REPORT

OF THE

SUBCOMMITTEE ON CLINICAL SERVICES FOR ADULTS

Dr. Alex Pokorny, Chairman

Miss Ruth Angelus
George H. Bush
H. Harlan Crank, M.D.
Miss Nina Cullinan
Judge William Elliott
Tom McGown
Marshall Wells

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CHARGE:

Survey needs and problems.

Establish priority for implementation.

PROCEDURE

Early in the study, the Sub-committee on Clinical Services for Adults had decided that there was a need for current measurement of services available for inpatient, outpatient, and supportive care (see Interim Report on Study of Mental Health Services, August 1962). Accordingly, a series of surveys was done through appropriate community organizations. Information on Harris County Hospitals was obtained by a survey, sponsored by the Houston Area Hospital Council, and data was obtained from 100% of member hospitals. Data on other hospitals, the State Hospital System, and the County Psychopathic Ward was obtained by personal communication with appropriate officials. Data from psychiatrists in private practice was obtained by a questionnaire formulated and distributed by the Houston Psychiatric Society. Data concerning private practice of Psychologists was obtained through a similar procedure via the Houston Psychological Association. Social Workers were approached by the National Association of Social Workers, San Jacinto Chapter. Finally, 25 community Social Agencies were approached directly through the Community Council.

HOSPITAL SURVEY

Hospitals with No Regular Psychiatric Beds:

1. Deaton Hospital, Galena Park
2. Gulf Coast Hospital and Clinic
3. Gulfway General
4. Heights Hospital
5. Medical Arts Hospital
6. North Houston Hospital
7. Northshore Hospital
8. Parkview Hospital
9. Pasadena Bayshore Hospital
10. Pasadena General Hospital
11. Riverside General Hospital
12. Rockglen General Hospital
13. Spring Branch Memorial Hospital
14. St. Elizabeth's Hospital
15. San Jacinto Memorial Hospital, Baytown
16. Southern Hospital
17. Southmore Hospital
18. Southmore Hospital
19. St. Luke's Episcopal Hospital
20. Texas Children's Hospital
21. M.D. Anderson Hospital
22. Texas Institute for Rehabilitation and Research
23. Tomball Hospital, Tomball, Texas
24. Red Bluff General Hospital, Pasadena

Hospitals with Designated Psychiatric Beds:

1.	Hedgcroft Hospital	42	
2.	Hermann Hospital	20	
3.	Jefferson Davis Hospital	24	
4.	Memorial Baptist	40	
5.	Methodist Hospital	28	(will be 56, May 1963)
6.	St. Joseph's Hospital	9	
7.	V. A. Hospital	367	
8.	Houston State Psychiatric Institute	42	
9.	Harris County Psychopathic Ward	60	
		632	
10.	Oak Place Hospital	30	
	TOTAL	662	

	Hospital Type	Auspices	Areas Served	Types of Care	Bed Capacity
Hedgecroft	Special	Voluntary	Harris County State Out-of-State	24 Hour Day Hospital	42
Hermann	General	Voluntary	Harris County State Out-of-State	24 Hour Out-Patient Dept.	20
Jefferson Davis	General	Governmental (City-County)	Harris County	24 Hour Out-Patient Dept.	24
Memorial Baptist	General	Voluntary	Harris County State Out-of-State	24 Hour	40
Methodist	General	Voluntary	Harris County State Out-of-State	24 Hour	28
V. A.	General	Governmental (Federal)	Harris County State Out-of-State	24 Hour Day Hospital Night Hospital Out-Patient Dept.	367
H.S.P.I.	Special	Governmental (State)	Harris County State	24 Hour Day Hospital Out-Patient Dept.	42
Harris County Psychopathic Ward	Special	Governmental (County)	Harris County	24 Hour	60
St. Joseph's	General	Voluntary	Harris County State	24 Hour	9
Oak Place	Special	Voluntary	Harris County State	24 Hour	30

	Average Length of Stay	Average Daily Census	Limit on Stay	Cases per Year per Bed (365 - Col. 1)	Estimate Total Cases per Year Col. 2 x Col. 4
Hedgecroft	19 Days	37	90 Days then Review	19	703
Hermann	7 Days	17	NO	52	884
Jeff Davis	23 Days	20	NO	16	320
Memorial	20 Days	36	NO	18	648
Methodist	18 Days	24	90 Days	20	480
V. A.	60 Days	345	NO	6	2070
H.S.P.I.	30 Days	25	NO	12	300
Harris County Psychopathic Ward	10 Days	35	14 Days	36	1260
St. Joseph's	-	-	-	-	-
Oak Place	15 Days	15	-	24	360
TOTAL		554			7767

Corrected Estimate of Individuals Served:
(Disregarding Duplications)

Hedgecroft	90% Harris County	= 633
Hermann	90% Harris County	=796
Jeff Davis	100% Harris County	= 320
Memorial	90% Harris County	= 583
V. A.	50% Harris County	= 1035
Methodist	90% Harris County	= 432
H.S.P.I.	95% Harris County	= 285
County Psychopathic Ward (rest duplicate of Austin State Hospital, Jeff Davis, or V. A.)	10% Discharged Directly	= 126
Austin State Hospital	100% Harris County	= 742
Oak Place	90% Harris County	= 324
		5276

or about 5000 of 1,250,000 or 1 in 250

Number of Discharges From Psychiatric Treatment
Total

	'59	'60	'61
Hedgecroft Hospital	182	667	621
Hermann Hospital	790	620	680
Jefferson Davis Hospital	262	252	256
Memorial Baptist Hospital	-	-	-
Methodist	450	493	504
St. Joseph's Hospital	-	-	-
Veterans Administration Hospital	3028	2922	3537
Houston State Psychiatric Institute	-	-	-
Harris County Psychopathic Ward	-	-	-
Oak Place Hospital	-	-	358
Austin State Hospital (Admissions) (Harris County Patients)	544	777	906

Income and Expense per Patient Day
Expense

	'59	'60	'61
Hedgecroft Hospital	-	30.40	25.82
Hermann Hospital	27.74	29.05	31.20
Jefferson Davis Hospital - In-Patient	24.03	23.71	25.12
Out-Patient	3.14	3.18	3.05
Memorial Baptist Hospital	-	-	-
Methodist Hospital	19.07	18.65	22.20
St. Joseph's Hospital	-	-	-
Veterans Administration Hospital	21.54	22.29	25.31.
Houston State Psychiatric Institute	-	-	-
Harris County Psychopathic Ward	15.20	15.84	16.68

CLINIC SURVEY

SUMMARY OF PSYCHIATRIC CLINIC CASELOADS

1. VA Hospital Mental Hygiene Clinic.

   A. Cases actively under treatment at any one time - average: 130

   B. Different individuals treated during a year: 210

      In addition to the above veterans, the Clinic treats occasional relatives when this contributes to the treatment of the veteran.

   C. Relatives under treatment at any one time: 10

   D. Different individuals among relatives treated in the course of an average year: 25

      The V.A. Mental Hygiene Clinci treats veterans from outside the county. Generally about 75% of the patients are from this county. Applying this to the two groups above would yield the following for Harris County residents:

   E. Veterans plus relatives under treatment at any one time: 105

   F. Different individuals treated during a year: 176

II. Houston State Psychiatric Institute, Adult Outpatient Clinic.

   A. No. of patients currently under treatment: 127

   B. No. of different individuals seen from September 1, 1962 through June 12, 1963: 318

      Since this is approximately a 10 month period, if this were extrapolated to 12 months, it would mean 382 different individuals.

III. Hermann Hospital.

   A. During calendar year 1962 the free and part-pay psychiatric clinic of Hermann Hospital saw 98 new cases or referrals to the Clinic.

   B. During the year these 98 cases made 362 separate visits to the Clinic.

SUMMARY OF PSYCHIATRIC CLINIC CASELOADS
(Continued)

IV. Jefferson Davis-Ben Taub Hospital

A. Active cases on books of Jefferson Davis Hospital January 1, 1962 totalled 1,556, of which approximately 32 were children (o through 17 years of age) and 1,524 were adults (18 years and over).

B. During calendar year 1962 the Clinic opened 21 different children's cases and 637 adult cases (new).

C. Therefore the total number of individuals treated during the year was as follows:

53 children
2161 adults

D. The active caseload on December 31, 1962 was 31 children and 1724 adults.

E. The active caseload at Ben Taub Hospital Psychiatric Out-patient Clinci on June 13, 1963 was 35 children and 1,973 adults.

RESULTS OF PSYCHIATRIST QUESTIONNAIRE

QUESTIONNAIRE
HOUSTON PSYCHIATRIC SOCIETY

(44 Returns of 60 mailed)
(4 not in prectice)
(40 valid returns - so n = 40)
(Zeros not listed here)

1. Approximately how many different individuals do you see during the Year?

total = 6206 (40 respond, 40 positive answers)

mean = 155

range = 20 to 500

median = 125

* Extrapolation: 6206 x 1.4 = 8688 individuals seen

(a) For treatment:

Total----------4435 (40 respond, 39 positive answers)
Mean, all 40---------- 111
Mean, Positive answers------ 114
Range---------- 5 to 500
Median, all 40---------- 70
Median, positive answers---- 71

* Extrapolation: 4435 x 1.4 = 6209 individuals seen

(b) For diagnosis and opinion:

Total----------1446
Mean, all 40---------- 36
Mean, positive answers------ 39
Range---------- 4 to 200
Median, all 40---------- 25
Median, positive answers---- 30

* Extrapolation: 1446 x 1.4 = 2024 individuals seen

* Extrapolation: 56 known to be in private parctice
40 replies
Assuming that caseload of 16 non-responders is similar to 40 responders, we would need to multiply all absolute figures by factor of 56/40, or 1.4 to get an estimate of the treatment capacity of the community's psychiatrists.

QUESTIONNAIRE - HOUSTON PSYCHIATRIC SOCIETY

(c) For other purposes:

Total - - - - - - - - - - - - 279 (40 respond, 11 positive answers)
Mean, all 40 - - - - - - - - 7
Mean, positive answers - - 25
Range - - - - - - - - - - - - 3 to 50
Median, all 40 - - - - - - - - 0
Median, positive answers - - 17

* Extrapolation: 279 x 1.4 = individuals seen

3. Do you have a waiting list?

Yes 17

No 23

How long is waiting list?

Few days: 3

1 to 2 weeks: 12

2 to 6 weeks: 5

4. (a) Do you frequently see patients who are unable to pay for recommended treatment? Estimate per year:

Yes (36 doctors)

* Extrapolation: 1161 x 1.4 = 1625

No (4 doctors)

Mean = 29 per doctor

(b) If some means of financing were available, could you take on some of these cases in addition to your present patient load?

Yes 22

No 16

(1) No, I prefer to see only those who themselves are able to pay. I hate the filling out of forms and reports that intermediary organizations usually require.

(2) No, but on an equal basis with other new patients.

(3) Occasionally, but the biggest obstacle is lack of time and not limited finances. However, it might improve referral chances to other resources.

