remains an important legal responsibility of the State Department of Mental Hygiene, the combined approach shifts the emphasis from custodial care to active, up-to-date treatment and from exclusively intramural services to extramural programs of both a preventive and rehabilitative nature.

The Department of Mental Hygiene has also helped to organize and finance many of the privately supported and administered community clinics. For example, it helped to create the California Association of Community Psychiatric Clinics, whose chief purpose is the reporting of uniform statistics.

There are now 57 community psychiatric clinics in California. Twenty-five are privately supported, sometimes with the aid of Community Chest funds and national mental health funds. Nineteen are operated by state agencies, such as the four maintained by the University of California, four operated jointly by the State Department of Mental Hygiene with local health departments, one established exclusively for parolees of the California Adult Authority, and ten administered by the Department of Mental Hygiene. Nine clinics are operated by counties and four by the Veterans Administration. Of the 57 psychiatric clinics or outpatient departments in California, 26 are attached to hospitals and 19 have received federal grants-in-aid.

In 1951 the State Mental Health Coordinating Committee, advisory to seven state departments (Corrections, Education, Mental Hygiene, Public Health, Recreation, Social Welfare, and Youth Authority), was created for the purpose of integrating and coordinating their mental health programs. The Department of Corrections, for example, has psychiatric personnel to deal with the offender from his conviction, through imprisonment and parole, to his release. The Youth Authority's two reception centers provide psychiatric evaluation as a basis for placement in a special facility. The Department of Education encourages inclusion of mental health in the school curriculum, provides consultation on mental health to educators and fosters increased use of school psychologists and social workers. The Bureau of Vocational Rehabilitation, under the Department of Education, includes psychiatric services for selected, physically or mentally handicapped persons. The Mental Health Unit in the preventive medical services division of the State Department of Public Health offers consultation to local health departments as well as to the rest of the State Department of Public Health. Since recreation and group-work may conserve and improve mental health, the State Recreation Commission encourages programs in hospitals, camps and other institutions; it also helps to create or expand community recreation programs. The State Department of Social Welfare utilizes mental health principles in the course of state-level consultation and supervision of local public assistance programs, foster home care and adoption procedures.

The combined approach considers the individual (ill or healthy) simultaneously as an individual and as a member of a family or larger social group. That is, the approach of psychosocial medicine to diagnosis, treatment and prevention is based upon the following assumptions: (1) Mental illness and health are relative to a hypothetical norm in a bio-psycho-social frame of reference; (2) biological, psychological and social components in either mental health or mental illness cannot be dissociated in considering either the causation and prevention of mental illness or the preservation of mental health; (3) the dynamics of personality are conceived in terms of the individual's continuous interaction with a social reality; and (4) mental illness or health is specifically determined by individual biological and psychological forces, but the social reality, including the psychological environment, may support or hinder the integrative forces within the personality.

GUIDING PRINCIPLES AND PRACTICAL CONSIDERATIONS

If the individual and his personality development cannot be separated from his social reality, the combined approach to a mental health program suggests practical considerations and some guiding principles:

1. Inclusion of both treatment services for individual patients and preventive services for groups of potential patients (for example, protection of the mental health of children and youth);

2. Recognition of multiple causation in both the production and prevention of psychiatric disorders, as well as in the conservation of mental health;

3. Joint responsibility of all levels of government (federal, state and local) for the establishment of mental health services, preventive and therapeutic;

4. Sharing or distribution of the costs of mental health services by those individuals who are directly served (through fees), by the public (through community chests and taxes), and by professional volunteers offering services without cost;

5. Local autonomy in both initiating and administering mental health services whether through local government or on some other basis;

6. Flexibility permitting wide local variations in program, so that each program may fit the special local conditions to the greatest possible extent;

7. Coordination and integration of efforts now scattered throughout different public and private agencies and professions, into a well organized program having mental health as a primary, rather than a merely secondary, goal;

8. Equality of opportunity for all citizens to secure services, both preventive and therapeutic, and to pay for these services according to their financial ability;

9. Recognition of the fact that administrative responsibility and financial responsibility do not necessarily go hand in hand;

10. Acknowledgment that scientific answers will always be incomplete no matter how long action is delayed; therefore, program evaluation and research should be included in programs for mental health services. (For example, the Department of Mental Hygiene, with both professional and financial help from the National Institute of Mental Health, is currently evaluating hospital and clinic treatment in comparable psychiatric cases);

11. Avoidance of false claims and over-selling of programs without minimizing the needs or problems encountered.

2900 Buena Vista Way, Berkeley 8.

For Your Patients—A number of specialists have asked that a slight copy change be made in Message No. 1. This has been done and now Message No. 1A is available as well as Message No. 1.

A Personal Message to YOU:

I consider it both a privilege and a matter of duty to be available in case of an emergency. However, you can understand that there are times when I may not be on call. I might be at a medical meeting outside the city, on a bit of a vacation—or even ill.

Consequently, I thought it would be a good precaution if—on this gummed paper which you can paste in your telephone book or in your medicine cabinet—I listed numbers where I can be reached at all times. Also, the number of a capable associate as an added service. Here they are:

_____	_____	_____
OFFICE	HOME	MY DOCTOR
_____	_____	_____
OFFICE	HOME	ASSOCIATE DOCTOR

Sincerely,

_____, M.D.

MESSAGE NO. 1A. Attractive, postcard-size leaflets printed on gummed paper, you to fill in telephone numbers and your signature. Available in any quantity, at no charge, as another service to CMA members. Please order by Message Number from CMA, PR Department, 450 Sutter, San Francisco.