QUESTIONNAIRE - HOUSTON PSYCHIATRIC SOCIETY

5. Estimate the number of individuals in the following age groups you see during an average year:

   (a) Under 18 years:

   Mean per doctor = 23

   (b) Between 18 and 65 years:

   Mean per doctor = 116

   (c) Over 65 years:

   Mean per doctor = 9

   * Extrapolation: 354 x 1.4 = 496

RESULTS OF PSYCHOLOGIST QUESTIONNAIRE

QUESTIONNAIRE
HOUSTON PSYCHOLOGICAL SOCIETY

(29 returns of 88 mailed.
Total number in private
practice unknown).

1. Approximately how many different individuals do you see during the year?

   (a) For treatment (12 in practice only):

   (3 omitted any absolute figures, age percentages only)

   Of 9 positive responders, average of 28 patients per year.

   (b) For diagnosis and opinion only:

   Of 10 positive responders, average = 151

2. Do you have a waiting list?

   How long do patients have to wait?

   0 to 3 weeks

3. Do you frequently see patients who are unable to afford the recommended treatment? Estimate number per year:

   Average of 17 = 15 cases per year

   If some means of financing therapy were available, could you take on some of these cases in addition to your present patient load?

   Yes 2

   Maybe 1

   No 4

4. Estimate the number of individuals in the following groups you see during an average year:

   (a) Under 18 years:

   Total 661. Average of 9 = 73 per year.

   (b) Between 18 and 65 years:

   Total 1509. Average of 11 = 137 per year.

   (c) Over 65:

   Total = 86. Average of 12 = 7 per year.

SURVEY OF SOCIAL AGENCIES

25 contacted, 18 returns

1. How many cases are being served by your agency that have recognizable emotional or mental implications?

   This question was interpreted in various ways, and evidently the wording was unclear. Many agencies stated that all of their cases fall into this category, and several said the majority. Those agencies which interpreted the question more as meaning having a recognizable psychiatric illness listed the following numbers:

   Total =898

   Average (of 10 responding) = 90

2. How many cases has your agency referred to a psychiatric agency or psychiatrist?

   Total = 1306

   Average (of 17 responding) = 77

3. How many cases having psychiatric implications did your agency wish to refer, but found no resources available?

   Total of 11 responders = 741

   Average = 67

RECOMMENDATIONS

Major unmet needs in community, as seen by reporting hospitals:

** 1. Part-pay clinic, low-fee clinics.

2. In-patient facilities for children.

** 3. Long-term facilities for aged, retarded, alcoholic.

4. Geriatric facilities

5. More general hospital psychiatric beds

** 6. An adequate county psychopathic ward

7. Rehabilitation, convalescent facilities to follow-up acute hospital care.

** 8. Better after-care facilities, including facilities for maintenance drug therapy.

** 9. Broadening and extension of vocational rehabilitation services, sheltered workshops, etc., to include psychiatric cases.

** 10. Community sponsored halfway house.

11. Better coordination of community mental services.

12. Setting up of a model community mental health unit.

13. Acute intensive treatment center, part of state hospital system, located in county.

14. Psychiatric home services.

Major Unmet Needs as Seen By Psychiatrists:

***** 1. In-patient facilities for children and adolescents.

** 2. After-care facilities, for patients returning from state hospital.

3. Better facilities, including hospital-type staffing, for county detention ward.

4. A good private out-patient clinic.

5. A psychiatric clinic for indigents, with capacity to handle emergencies.

6. Psychiatric consultation services to Probation Dept.

7. An integrated council of all mental health services.

8. Supervisory and consultation structure for Houston's family doctors.

9. More first class hospital beds, to eliminate waiting lists.

10. Better trained nurses (psychiatrically) in general hospitals.

11. Low cost out-patient psychotherapy.

Major unmet needs as seen by Psychologists:

1. More concentration on prevention, better education and patterning during growth years.
2. Better in-patient facilities to serve the Negro population.
3. Focus on social causes of maladjustments.
4. Human relations training, training schools for marriage, child rearing practices, etc.
5. More low-cost psychiatric service, especially for adults, preferably in the evening.
6. Establishing or altering some community facility so that psychologists might volunteer services (as physicians do in clinics).
7. Treatment facilities for children, in-patient and out-patient.

Major Unmet Needs As Seen By Social Agencies:

1. Facilities for prompt psychiatric examination, as needed by social agencies.
2. Elimination of need to go through another medical doctor in order to consult psychiatrist.
** 3. Fill in the large gap, between the facilities available to indigent, and more available to the well-to-do.
4. Provide more services, especially for children, to eliminate deplorably long waiting-lists.
5. Greatly expanded out-patient psychiatric facilities.
6. Part-pay clinics.
7. In and out-patient care for alcoholics, both public and private.
8. Evening clinics for adults who have little money.
** 9. In-patient facilities for children.
10. Organized proper follow-up of released state hospital patients.
11. More and better nursing homes for senile patients.
12. More emphasis on prevention.

Sub-committee's Own List Of Unmet Needs:

1. Better county detention ward, or replacement of this with a receiving hospital.

2. Location of a state hospital or state acute intensive treatment unit in Houston or nearby.

3. Better coordination all around, including state hospital, detention ward, follow-up clinics,pre-admission service, etc.

4. Some mechanism to finance all or part of cost of care for those unable to meet full cost.

5. The need in #4 might be partly met by organization of some late afternoon or evening clinic or mental health center to which appropriate professionals might donate time.

6. Broadening of hospital and health insurance plans to cover all short-term psychiatric care.

COMMUNITY COUNCIL

CITIZEN PLANNING FOR BETTER COMMUNITY LIVING

1209½ CAPITOL AVENUE ☐ HOUSTON 2, TEXAS ☐ CApitol 4-1701

August 15, 1962

MEMORANDUM

TO: Members of the Mental Health Services Steering Committee

FROM: Mrs. I. H. Kempner, Jr., Chairman

Enclosed are reports from five subcommittees for your review in preparation for the meeting on:

Friday, July 17, 1962
12 Noon

YWCA -- 1320 Rusk
Luncheon $1.65

The report from the sixth study committee, Preventive Services for Adults, will be available at the Friday meeting.

We look forward to seeing you.

MK:sam

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MINUTES

MENTAL HEALTH SERVICES STUDY
CLINICAL SERVICES FOR ADULTS
HEALTH SECTION

THURSDAY, JULY 12, 1962
11:45 A.M.
YWCA

PRESENT

Dr. Alex Pokorny, Chairman
Miss Ruth Angelus
Marshall Wells

ABSENT

George Bush
Dr. Harlan Crank
Miss Nina Cullinan
Judge William Elliott
Tom McGown

STAFF

Mrs. Helen J. Lewis, ACSW, Community Planning Associate

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There was general agreement that it would be advisable to proceed with a measurement of the kind and quantity of clinical services available for adults in this community. Since this is traditionally the most formalized kind of care for emotionally disturbed and mentally ill adults, the study should proceed to examine what already exists. It should then determine whether or not more of the same kinds of services are needed, and if so, how much, and whether or not some different kinds of services or different arrangements of the kinds of service are needed. For these reasons, one of the first recommendations from this committee would be to proceed with the questionnaire to hospitals in order to measure the extent of service to mental patients available in the general hospitals in Harris County. It was considered advisable to request the Area Hospital Council to conduct this survey in cooperation with representatives from the Mental Health Services Study Steering Committee. It was recognized that the results of such a survey would be useful, not only in the Mental Health Services Study but also to the boards and administrators of general hospitals, as they planned for the kinds of services to be provided to patients in this community. Dr. Pokorny would review the hospital questionnaire to determine possible revisions, and would consult unofficially with Dr. Cady about the approach to the Area Hospital Council.

Another area needing survey would be the extent of service being provided by psychiatrists in private practice. There was consensus that the Psychiatric Society, as a professional group, should be requested to develop this survey. Such a survey should define the kinds of care, the number of patients being served or the extent of service, the determination of waiting lists, if any, estimates of need for care, and some information on the problems occurring in the provision of care, such as finances, etc.

A similar survey of private care should be made by the Psychological Society and by social workers in private practice.

The amount and kinds of out-patient clinic service through agencies should likewise be surveyed.

There was also a need to clear with the professional staff at the psychopathic ward in order to determine the needs recognized in that service. It was proposed that representatives of this committee meet with representatives of the Psychopathic Ward staff in order to explore the kinds of services and the extent of need for services for the patients who come to the attention of this facility.

One of the key problems in the treatment and care of adult patients was the financing of care. There was a need to examine carefully the extent of care needed for patients who were unable to pay for services. It may be advisable to make a special study of this need and to explore possible ways of financing such care. This should also include some examination of the affect of lack of financing on the choice of state hospital as a resource for treatment. Again there was the impression that patients were being committed to the state hospital, who might better be treated through some other type of facility. This would relate to the suggestion of the Subcommittee on Services for the Aging, proposing a casework service to do pre-commitment studies. There was a need to examine who enters the state hospital and why these patients are admitted. This subcommittee would propose that the recommendation for pre-commitment studies be extended to all patients and hopefully to patients who were requesting voluntary commitment.

It was decided that the subcommittee would have one more meeting prior to the preparation of a preliminary report for the steering committee in mid-August.

Respectfully submitted,

(Mrs.) Helen J. Lewis, ACSW
Community Planning Associate

HJL:sm

REPORT

TO: Mental Health Services Steering Committee

FROM: Subcommittee on Preventive Services for Children

DATE: July 16, 1962

NEEDS

1. There is a need for the identification of childrens' problems and need for special help at the earliest possible opportunity.

2. There is a need to educate and orient both professional personnel and parents and family members to detect childrens' problems and to be aware of community resources for needed services.

3. There is a need to have services for childrens' problems and families' problems made more easily accessible. If difficulties could be detected early and services could be promptly accessible, many situations could be handled with a minimum of service before problems become aggravated into chronic situations.

4. There is a need to develop resources such as neighborhood agency workers, teachers, ministers, and the like to be accessible to families who need help.

5. There is a need for coordination of resources providing services for childrens' problems.

DISCUSSION OF NEEDS

Attached please see the outline for detection of mental illness and emotional disturbances in children.

SUGGESTIONS FOR ACTION

The Community Council should commend, encourage, and promote community support for the public school districts in Harris County which are conducting programs for screening and detecting childrens' problems at the beginning of school and during the early grades. This subcommittee endorses the allocation of staff personnel to the detection and servicing of problems at the kindergarten and elementary grade level.

It is hoped that the Survey of Special Education Services will indicate specific action to carry out this recommendation.

Agencies serving children and their families should consider the development of procedures which will make their services more accessible to individuals and families at the point of immediate need. For example, the walk-in psychiatric clinic in New York City claims to have demonstrated success with less treatment when problems are reached before they become chronic and fixed. Some agencies have experimented with assigning their most skilled personnel to in-take service in order to make their services more immediately accessible.

Programs for parent education on family life, child development, and parent-child relationships should be organized and provided by appropriate agencies to fit the needs of the several cultural groups of various socio-economic levels.

Agencies providing education in the field of mental health, such as the Mental Health Association, family agencies, and professional education institutions, should develop programs for training and orienting people in the various professional disciplines to the detection of mental illness and emotional disturbance, and to available resources for service.

Further consideration should be given to the tools of coordination such as a juvenile index, a school child's comprehensive permanent record, a centralized medical record, etc.

DETECTION OF MENTAL ILLNESS AND EMOTIONAL DISTURBANCES IN CHILDREN

EARLY IDENTIFICATION OF CHILDREN'S PROBLEMS AND NEEDS FOR SPECIAL HELP

Screening points:

1. at birth and periodically through first 5 years, for indications of physical and neurological disabilities, and impairments in growth and development;

2. admission to school, for school readiness and any indications of impairment of learning capacity and emotional development;

3. periodically during school years, for frustrations due to learning difficulties such as reading disability, lack of achievement up to capacity, emotional disturbance, etc.;

4. adolescence, for learning frustrations, emotional disturbances and any inappropriateness or inadequacy in vocational aspiration.

EDUCATION AND ORIENTATION OF PEOPLE TO DETECT PROBLEMS

1. professional personnel:

   all practitioners in the helping professions should be oriented to mental illness and emotional disturbances, and to procedures of referral to appropriate resources;

there should be more professional personnel trained in methods of detection;

there should be more research in methods of detection.

2. parents and family members:

there is a need for education of young people to prepare for marriage;

programs for parent education on family life, child development, and parent-child relationships should be organized and provided to fit the needs of the several cultural groups of various socio-economic levels.

SOCIAL INSTITUTIONS FOR DETECTION

1. the family
2. regular examinations and conferences with a pediatrician or family physican
3. well-child conferences
4. nursery schools
5. day care services
6. Sunday schools
7. pre-school screening program
8. schools' continuing general testing and screening programs and special guidance and counselling services
9. neighborhood centers and other group work services.

REPORT

TO: Mental Health Services Steering Committee

FROM: Subcommittee on Clinical Services for Children

DATE: July 5, 1962

NEEDS

There is a need to measure diagnostic and treatment services in relation to the need for these services, and to make them more accessible.

More professional counseling services are needed in schools.

There is a need for more professional diagnostic services for delinquent and neglected children.

A Half Way House for adolescents discharged from mental hospitals is needed.

A Residential Treatment Center is a well documented need and there is a need for in-patient care services for children.

DISCUSSION OF NEEDS

1. Diagnostic and treatment services are currently available at:

   a. Child Guidance Center, where there is a screened waiting list;
   b. Houston State Psychiatric Institute, information is needed re extent of service and waiting list;
   c. private practice, needs measurement;
   d. Jefferson Davis Hospital, needs measurement;
   e. Texas Children's Hospital, Junior League Clinic, concerned primarily with the emotional implications of illness;
   f. Lighthouse for the Blind, Children's Division, blind children only.

2. Services should be more accessible to children and their families. Early attention to a child's difficulty, or a family disturbance about a child, will often preclude the development of a chronic problem that is less amenable to treatment and, therefore, requires more resources to correct it. Unless some arrangements can be made for early case finding and access to service, acute cases stay on waiting lists until they become chronic and more time-consuming to treat.

3. The need for more professional diagnostic services in the Probation Department for delinquent and neglected children requires further study. This study should include the kinds of services needed, the extent of service and the best possible use of such diagnostic services.

4. Services for in-patient care for psychotic children are still considered inadequate. It is hoped that there will be a 30 bed unit at the Galveston Branch of the Medical School in 1963. We understand that the 50 bed unit at Austin State Hospital for care for children is currently being used for other kinds of service.

SUGGESTIONS FOR ACTION

1. The diagnostic and treatment services currently available should be measured in relation to the need for these services, and procedures should be developed to make these services accessible as nearly at the point of need as possible.

2. As the Guidance Center shifts emphasis to care of acute cases, a study should be made of the needs and resources for suitable care to chronic cases. For example, once such a case has been diagnosed and the treatment potential has been evaluated, the resources for required treatment should be structured in the most economical and effective way.

3. The need for diagnostic services at Probation Department should be evaluated.

4. Group therapy services for parents should be developed and studied further by the Child Guidance Center and family counseling agencies.

5. The Pediatric Society of the County Medical Society should be approached to consider the development of some orientation for their members to mental health resources and referral procedures.

REPORT

To: Mental Health Services Steering Committee

From: Sub Committee on Clinical Services for Adults

Date: August 9, 1962

NEEDS

There is need for current measurement of services available for in-patient, out-patient, and supportive care, in order to project additional services, new services, and potential changes in services.

DISCUSSION

There was general agreement that it would be advisable to proceed with a measurement of the kind and quantity of clinical services available for adults in this community. Since this is traditionally the most formalized kind of care for emotionally disturbed and mentally ill adults, the study should proceed to examine what already exists. It should then determine whether or not more of the same kinds of services are needed, and if so, how much, and whether or not some different kinds of services or different arrangements of the kinds of service are needed. For these reasons, one of the first recommendations from this committee would be to proceed with the questionnaire to hospitals in order to measure the extent of service to mental patients available in the general hospitals in Harris County. It was considered advisable to request the Area Hospital Council to conduct this survey in cooperation with representatives from the Mental Health Services Study Steering Committee. It was recognized that the results of such a survey would be useful, not only in the Mental Health Services Study but also to the boards and administrators of general hospitals, as they planned for the kinds of services to be provided to patients in this community. Dr. Pokorny would review the hospital questionnaire to determine possible revisions, and would consult unofficially with Dr. Cady about the approach to the Area Hospital Council.

Another area needing survey would be the extent of service being provided by psychiatrists in private practice. There was consensus that the Psychiatric Society, as a professional group, should be requested to develop this survey. Such a survey should define the kinds of care, the number of patients being served or the extent of service, the determination of waiting lists, if any, estimates of need for care, and some information on the problems occurring in the provision of care, such as finances, etc.

A similar survey of private care should be made by the Psychological Society and by social workers in private practice.

The amount and kinds of out-patient clinic service through agencies should likewise be surveyed.

SUGGESTIONS FOR ACTION

1. Request that the Area Hospital Council sponsor and/or conduct, in cooperation with representatives of the Mental Health Services Study Committee, a survey

of clinical psychiatric services for adults - and children - provided through general hospital facilities. A proposed schedule of data desired is attached to this report.

2. Request that the Psychiatric Society conduct a survey of private care services to secure information on the kinds of care, the number of patients being served or the extent of service, waiting lists, estimates of need for care, and problems occurring in the provision of care, such as inability to pay cost of care, need for ancillary and supportive services, etc.

3. Request that the Psychological Society and Social Workers in private practice conduct similar surveys, and that these be related through the liaison committee of these three professional societies.

4. Conduct a survey of clinical and supportive services provided through agency resources.

5. Secure statistical data regarding services to Harris County patients and opinion about problems in providing care in Harris County, from the appropriate division of the Board for State Hospitals and Special Schools. The data requested should relate to the survey of general hospital services, covering the years 1959, 1960 and 1961 and providing information on such items as the number of Harris County patients admitted and discharged per month, the readmission rate, description of patients, diagnostic categories, average length of stay, and financial arrangements. Opinion is desired on special problems noted, and information is needed about facilities and services that the Board is planning to offer to Harris County in the near future.

6. Secure opinion on problems of patient care observed by staff of the Mental Health Division of the Texas Board of Health, and information about facilities and services that the Department is planning to offer and/or develop in Harris County in the near future.

NEED

There is a need to provide care for patients who cannot pay full cost of care.

DISCUSSION

One of the key problems in the treatment and care of adult patients was the financing of care. There was a need to examine carefully the extent of care needed for patients who were unable to pay for services. It may be advisable to make a special study of this need and to explore possible ways of financing such care.

SUGGESTIONS FOR ACTION

Arrangements for financing care should be considered throughout all other surveys; and later if indicated, this problem may receive specific attention in order to develop procedures and resources for financing services.

NEED

There is a need for clarification of appropriate use of State Hospital and other treatment resources.

DISCUSSION

There is an impression that lack of finances may affect the choice of treatment facility. Again there was the impression that patients were being committed to the state hospital, who might better be treated through some other type of facility. This would relate to the suggestion of the Subcommittee on Services for the Aging, proposing a casework service to do pre-commitment studies. There was a need to examine who enters the state hospital and why these patients are admitted.

SUGGESTIONS FOR ACTION

This Subcommittee concurs with the suggestion of the Subcommittee on Mental Health Services for the Aged, that casework service be offered to the Harris County Judge to perform pre-commitment studies on patients over 65. This Subcommittee recommends that casework service be developed to provide this service not only to the aged but to all patients being committed and to all patients applying for voluntary admission from Harris County. These studies are to be directed to the same purposes and for the same uses as are spelled out in the suggestion of the Subcommittee on the Aged.

NEED

There is a need to improve the service now used by Harris County for receiving and detaining patients pending commitment to State Hospital.

DISCUSSION OF NEED

There was a need to clear with the professional staff at the psychopathic ward in order to determine the needs recognized in that service. It was proposed that representatives of this committee meet with representatives of the Psychopathic Ward staff in order to explore the kinds of services and the extent of need for services for the patients who come to the attention of this facility.

SUGGESTION FOR ACTION

This Subcommittee should review and consider the recommendations made by the Mental Health Association in regard to the Harris County Psychopathic Ward.

DATE: _____

TO: _____

_____

_____

HOSPITAL FACILITIES FOR PSYCHIATRIC TREATMENT

FOR PATIENTS IN HARRIS COUNTY

I. A. TYPE OF FACILITY

Type of Facility	Auspices		
	Governmental	Voluntary	Proprietary
General Hospital			
Special Hospital			
Other, Please Specify			

B. GEOGRAPHIC AREAS SERVED:

Harris County	
State	
Out of State	

II. A. TYPES OF CARE AND LENGTH OF STAY

Types of Care	Yes	No	Average Length of Stay
24 Hour Care			
Day Hospital Care			
Night Hospital Care			
Out-Patient Clinic Care			

B. Do you have a limit on length of stay? NO____ YES ____

If YES, how long? _____

III. A. NUMBER OF PSYCHIATRIC BEDS BY TYPE

Type of Beds	Number of Beds		
	1959	1960	1961
Locked Unit			
Separate but Open Unit			
Other			

B. ESTIMATED PERCENTAGE OF OCCUPANCY

	Percentage		
	1959	1960	1961
Estimated Average Percentage of Occupancy of Psychiatric Beds			

IV. NUMBER OF DISCHARGES FROM PSYCHIATRIC TREATMENT

Diagnosis	Number Discharged		
	1959	1960	1961
With Psychiatric Diagnosis Primary			
With Psychiatric Diagnosis Secondary			

V. DESCRIPTION OF PATIENTS

A. AGE OF PATIENTS GIVEN PSYCHIATRIC TREATMENT

	Pediatric (Under 12)	Youth (12-20)	Adult (21-65)	Aged (65+)
1959				
1960				
1961				

B. RACE AND SEX OF PATIENTS

	Anglo-American		Latin American		Negro		Other	
	M	F	M	F	M	F	M	F
1959								
1960								
1961								

VI. Do you usually have a waiting list?

YES _____ NO _____

If YES, how many on it on the average? _____

VII . COST OF PSYCHIATRIC CARE

A. TOTAL BUDGET FOR PSYCHIATRIC SERVICE

	1959	1960	1961
Budget			

B. SOURCES OF FUNDS BY PERCENT OF TOTAL BUDGET FOR PSYCHIATRIC SERVICES

Sources of Funds	Amounts Spent for Psychiatric Services		
	1959	1960	1961
Fees			
Individual			
Insurance			
Taxes			
Federal			
State			
Local			
Voluntary Funds, Grants and Contributions			
Others, Please Specify			

C. INCOME AND EXPENSE PER PATIENT DAY
(Please indicate if this includes amortization and depreciation.)

	1959	1960	1961
Expense per Patient Day			
Fee Income per Patient Day			

VIII. A. Do the people whom you serve need more or less of this service? If so how much?

B. What do you base this estimate on?

C. What are the major unmet needs for psychiatric service in our community as observed by the staff and board of your facility?

D. What are the plans of your facility for extending and/or changing services to meet what kind and amount of needs during 1963?

during the next five years?

in the indefinite future?

E. How do you propose that these future services be financed?

REPORT

TO: Mental Health Services Steering Committee

FROM: Subcommittee on After Care Services

DATE: July 17, 1962

NEEDS

In general, the services recognized as needed to provide after care services for state hospital patients were the following:

1. out-patient, comprehensive, supportive, medical care, including psychiatric care, any other medical care required, medication, medical social work services, and any other ancillary services required to provide comprehensive medical care;

2. half-way house;

3. foster care;

4. sheltered workshop;

5. vocational services.

DISCUSSION OF NEEDS

It would be very difficult to estimate the amount of such services needed without some specific exploration. The only thing available at present is an estimate of an average of 120 patients per month discharged from state hospital to Harris County based on information from state hospital reports. There is also the question of services for patients discharged from other facilities.

Concern about ways of measuring the extent of need led to the proposal of the following project.

SUGGESTION FOR ACTION

A social work service should be established to receive every Harris County patient discharged from in-patient care. The purpose of this service would be two fold:

1. to contact all returning patients and their families in order to determine whether or not these patients or families needed any services; and if so, to assist them to use appropriate community services and resources;

2. to measure the kinds and amounts of services needed, and the resources available to provide these services for returning patients in Harris County.

This project should be staffed by a well-qualified social worker and secretarial staff. Such a project could be sponsored by the Mental Health Association, by the state service at Houston State Psychiatric Institute, or through the public health departments.

Such a liaison service between hospital and community for the coordination of service to patients should be related to the proposal for casework service to provide pre-admission studies. While this demonstration and evaluation of a liaison service may be structured as a specific project for the evaluation period, it will be needed as an integral part of continuing casework service for patients and their families.

As an outgrowth of aspect 2. of the above proposal, that is to measure the kinds and amounts of services needed and the resources available for these services, such a measurement would provide direction for the development of the other services listed as needed.

REPORT

TO: Mental Health Services Steering Committee

FROM: Subcommittee on Services for the Aged

DATE: August 8, 1962

NEEDS

Need for clarification of kind of treatment best suited for each senile aged patient.

Need to make more accurate use of such treatment resources as state hospital services, nursing home facilities, general hospital care, and out-patient clinic care.

Need to clarify relative and family responsibilities for care of each senile aged patient.

Need to provide for release from state hospital care of some senile aged patients who can be cared for more appropriately in local facilities or in their own homes.

DISCUSSION OF NEEDS

It was recognized that some patients are committed to State Hospital for care because of financial need, because family members do not understand about other resources for care, because there may not be clarification of the kind of service needed, or because appropriate treatment facilities are not available or accessible.

It was also recognized that senile patients could be more appropriately cared for in local facilities, nearer to family and home ties, if suitable medical and supportive services were available.

It was recognized that there was confusion in the interpretation of what was meant by a senile aged patient and what was meant by a mentally ill aged patient. The specific diagnostic terms were recognized as not being helpful in this instance. What was needed was a descriptive diagnosis including a description of behavior so that determination could be made about the kind of care and protection that such patients needed.

Dr. Gaitz described the information sought by the state hospital study of senile patients, and pointed out that this led to the need for information about why these patients were committed to the state hospital rather than placed in protective care in their own local community. It would be difficult to secure information on patients who had been committed in the past. It would be more helpful to secure such data at the time of commitment. It was recognized that casework services to assist with planning care for disturbed patients, as illustrated in the casework service at Jewish Home for the Aged are needed. This service was needed at St. Anthony's Home, Eliza Johnson Home and in the many proprietary nursing homes throughout the community. If

homes such as St. Anthony's Home and the Eliza Johnson Home did have casework service, either by staff or by purchase of service, it might be possible to use their facilities for temporary care and placement of some patients with acute conditions, and thereby preclude commitment to state hospital. These services were particularly needed to keep close relationship between the patient and his family and to help the family for the patient's return to the home.

SUGGESTIONS FOR ACTION

1. Descriptive Diagnosis for Senile Aged Patients

With the assistance of Dr. Gaitz, representatives of the Nursing Home Operators Association, and the Community Council Research Bureau, the Division of Chronic Disease Control of the Houston Health Department has offered to develop a questionnaire that will describe the behavior and condition of senile patients so that a descriptive diagnosis of patients in nursing homes can be secured in a sampling survey. This should be developed and used in arranging for nursing home care for senile aged patients.

2. Precommitment Study

It is proposed that casework service be offered to the Harris County Judge to perform a precommitment study on the patients over 65 for whom application for commitment to state hospital was made. Mrs. Ellington, of Sheltering Arms offered to provide casework service to do these precommitment studies as a demonstration in order to determine the service needed by the Judge's office in processing these applications and the service needed by these aged people in order to provide the most appropriate service for their care.

Sheltering Arms had had some experience in providing social work service to patients and their families in relation to commitment, hospital care and return to family. It was agreed that such a study should cover the following areas:

1. the physical and mental status of the patient, involving a determination of whether or not appropriate medical care facilities are available for this patient in the community;

2. total family situation and its affect upon planning for treatment and care for the patient;

3. determination of all possible alternatives for care of the patient, for example, the patient may have an acute condition, which could be cleared up in a matter of a few days or a few weeks of hospitalization, and where the best possible plan for such a patient would be temporary care in a general hospital or specialized nursing home, so that this patient would not have to be separated from his family and resources;

4. financial situation, and how this relates to the patient's need for commitment, to the possibility of the patient remaining in the community, and to the services needed by the patient for treatment and supportive care upon his return.

A careful precommitment study would help to clarify the responsibility of the family for the patient, and would help the family understand these responsibilities. Such a study would be useful not only to the patient, his family and his physician, but to the County Judge, in his considerations of the need for commitment, and to the hospital admissions service if a patient is committed.

It was agreed that Sheltering Arms would proceed directly to offer this service and to carry out a demonstration procedure on a sampling of cases, as soon as it was possible to complete arrangements. This particular service did not need to wait for approval or recommendations from the Mental Health Services Study Committee. Actually it was a service to be offered to the County Judge's office by a community agency as a demonstration. The Mental Health Services Study Committee would be interested in results.

3. After Care Supportive Services

This Subcommittee concurs with the suggestion of the Subcommittee on After Care Services that casework service project be developed to determine and provide for the supportive services needed by discharged patients and their families.

Dr. Jensen noted the similarity between this project and the various ways in which such a followup service had been established in public health departments in other metropolitan areas. This led to discussion of whether or not such a project should be sponsored and conducted by a voluntary agency or might better be placed in a public health service, appropriately staffed by a casework consultant and public health nurses. The pattern for this kind of service has already been set by the Public Health Department being responsible for following up on tuberculous patients after discharge from state hospital.

NEEDS

Need for medical care by patients in nursing homes.
Need for medical care by homebound patients.

DISCUSSION OF NEEDS

These needs occur particularly after intensive hospital care, when patients need supportive services and medical care services for rehabilitation.

Under the current structure of the Vendor Payment plan, there are no medical or nursing care services, medications, or services of ancillary disciplines, such as physical therapy, occupational therapy, etc., available to patients in their own homes.

Similarly, there are some problems of securing physician care and medication for patients in nursing homes.

Another problem occurs when, under the present structure of the plan, a premium is placed on keeping patients bedfast, because bedfast patients are classified as III, and nursing homes receive the highest payment, $255, for bedfast patients. Actually nursing homes will have to operate a more expensive program in order to activate their patients needing rehabilitation services by putting in additional staff such as physical therapists and nurses skilled in providing training in activities of daily living. However, when they are successful in activating such patients, the fee to the nursing home is then reduced to class II and class I which pay $191 and $155 respectively.

Type Care	Maximum Vendor Payment		Exempted Relative Contribution	TOTAL CHARGE
Type I	$120	plus	$35	$155
Type II	$141	plus	50	191
Type III	$180	plus	75	255

This chart shows the maximum vendor payment which may be supplemented from other sources either Social Security benefits, Old Age Assistance, personal income, or family contributions. When the income from any other resource exceeds the amount listed in this table, the vendor payment is reduced so that the maximum payment to the nursing home is the figure seen in the column listed, TOTAL CHARGE.

SUGGESTION FOR ACTION

It is proposed that a study be made under the auspices of the Chronic Disease Control Division of the Houston Health Department as follows. A sampling of 100 patients in nursing homes be studied, securing data on diagnosis, including descriptive diagnosis for senile patients, current source of medical care, and any problems in securing or providing medical care needed by these patients. Then Dr. Jensen, with the assistance of physician volunteers, will review a sampling of these patients to verify the circumstances of any problems in the provision of medical care.

Then if indicated, the subcommittee suggests that a committee, made up of appropriate representation of professionals involved and community members concerned, proceed with a review of the medical care services provided by the vendor payment plan in order to examine the application of this service to the needs noted above and to other problems as they occur.

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Steering Committee

Action for MENTAL HEALTH

Digest of Final Report of JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH

The Mental Health Study Act of 1955 directed the Joint Commission on Mental Illness and Health, under grants administered by the National Institute of Mental Health, to analyze and evaluate the needs and resources of the mentally ill people of America and make recommendations for the national mental health program.

The purpose of this final report is to arrive at a program that would approach adequacy in meeting the needs of the mentally ill — to develop a plan of action, in other words, that would satisfy us that we are doing the best we can toward their recovery.

This Digest is a 10,000 word condensation of ACTION FOR MENTAL HEALTH, a 100,000 word report made to Congress, the Governors, and the Legislatures of the United States. The Digest is provided as a convenience to public officials and the press, who require a quick impression of the findings and recommendations contained in the full report. Under no other circumstance, however, does the Digest constitute an appropriate substitute for the thoughtful and extensive analysis to be found in ACTION FOR MENTAL HEALTH. For documentation of statements in this Digest, the interested reader is referred to the full work, published by Basic Books Incorporated, 59 Fourth Avenue, New York 3, N.Y. $6.75.

Reprinted from The MODERN HOSPITAL, *March 1961*

The latter is not at present the case. We have not been able to do our best for the mentally ill to date, nor have we been able to make it wholly clear what keeps us from doing so. Attempts to provide more humane care for the mentally ill and to transform "insane asylums" into hospitals and clinics true to the healing purpose of medicine have occurred periodically during the last two centuries. While each reform appears to have gained sufficient ground to give its supporters some sense of progress, each has been rather quickly followed by backsliding, loss of professional momentum, and public indifference.

Even if we can find the road to a substantial reduction in the human and economic problems of mental illness, we are obliged to remain in full view of certain intervening observations that provide little cause for hope except as we can dispose of them. We must note, for instance, the curious blindness of the public as a whole and of psychiatry itself to what in reality would be required to fulfill the well publicized demand that millions of mentally ill shall have sufficient help in overcoming the disturbances that destroy their self-respect and social usefulness.

Further, we must rise above our self-preservative functions as members of different professions, social classes, and economic philosophies and illuminate the means of working together out of mutual respect for our fellow man. We each have a responsibility that is common to all — our responsibility as citizens of a democratic nation founded out of faith in the uniqueness, integrity and dignity of human life.

Why has care of the mentally ill lagged?

The United States Congress, in the last ten years, has given the American public a working demonstration of a new willingness to accept leadership and responsibility in active efforts to help citizens who are threatened by mental illness. The federal government's chief exemplifications of this demonstration may be found in the programs of the National Institute of Mental Health and the Veterans Administration. The good example has been followed in the efforts of state legislatures, governors, and their public health, mental health, and public welfare agencies in many states.

It is tempting to congratulate ourselves on the gains scored — in increased amounts of money spent for mental health research, in the increases in mental health personnel, in the beneficial effects of the new drugs. But the demand for public mental health services is still largely unmet, despite the gains.

One of the most revealing findings of our mental health study is that comparatively few of 277 state hospitals — probably no more than 20 per cent — have participated in innovations designed to make them therapeutic, as contrasted to custodial, institutions. Our information leads us to believe that more than half of the patients in most state hospitals receive no active treatment of any kind designed to improve their mental condition. This is the core problem and unfinished business of mental health. Eight of every ten mental hospital patients are in state institutions. These hospitals carry a daily load of more than 540,000 patients, and look after nearly a million in a year's time.

Commonly, a clearly defined, well established public demand and need for a particular health program is sufficient to stimulate aggressive public action toward its support and progressive steps to organize whatever high-quality facilities may be needed. Quick responsiveness in meeting the demand is not characteristic in the mental illness field, however.

Mental illness, commonly regarded as America's No. 1 health problem, ranked fourth in the categorical interests of the National Institutes of Health in 1950, as measured by dollars spent; by 1960, it had risen to second, behind cancer (see Table 1). The gains of the voluntary campaign have not been commensurate, however. Voluntary mental health funds ranked eighth at the beginning and seventh at the end of the period, and were eighth in grand total, as shown in Table 2.

Over a ten-year period, poliomyelitis had the greatest public appeal, followed by tuberculosis, cancer, heart disease, crippled children, cerebral palsy, muscular dystrophy, and mental health, in that order.

Despite the repeated snakepit exposés and the great amount of attention given to mental illness by the press, surveys have shown that mental illness has had a lower reader impact than has heart disease, cancer, or polio.

Despite the "big push" in recent years to do something about major mental illness, the average proportion of general state expenditures and of state health expenditures going for the care of mental hospital patients actually declined.

TABLE 1
Total Appropriations of Congress for Major Activities
of the National Institutes of Health, 1950-1961*
(in Millions of Dollars)

Fiscal Year	Cancer	Mental Health	Heart	General	(Arthritis, Allergy and Infectious Diseases, Neurology and Blindness became separate categories in 1954.) Arthritis	Allergy	Neurology
1950	$ 18.9	$ 8.7	$ 10.7	$ 12.0			
1951	20.0	9.5	14.2	14.3			
1952	19.6	10.5	10.0	15.7			
1953	17.9	10.9	12.0	16.6			
1954	20.2	12.1	15.2	4.7	$ 7.0	$ 5.7	$ 4.5
1955	21.7	14.1	16.7	4.7	8.2	6.1	7.6
1956	25.0	18.0	18.9	5.9	10.8	7.8	9.9
1957	48.4	35.1	33.4	12.1	15.9	13.2	18.7
1958	56.4	39.2	35.9	14.0	20.3	17.4	21.3
1959	75.3	52.4	45.6	29.0	31.2	24.0	29.4
1960	91.2	68.1	62.2	46.0	46.9	34.0	41.4
1961	111.0	100.9	86.9	83.9	61.2	44.0	56.6
TOTALS	$555.6	$379.5	$361.7	$258.9	$201.5	$152.2	$189.4

*Source: D.H.E.W.-P.H.S.-National Institutes of Health Operating Appropriations by Activity, 1950 through 1961. From Office of the Director, N.I.M.H.

TABLE 2
Total Funds Raised Nationally
in Ten Leading Voluntary Health Campaigns, 1950-1959*
(in Millions of Dollars)

	Polio	TB	Cancer	Heart	Crippled Children	Cerebral Palsy	Muscular Dystrophy	Mental Health[b]	Arthritis	Multiple Sclerosis
1950	30.8	21.0	13.9	4.1	5.8	1.0	(a)	(c)	0.7	0.18
1951	33.5	21.7	14.6	5.5	6.1	2.1	(a)	0.7	1.0	0.19
1952	41.4	23.2	16.4	6.7	6.7	4.0	0.26	0.6	1.0	0.25
1953	51.4	23.8	19.8	8.5	7.7	6.4	0.6	0.7_A	1.4	0.45
1954	65.0	24.0	21.7	11.3	8.1	8.2	4.0	1.7_A	1.5	0.8
1955	52.5	24.6	24.4	13.6	8.5	7.5	3.9	2.4	1.8	1.3
1956	51.9	25.8	27.2	17.5	9.8	8.1	3.0	2.6	2.2	2.0
1957	44.0	26.3	29.6	20.5	10.3	8.4	3.7	3.8	2.4	2.3
1958	35.4	26.0	29.7	22.3	10.4	9.2	4.9	4.5	3.0	2.5
1959	31.3_E	26.0	31.0_E	24.0	10.3	9.5	4.6	5.5_E	3.6	(d)
TOTALS	437.2	242.4	228.3	134.0	83.7	64.4	24.96	22.5	18.6	9.97

*"Rough" figures supplied by National Information Bureau for (1) National Foundation, (2) National Tuberculosis Association, (3) American Cancer Society, (4) American Heart Association, (5) National Association for Crippled Children and Adults, (6) United Cerebral Palsy Association, (7) Muscular Dystrophy Association of America, (8) National Association for Mental Health, (9) Arthritis and Rheumatism Foundation, (10) National Multiple Sclerosis Society.

(a) No campaign.
(b) Figures for 1951 and 1952 from National Information Bureau, for 1953-1959 from National Association for Mental Health.
(c) Not available, due to merger.
(d) Not available.
E: Estimate.
A: Approximate.

TABLE 3
Movement of Patient Population
in Public Mental Hospitals, United States, 1956-1959

Item	1956	1957	1958	1959	% Change 1956-1957	% Change 1957-1958	% Change 1958-1959
All admissions	185,597	194,497	209,503	223,225	4.8	7.7	6.5
First admissions	125,539	129,278	137,061	142,881	3.0	6.0	4.2
Readmissions	60,058	65,219	72,442	80,344	8.6	11.1	10.9
Discharges	133,208	145,116	161,972	175,727	8.9	11.6	8.4
Deaths in hospital	48,236	46,848	51,294	49,640	−2.9	9.5	−3.2
Resident patients at end of year	551,390	548,626	544,863	542,721	−0.5	−0.7	−0.4
Personnel employed full time at end of year	153,715	162,753	169,438	174,218	5.9	4.1	2.8
Maintenance expenditures:							
Total	$663,280,934.00	$731,875,462.00	$805,861,786.00	$854,354,503.00	10.3	10.1	6.0
Per patient	$1,194.88	$1,332.31	$1,475.26	$1,577.54	11.5	10.7	6.9

The quality of care given these patients may be judged from the fact that state hospitals spend an average of $4.44 per patient per day compared to $31.16 for community general hospitals and $12 or more per patient day both for tuberculosis and Veterans Administration psychiatric hospitals. Likewise, state hospitals have the lowest ratio of hospital personnel to patients, 0.32 per patient as compared to 2.1 in community general hospitals.

For the last four years, there has been a net decrease in the number of patients living in state hospitals (see Table 3). This trend primarily reflected the benefits of tranquilizing drugs, the drugs making it possible to increase the number of patients who can be released from the hospital. However, since the number of patients admitted to these hospitals has continued to climb, the net decrease in the hospitals' population cannot be said to represent a reduction in the mental illness problem. What has occurred is an increase in the turnover and a shift in the whereabouts of mental patients. More are being maintained at home or treated elsewhere.

There are two ways to measure progress: from the standpoint of how far we have come, or from the standpoint of how far we yet have to go. By the first measure, we have made progress. By the second measure, we have little cause for self-congratulation and no cause for relaxation of efforts.

The first and pivotal question in appraising where we now stand and next should go is this: ***Why have our efforts to provide effective treatment for the mentally ill lagged behind our objectives, behind public demand, and behind attacks on other major health problems?***

With proper treatment, the schizophrenic patient has three-in-five chance of leading a useful life in the community

We began with the statement that we have not done as well as we know how for the major mentally ill, in terms of humane and healing care. This is to say that if all or most had the benefit of modern treatment, more patients would recover or show improvement. Palpably, if this assumption is untrue then we have no immediate incentive for greater efforts to reduce lag and accelerate progress.

Actually, the typical patient with schizophrenia or other functional psychosis (so called because no organic cause is known) has a much better outlook than do patients with some of the better known chronic degenerative diseases, such as cancer of the lung or stomach.

Treatment of mental illness stands on two rational pedestals, one social and one medical: humanitarianism and science.

Modern methods of treatment of major mental illness seek to systematize and capitalize on a historic trend away from punishment and toward "moral treatment," based on humane consideration for the patient as an individual and member of society. No longer does progressive psychiatry hold with the early dictum that "terror acts powerfully on the body through the medium of the mind, and should be employed in the cure of madness." We do still see residual manifestations of this latter approach in shock treatments.

To moral treatment has been added both psychotherapeutic and sociological insight into how patients may be treated either individually or in groups to bring about solutions of their problems of living with themselves and with others. To psychotherapy and social therapy (the "therapeutic community") have been added the tranquilizing drugs, which may be described as "moral treatment in pill form." These drugs quiet the patient and make him more agreeable and easier to work with. In summary of what we know about the treatment of the major mental illnesses which fill our public mental hospitals, we may say:

1. The persistent attitude that schizophrenia is a hopeless, incurable disease requiring the patient to be removed from human society for the rest of his life is baseless.

2. The idea that the patient is totally insane is likewise without foundation. Medical psychology has consistently observed and generally accepts the fact

that functional psychosis involves only certain of the components of the personality. The patient is sick in some ways and healthy in others. Rational treatment directs itself toward salvaging the healthy and reducing the sick parts of the mind.

3. Human beings regard loss of liberty, forcible detention, removal from the community, and imprisonment as punishment for wrongdoing; the mentally ill are no exception. It is generally agreed that the typical locked-ward state hospital, centering its interest on the phyical rather than the mental welfare of the patient, increases the patient's disability by reinforcing rather than counteracting public pressure to reject the patient from the community. As the pioneer reformer, Clifford Beers, said, "Madmen are too often man-made." The open hospital, with unlocked wards, is one antidote to this disabling process. Another is treatment in mental health clinics of patients not actually requiring hospitalization. Many of the patients in state hospitals do not need to be there.

4. The insistent professional preoccupation with "cures" presents a blind alley. The present state of our scientific knowledge does not permit psychiatry as yet to formulate exact tests of cure. The outlook for the schizophrenic, the main source of the long-term accumulation of patients in state hospitals, is not poor but good under optimum treatment conditions. He has a one-in-five chance of spontaneous recovery without systematic treatment. Through proper treatment, he has at least a three-in-five and perhaps as much as four-in-five chance of improving sufficiently to lead a useful life in his community.

Many people—including physicians—find it hard to recognize psychological illness as illness

The way society handles its mentally ill has been the subject of scandalized attack many times. But, as already implied, repeated exposure of the shameful, dehumanized condition of the mentally sick people who populate the back wards of state hospitals does not arouse the public to seek sweeping humanitarian reforms, let alone stimulate widespread application of modern methods of treatment. Presumably, if we can answer why there has not been a strong public response (as there has been, for example, in the campaigns against tuberculosis, cancer and heart disease) we then can determine why effective treatment for the mentally ill has lagged.

The answer, according to our analysis in the following pages, is that the mentally ill are singularly lacking in appeal. They tend to disturb or offend other people and, when they do, people generally treat them as disturbers and offenders and, of course, as if they were responsible for their behavior. In contrast, it has been the special view of the mental health professions that people should understand and accept the mentally ill and do something about their plight.

The public has not been greatly moved by this protest. People do feel sorry for the mentally ill, but, in the balance, they do not feel as sorry as they do relieved to have out of the way persons whose behavior disturbs and offends them. Patients with major mental illness come to be viewed as "impossible people" and mental institutions as places where they are sent when their families and communities "no longer can stand them."

The fact that society tends to reject the mentally ill is, of course, well known; little significance seems to have been attached to it, however. The full reach of the rejection mechanism is little recognized and even denied by some who have learned to overcome it in their own professional relations with persons suffering mental disturbances or disorders.

We can name a number of processes, all of which add up to, or reinforce, the fact that the mentally ill repel more than they appeal. One characteristic of a psychotic is that he becomes a stranger among his own people. Since antiquity mankind has been prone to feel hostility toward the stranger, and this applies equally to any persons who behave strangely. A social system depends on order, and order depends on predictability in the behavior of one's fellows.

Normal persons for the most part want to do what they have to do to "get along." The typical psychotic does not. In consequence, society conventionally closes ranks against him. Identified major mental illness carries a stigma that cuts the bonds of human fellowship.

Many other diseases — tuberculosis, syphilis, cancer, for example —, have at times stigmatized their victims. But the stigma of a disease recognized to be physical and lethal tends to disappear, or be offset, as it becomes better understood and publicly attacked.

The reason, as we analyze it, is not that science has found causes and cures — the causes and cures of cancer and the leading forms of heart disease are still the subject of an intensive search.

Rather, the physically sick person fits society's deep-seated conception of a sick person. Feeling helpless, he turns to others for help and, receiving help, is responsive to it. He evokes sympathy. Commonly, the acutely ill psychotic does not appear to want help or accept help but, quite the reverse, thinks he is not sick and may interpret "help" as "harm." He repels sympathy. He is mad.

This lack of appeal has many dimensions. The rise of state hospitals and their persistence, despite all efforts to reform them, is the most outstanding example. Mental health authorities are in general agreement that society uses these huge institutions as dumping grounds for social rejects, rather than as true hospitals.

A rejection effect may also be detected in the rise of the mental hygiene movement. Its founder, Clifford Beers, as his book "A Mind That Found Itself" clearly reveals, intended the movement to be primarily one of stopping brutal treatment of the mentally ill and converting mental hospitals into humane, healing institutions. It did not become so. Attention became focused on mentally healthy living rather than help for the sick.

The mentally ill's lack of appeal as a public cause has been reflected in a lack of strong leadership and strong organization in the voluntary mental health movement, some state organizations excepted. An organization can hardly develop and mature, as a matter of fact, if followers or members cannot be persuaded in sufficient numbers to identify with the cause at hand. It has been observed that the mentally ill are inherently handicapped in any effort to form a strong public pressure group. Lacking in a reasonable capacity to get along with other people, they find organization behind a leader to be difficult, if not impossible. The friends or relatives are equally immobilized through an aversion to identifying themselves with the mentally ill.

Several studies of public attitudes have shown a major lack of recognition of mental illness as illness, and a predominant tendency toward rejection of both the mental patient and those who treat him. There is a general agreement on these points in contrast to the lack of confirmation often characterizing parallel studies in the mental health field. (It is encouraging to note, however, that these negative attitudes are less among younger and better educated persons than the older and less educated groups.)

The circle of negligence and indifference becomes complete when we recognize that many members of learned professions are likewise prone to turn their back on the core problem of major mental illness.

General practictioners as well as other members of the medical profession have been found in a majority of instances to be both uninformed and unsympathetic when they are confronted with mental illness. The same observation applies, oddly enough, to many psychiatrists in private practice when we narrow discussion to the core problem of severe mental illness. The main concern of the popular psychoanalyst is with neurosis rather than psychosis; this is also true of other types of psychiatrists in private practice. Their major focus is on minor and more easily treatable forms of mental illness. Even mental hospital superintendents themselves, it has been noted, may share the public's stigmatizing attitudes toward mental patients.

In summary, we need to become conscious, at the action level, of two points if we are to overcome the lag in the care of the mentally ill: (1) People find it difficult to think about and recognize psychological illness as illness, or to see sickness as having psychological forms. (2) The major mentally ill as a class lack in appeal, which is to say that they are overburdened with liabilities as persons and as patients.

To explain the first point: Man is prima facie an outward-looking, tool-operating, thing-oriented creature, the man of science not excepted. We use our unique human intelligence principally to think about picturable, tangible, concrete, measurable, recordable things. Recent anthropological and neurological evidence indicates that tools were used by prehistoric apes in the absence of a human brain, and that continued use of tools may have conditioned the way in which the human brain evolved. Also, the interpretation is borne out by the more rapid advancement of the physical and mathematical than of the behavioral and social sciences, and by the fact that the most crucial questions facing mankind today involve psychological and social conduct. In any event, education of the average man appears to favor greater understanding of matter than of mind. Most of us are in this way psychologically handicapped persons, mentally blind to our physical bias.

To elaborate the second point: It is not so much his symptoms themselves that bring the psychotic patient into a mental hospital — many people in the general population have equally strange symptoms—but that his behavior reaches a point where people no longer can stand it. Violence is more the exception than the rule, popular misconceptions to the contrary. It is basically that normal people are disturbed by the patient's refusing to comply with expectations of time and place. Challenged by the problem, the psychiatrist in the hospital nonetheless may find the

patient uncooperative — too wearing, too trying, too tiring. Thus the most conscientious and devoted doctor may be forced to turn his back on the patient, completing the circle of rejection.

It should now be clear that one way around the impasse of public and professional attitudes that we appear to have erected would be to emphasize that persons with major mental illness are in certain ways *different* from the ordinary sick. With such an understanding and agreement, it might then be possible to proceed in the light of fuller reason to adopt more helpful attitudes.

The mentally ill usually behave irresponsibly; society usually behaves toward them the same way

It is commonly stated that one in ten is mentally ill or psychologically disturbed. When this estimate is limited to those with severe disorders that are socially disruptive or individually incapacitating, the ratio is perhaps one in 100. Society has organized itself and its handling of the one in 100 out of primary concern for the 99 who do not disturb their fellow men sufficiently to acquire the mental patient label. This does not mean, however, that we would long hesitate in modifying the system of exiling and thereafter dehumanizing patients whose illness makes them socially unacceptable if we could be shown that a more desirable alternative is available.

The current trend, among more progressive mental health professionals and interested laymen, is to recognize and to pursue alternatives — to demonstrate that negative public attitudes are not insurmountable roadblocks; to show that it is possible to develop and practice friendly and accepting attitudes toward the mentally ill; to show that it is possible to work with them, to treat them as human beings, and get good results. For example, during the last six years more than 1000 volunteer students from Harvard and Radcliffe colleges and Brandeis University have worked regularly with chronic psychotics at Metropolitan State Hospital in Waltham, Mass. They have been active in ward improvement projects and as case aides — without harm to themselves or the patients. On the contrary, there has been a mutual benefit, in the notable improvement of patients and higher motivation of students, some of whom have chosen mental health as their career work. Many other examples of lay volunteers who work with mental patients could be cited.

It is a characteristic of the mentally ill that they behave in an irresponsible manner; it is a characteristic of society that we behave toward them in the same manner. The findings of the various projects undertaken as part of the Joint Commission's mental health study bear out our belief that this circle of rejection can be broken. Indeed, there are many signs that the process is well under way.

In all categories of service — hospitals, clinics, community agencies, schools, for example — we found a tremendous demand for authoritative information about mental illnesses and for access to available services. Waiting lists are the rule. It is a demand that we have not begun to meet. Only in the meeting of it will we have the opportunity for large-scale demonstration that public attitudes can be improved and mentally troubled persons can be helped.

In our nationwide survey of the American people's views of their own mental health, one in four adults disclosed he at some time had had a psychological problem in which professional help would have been useful. One out of seven actually sought help — mainly for problems involving marriage, personal adjustment, or children. Forty-two per cent of those who sought help turned to their clergymen, 29 per cent to physicians in general, 18 per cent to psychiatrists and psychologists, and 10 per cent to social agencies and marriage clinics.

More than half of these troubled persons were sure that they had been helped — more in problems they saw as physical or external to them than as psychological or within themselves. But more were helped in making personal adjustments than in solving marital troubles.

The foregoing study together with our studies of community services, churches and schools indicated the following: While the younger generation and better educated persons have greater recognition of the psychological nature of many of their problems and therefore see the need to deal with them psychologically, the demand for such services is not being met. Indeed, mental health facilities and skills are inadequate wherever one looks, whether to mental or general hospitals, clinics, counseling services, clergy-

men, family doctors, special rehabilitation services, or elsewhere.

Much information has been disseminated. Many meetings have been held. But the shortage of trained mental health personnel works totally against the purposes of mental health education. Increased mental health education only serves to tax already inadequate mental health services.

The Joint Commission made an intensive study of the demand for and supply of mental health professional manpower — particularly psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers. This study made forcibly clear that the great shortages of manpower in these categories is inextricably related to the shortage of professional manpower in general — teachers, lawyers, physicians, scientists, technologists. And the professional manpower shortage is related to defects in our system of public school and college education. Most importantly, a large part of the nation's potential brainpower is being lost between high school and college. In fact, only about one-tenth of American youth become college graduates; only one-third of those of outstanding intelligence in high school go on to finish college.

It is of special interest to a national mental health study, we may say in passing, that our culture does not manifest a great respect for the mind. Our minds, the findings indicate, seem to be of small moment to us, whether normal or sick. The critical problem is one of intellectual motivation. What examples do we set? What new challenges do we offer? What spiritual rewards do we offer? What degree of economic security do we provide?

Our manpower study concluded, with frank pessimism, that sufficient professional personnel to eliminate the glaring deficiencies in our care of mental patients will never become available if the present population trend continues without a commensurate increase in the recruitment and training of mental health manpower. The only possibilities for changing this negative outlook for hundreds of thousands of mental hospital patients would require a great change in our social attitudes, and a consequent massive national effort in all areas of education, including large increases in the number of persons engaged in mental health work, or a sharp break-through in mental health research.

A sound research attack on mental illness must be mounted on a long-term base

The demand for professional services for the custody and continuous care of patients with schizophrenia or cerebral arteriosclerosis could be greatly reduced by a major break-through in the prevention or treatment of either of these conditions with a biochemical or other technic that could be administered to large numbers by a single therapist. Together, these patients fill the great majority of mental hospital beds.

But even with maximum research support, we cannot count on increased purchasing power in the science market to produce the desired result within a given time. A characteristic of scientific research is that it ultimately produces results of potential benefit to us all, but we cannot predict when the result will come or even that it will be the one we are looking for. There was a lag of forty years between the time Karl Landsteiner discovered the cause of poliomyelitis and when John Enders' group accomplished the tissue-culture break-through that made production of a polio vaccine possible. Sir Alexander Fleming was not looking for a penicillin when he observed its effects, and yet the antibiotics have made more difference in the control of infectious diseases than any other drug in medical history. It was research in anesthesia and motion sickness rather than mental health that brought us the tranquilizing drugs.

Our purpose here is not to be defeatist; only realistic. The enormous task of taking care of mental patients is matched by the enormous research lag in the study of human behavior. Only by making the research possible can we hope to overcome the lag. What we mean is that our total national investment in mental health research — in time, money, men and research and training facilities — simply does not measure up to the need for useful and reliable knowledge that could form the foundation of future progress.

The mental health sciences address themselves to the alleviation of a complex of biological, psychological, and sociological problems that have plagued man through his history; mental health scientists face this task with an incredibly small fund of knowledge about causes and cures. It is a field where much-qualified guesses abound and general agreement is difficult to obtain.

A sound research attack on problems of mental illness and mental health can be mounted on no other

base than a *long-term* one. The prospect of a crash program and a quick break-through is not realistic in the absence of a vast increase in basic knowledge. We have the examples in other fields, such as cancer and heart disease, where intensified research has been going on for some years in response to an earlier public focus of effort to solve these health problems. Hopes have been high and have remained so. Yet even in these areas the quick fulfillment of grand objectives is not yet at hand.

We can again illustrate our point via the major advance represented by introduction of the tranquilizing drugs, now used in the treatment of probably one-third of all mental hospital patients. Although these drugs quiet the patients, inspire hopefulness, and make mental hospital employment more interesting and attractive, they do not relieve but rather increase the need for professional experience and skills. The effects of the drugs must be closely watched and evaluated, for they are not without harm. At the same time, they make many more patients accessible to psychotherapy, rehabilitation and discharge from the hospital. Such drugs actually increase the need for trained therapists and helping personnel.

In making a statement of the aims and strategy for a more effective research effort in the mental health field, certain characteristics of the research enterprise must be taken into account.

One characteristic is the great *diversity* of persons, sciences, methods and goals involved in "mental health research."

Another characteristic is the sharp cleavage in attitudes about *basic* and applied research: Basic research is defined as any scientific inquiry for the purpose of discovering and generalizing truths about the essence of nature, including man; applied research here refers to studies directed primarily toward the practical problems of preventing mental illness or treating mental patients. This cleavage leads to a neglect of basic research as impractical or unpromising, and to the false assumption that basic research should be done in universities; applied research, in hospitals.

Efforts should be made to increase communication between researchers and practitioners. Their differing interests and training at present lead them in opposing directions. One result is poorly designed or "sloppy" clinical research. Actually, research is a service to practitioners as well as to the patients served.

Our study shows that the mental health research output is concentrated in a relatively small number of major universities and their medical centers. Smaller colleges and state mental hospitals account for an extremely small portion of the total research effort. There should be support for *flexible* and *experimental* programs of *stimulating* research in many different areas and settings.

The mental health sciences are preponderantly dependent on the federal government for thir financial support, and bcoming more so. The greatest single source is the National Institute of Mental Health. The federal percentage of total support for mental health research in 1958 was 57 per cent; the state percentage was 20 per cent. The pharmaceutical foundations supplied 17 per cent; private foundations and other sources, less than 6 per cent. In 1959 and again in 1960, Congress sharply increased its N.I.M.H. appropriations.

The above figures adequately demonstrate that federal government policies determine the shape, size, direction and soundness of the over-all effort in mental health research. Current policy, emphasizing annual grants for specific projects by individual investigators, favors short-term research and applied research, as opposed to the long-term, more fundamental approach needed.

The present effectiveness of our mental health services is seriously limited by large gaps in our scientific knowledge about the fundamentals of mental illness and mental health. Our research recommendations therefore will concern themselves with the particular kinds of support needed to fill the gaps as fast as possible.

Science and education are resources that must have adequate support from human society, whether public or private

The philosophy the federal government needs to develop and crystallize is that science and education are resources — like natural resouces. They can meet an ends test but not a means test or a time schedule. Science and education operate not for profit but profit everybody; hence, they must have adequate support from human society, whether public or private. The following recommendations are designed to help achieve this:

RECOMMENDATIONS

1. A much larger proportion of total funds for mental health research should be invested in basic research as contrasted with applied research. Only through a large investment in basic research can we hope ultimately to specify the causes and characteristics sufficiently so that we can predict and therefore prevent or cure various forms of mental illness or disordered behavior.

2. Congress and the state legislatures should increasingly favor long-term research in mental health and mental illness as contrasted with short-term projects.

3. Increased emphasis should be placed on, and greater allocations of money be made for, venture, or risk, capital both in the support of persons and of ideas in the mental health research area.

4. The National Institute of Mental Health should make new efforts to invest in, provide for, and hold the young scientist in his career choice. This recommendation would require that more full-time positions be supported for ten-year periods as well as some on the basis of lifetime appointments.

5. Support of program research in established scientific and educational institutions, as initiated by the National Institutes of Health, should be continued and considerably expanded in the field of mental health.

6. The federal government should support the establishment of mental health research centers, or research institutes operated in collaboration with educational institutions and training centers, or independently.

7. Some reasonable portion of total mental health research support should be designated as capital investment in building up facilities for research in states or regions where scientific institutions are lacking or less well developed.

8. Diversification should be recognized as the guiding principle in the distribution of federal research project, program, or institute grants from the standpoint of categories of interest, subject matter of research, and branches of science involved.

The lag in treating the mentally ill is reflected in the continued existence of custodial care hospitals

The patient care portion of our study centers on new patterns in the treatment of the mentally ill in the community and in institutions. These patterns, which together comprise the current trend in care of the mentally ill, involve:

Providing immediate help for the emotionally disturbed.

Extending the care of mental patients into the community via clinics and other agencies.

A broader conception of what constitutes treatment.

Individualizing of patient care in mental hospitals.

The breaking down of barriers between the hospital and the community — in effect, the open-hospital movement.

The development of a therapeutic milieu in mental hospitals — social treatment.

Development of after-care programs concerned with adequately supporting the patient so he can remain in the community or return there.

The practitioners who are developing new treatment programs believe in them and hope that they will result in better care and more effective treatment. The one constant in each new method appears to be the enthusiasm of its proponents, and most probably such enthusiasm transmits itself to patients in beneficial ways.

The salient characteristic of the best available treatment of psychotics, as we now understand it, is that some kind of relationship — psychological or social — takes place between the patient and the helping person. This relationship can be formed by informed laymen working individually or in groups under the guidance of psychiatrists, clinical psychologists, or psychiatric social workers, as well as by these and other classes of mental health workers — for example, nurses, attendants and occupational and recreational therapists.

But programs reflecting newer concepts of treatment are relatively rare and unevenly distributed, with the large majority of state hospitals remaining custodial and punitive in their approach. The thesis of ACTION FOR MENTAL HEALTH, that the lag in the treatment of the mentally ill reflects a fundamental pattern of social rejection, is nowhere better evidenced than by the continued existence of these "hospitals" that seem to have no defenders but endure despite all attacks.

To achieve better care of patients, the mental hospital needs to be integrated into the community. This means keeping the hospital and its staff in closer touch with all the community's public and private service agencies. It means an end to the hospital's isolation from the community; in isolation, the backward, custodial system may thrive, whereas in the mainstream of community activity, a hospital's shortcomings may come to attention.

The state hospital must cease to be treated as a target for political exploitation. Patronage must end. These hospitals and their logical community extensions — clinics and after-care programs — must be manned in all cases by properly motivated career workers and not by hacks, professional or lay. These workers need to be well trained and well paid; they need the opportunity to do a good job and hence to demonstrate to the public what they can do.

The newer programs do nothing to solve the manpower problem, although they indicate the direction in which a solution may lie. This brings us to recommendations for improved care of the mentally ill.

A national mental health program should avoid the risk of false promise in public education

RECOMMENDATIONS

1. POLICY.

In the absence of more specific and definitive scientific evidence of the causes of mental illnesses, psychiatry and the allied mental health professions should adopt and practice a broad, liberal philosophy of what constitutes and who can do treatment within the framework of their hospitals, clinics and other professional service agencies, particularly in relation to persons with psychoses or severe personality or character disorders that incapacitate them for work, family life, and everyday activity. All mental health professions should recognize:

A. That certain kinds of medical, psychiatric and neurological examinations and treatments must be carried out by or under the immediate direction of psychiatrists, neurologists or other physicians specially trained for these procedures.

B. That psychoanalysis and allied forms of deeply searching and probing "depth psychotherapy" must be practiced only by those with special training, experience and competence in handling these technics without harm to the patient (namely, by physicians trained in psychoanalysis or intensive psychotherapy plus those psychologists or other professional persons who lack a medical education but have an aptitude for, adequate training in, and demonstrable competence in such technics of psychotherapy).

C. That nonmedical mental health workers with aptitude, sound training, practical experience, and demonstrable competence should be permitted to do general,

short-term psychotherapy — namely, the treating of persons by objective, permissive, nondirective technics of listening to their troubles and helping them resolve these troubles in an individually insightful and socially useful way. Such therapy, combining some elements of psychiatric treatment, of client counseling, of "someone to tell one's troubles to," and of love for one's fellow man, obviously can be carried out in a variety of settings by institutions, groups and by individuals, but in all cases should be pursued under the auspices of recognized mental health agencies.

2. RECRUITMENT AND TRAINING.

The mental health professions need to launch a national manpower recruitment and training program, expanding on and extending present efforts and seeking to stimulate the interest of American youth in mental health work as a career. This program should include all categories of mental health personnel. This program should emphasize not only professional training but also short courses and on-the-job training in the subprofessions and upgrading for partially trained persons.

3. SERVICES TO MENTALLY TROUBLED PEOPLE.

Persons who are emotionally disturbed — that is to say, under psychological stress that they cannot tolerate — should have skilled attention and helpful counseling available to them in their community if the development of more serious mental breakdowns is to be prevented. This is known as secondary prevention, and is concerned with the detection of beginning signs and symptoms of mental illness and their relief; in other words, the earliest possible treatment. In the absence of fully trained psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses, such counseling should be done by persons with some psychological orientation and mental health training and access to expert consultation as needed.

4. IMMEDIATE CARE OF ACUTELY DISTURBED MENTAL PATIENTS.

Immediate professional attention should be provided in the community for persons at the onset of acutely disturbed, socially disruptive, and sometimes personally catastrophic behavior — that is, for persons suffering a major breakdown. The few pilot programs for immediate, or emergency, psychiatric care now in existence should be expanded and extended as rapidly as personnel becomes available.

5. INTENSIVE TREATMENT OF ACUTELY ILL MENTAL PATIENTS.

A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement, and that among those with severe mental illnesses the intensive treatment of those with critical and prolonged breakdowns should have first call on fully trained members of the mental health professions. There is a need for expanding treatment of the acutely ill mental patient in all directions, via community mental health clinics, general hospitals, and mental hospitals, as rapidly as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, and occupational, physical and other nonmedical therapists become available in the community.

A. Community Mental Health Clinics.

Community mental health clinics serving both children and adults, operated as outpatient departments of general or mental hospitals, as part of state or regional systems for mental patient care, or as independent agencies, are a main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization. Therefore, a national mental health program should set as an objective one fully staffed full-time mental health clinic available to each 50,000 of population. Greater efforts should be made to induce more psychiatrists in private practice to devote a substantial part of their working hours to community clinic services, both as consultants and as therapists.

B. General Hospital Psychiatric Units.

No community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short-term hospitalization and therefore provides a psychiatric unit or psychiatric beds. Every community general hospital of 100 or more beds should make this provision. A hospital with such facilities should be regarded as an integral part of a total system of mental patient services in its region.

It is the consensus of the Mental Health Study that definitive care for patients with major mental illness should be given if possible, or for as long as possible, in a psychiatric unit of a general hospital and then, on a longer-term basis, in a specialized mental hospital organized as an intensive psychiatric treatment center.

C. Intensive Psychiatric Treatment Centers.

Smaller state hospitals, of 1000 beds or less and suitably located for regional service, should be converted as rapidly as possible into intensive treatment centers for patients with major mental illness in the acute stages or with a good prospect for improvement or recovery if the illness is more prolonged. All new state hospital construction should be devoted to these smaller intensive treatment centers.

6. CARE OF CHRONIC MENTAL PATIENTS.

No further state hospitals of more than 1000 *beds should be built, and not one patient should be added to any existing mental hospital already housing* 1000 *or more patients. It is recommended that all existing state hospitals of more than* 1000 *beds be gradually and progressively converted into centers for the long-term, combined care of persons with chronic diseases, including mental illness. This conversion should be completed in the next ten years.*

Special technics are available for the care of the chronically ill and these technics of socialization, relearning, group living, and gradual rehabilitation or social improvement should be expanded and extended to more people, including the aged who are sick and in need of care, through conversion of state mental hospitals into combined chronic disease centers.

It would be necessary to provide the intensive treatment services for the acutely ill, outlined in the preceding section, before large state hospitals could be converted to chronic diseases. It also would be necessary to make certain changes in federal and state laws.

7. AFTER-CARE, INTERMEDIATE CARE, AND REHABILITATION SERVICES.

The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter maintain him in the community as long as possible. Therefore, after-care and rehabilitation are essential parts of all service to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them: day hospitals, night hospitals, after-care clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and ex-patient groups. We recommend that demonstration programs for day and night hospitals and the more flexible use of mental hospital facilities, both in the treatment of the acute and the chronic patient, be encouraged and augmented through institutional, program, and project grants.

PUBLIC INFORMATION ON MENTAL ILLNESS

A national mental health program should avoid the risk of false promise in "public education for better mental health" and focus on the more modest goal of disseminating such information about mental illness as the public needs and wants in order to recognize psychological forms of sickness and to arrive at an informed opinion in its responsibility toward the mentally ill.

It is possible to make certain general recommendations about dissemination of information concerning mental illness aimed at (1) greater public understanding of the mentally ill person and those who care for him, (2) the avoiding of misunderstanding in the relations of one professional group with another, and (3) the importance of making sure, in the relations of the mental health professions with the lay public, that others understand what we are driving at.

An important point has been missed in overinsistence that the public recognize that mentally ill persons are sick, the same as if they were physically sick, and should be treated no differently from other sick persons. Mental illness is different from physical illness in the one fundamental aspect that it tends to disturb and repel others rather than evoke their sympathy and desire to help.

A sharper focus in a national program against mental illness might be achieved if the information publicly disseminated capitalized on the aspect in which mental differs from physical illness. Such information should have at least four general objectives:

1. To overcome the general difficulty in thinking and recognizing mental illness as such — that is, a disorder with psychological as well as physiological, emotional as well as organic, social as well as individual causes and effects.

2. To overcome society's many-sided pattern of rejecting the mentally ill, by making it clear that the major mentally ill are singularly lacking in appeal, why this is so, and the need consciously to solve the rejection problem.

3. To make clear what mental illness is like as it occurs in its various forms and is seen in daily life and what the average person's reactions to it are like, as well as to elucidate means of coping with it in casual or in close contact. As an example, the popular stereotype of the "raving maniac" or "berserk madman" as the only kind of person who goes to mental hospitals needs to be dispelled. We have not made it clear to date that such persons (who are wild and out of control) exist, but in a somewhat similar proportion as airplanes that crash in relation to airplanes that land safely.

4. To overcome the pervasive defeatism that stands in the way of effective treatment. While no attempt should be made to gloss over gaps in knowledge of diagnosis and treatment, the fallacies of "total insanity," "hopelessness" and "incurability" should be attacked, and the prospects of recovery or improvement through modern concepts of treatment and rehabilitation emphasized. One aspect of the problem is that hospitalization taking the form of ostracization, incarceration or punishment increases rather than decreases disability.

Attention is also needed to the manner in which professional persons and groups approach the public, since winning friends and support for care of the mentally ill depends first and foremost on not giving cause for

offense. We recommend that the American Psychiatric Association make special efforts to explore, understand and transmit to its members an accurate perception of the public's image of the psychiatrist. Such efforts could pay a great dividend in "education of the public" if the profession were to be educated, perhaps as a part of its formal training, against overvaluing, overreaching, and overselling itself.

The primary responsibility for preparation of mental health information for dissemination to laymen should rest with "laymen" who are experts in public education and mass communications and who will work in consultation with mental health experts. But the mental health expert and the educator or mass communications expert have the primary problem of fully communicating with one another before communicating with the public. Too often the basis for discussions among mental health professionals and laymen is the easy assumption on both sides that the other fellow doesn't "understand the problem" or "know what he is talking about."

As a matter of policy, the mental health professions can now assume that the public knows the magnitude if not the nature of the mental illness problem and psychiatry's primary responsibility for care of mental patients. Henceforth the psychiatrist and his teammates should seek ways of sharing this responsibility with others and correcting deficiencies and inadequacies without feeling the need to be overbearing, defensive, seclusive or evasive. A first principle of honest public relations bears repeating: To win public confidence, first confide in the public.

How can we make state hospitals in fact what they now are in name only— hospitals for mental patients?

Federal, state and local expenditures for public mental patient services should be doubled in the next five years — and tripled in the next ten.

Only by this magnitude of expenditure can typical state hospitals be made in fact what they are now in name only — hospitals for mental patients. Only by this magnitude of expenditure can outpatient and former-patient programs be sufficiently extended outside the mental hospital, into the community. It is self-evident that the states for the most part have defaulted on adequate treatment for the mentally ill, and have consistently done so for a century. It is likewise evident that the states cannot afford the kind of money needed to catch up with modern standards of care without revolutionary changes in their tax structure.

Therefore, *we recommend that the states and the federal government work toward a time when a share of the cost of state and local mental patient services will be borne by the federal government, over and above the present and future program of federal grants-in-aid for research and training.* The simple and sufficient reason for this recommendation is that under present tax structure only the federal government has the financial resources needed to overcome the lag and to achieve a minimum standard of adequacy. The federal government should be prepared to assume a major part of the responsibility for the mentally ill insofar as the states are agreeable to surrendering it.

For convenience, the Veterans Administration mental hospitals can be taken as financial models of what can be done in the operation of public mental hospitals. *Congress and the National Institute of Mental Health, with the assistance of the intervening administrative branches of government, should develop a federal subsidy program that will encourage states and local governments to emulate the example set by V. A. mental hospitals.*

Certain principles should be followed in a federal program of matching grants to states for the care of the mentally ill:

The *first principle* is that the federal government on the one side and state and local governments on the other should *share in the costs* of services to the mentally ill.

The *second principle* is that the total federal share should be arrived at in a series of graduated steps over a period of years, the share being determined each year on the basis of state funds spent in a previous year.

The *third principle* is that the grants should be awarded according to *criteria of merit and incentive* to be formulated by an expert advisory committee appointed by the National Institute of Mental Health.

In arriving at a formula, such an expert committee would establish conditions affecting various portions of the available grant, including the following:

1. Bring about any necessary changes in the laws of the state to make professionally acceptable treatment as well as custody a requirement in mental hospitalization, to differentiate between need of treatment and need of institutionalization, and to provide treatment without hospitalization.

2. Bring about any necessary changes in laws of the state to make voluntary admission the preferred method and court commitment the exceptional method of placing patients in a mental hospital or other treatment facilities.

3. Accept any and all persons requiring treatment and/or hospitalization on the same basis as persons holding legal residence within the state.

4. Revise laws of the state governing medical responsibility for the patient to distinguish between administrative responsibility for his welfare and safekeeping and responsibility for professional care of the patient.

5. Institute suitable differentiation between administrative structure and professional personnel requirements for (1) state mental institutions intended primarily as intensive treatment centers (i.e. true hospitals) and (2) facilities for humane and progressive care of various classes of the chronically ill or disabled, among them the aged.

6. Establish state mental health agencies with well defined powers and sufficient authority to assume over-all responsibility for the state's services to the mentally ill, and to coordinate state and local community health services.

7. Make reasonable efforts to operate open mental hospitals as mental health centers, i.e. as a part of an integrated community service with emphasis on outpatient and after-care facilities as well as inpatient services.

8. Establish in selected state mental hospitals and community mental health programs training for mental health workers, ranging in scope, as appropriate, from professional training in psychiatry through all professional and sub-professional levels, including the on-the-job training of attendants and volunteers. Since each mental health center cannot undertake all forms of teaching activity, consideration here must be given to a variety of programs and total effort. States should be required ultimately to spend 2½ per cent of state mental patient service funds for training.

9. Establish in selected state mental hospitals and community mental health programs scientific research programs appropriate to the facility, the opportunities for well designed research, and the research talent and experience of staff members. States should be required ultimately to spend 2½ per cent of state mental patient service funds for research.

10. Encourage county, town and municipal tax participation in the public mental health services of the state as a means of obtaining federal funds matched against local mental health appropriations.

11. Agree that no money will be spent to build mental hospitals of more than 1000 beds, or to add a single patient to mental hospitals presently having 1000 or more patients.

Our proposal would encourage local responsibility of a degree that has not existed since the state hospital system was founded, while at the same time recognizing that the combined state-local responsibility cannot be fulfilled by the means at hand.

Table 4 provides a hypothetical example of how a federal-state-local matching program incorporating the suggested merit and incentive features might work. We have assumed for ease of illustration that the states will soon reach an expenditure of $1 billion a year for mental patient care (in 1959 the figure was $854 million). We also have assumed that such a program can induce local tax participation to the extent of $60 million after a five-year period and $250 million after a ten-year period.

Our proposal is the first one in American history that attempts to encompass the total problem of public support of mental health services and to make minimum standards of adequate care financially possible.

The outstanding characteristics of mental illness as a public health problem are its staggering size, the present limitations in our methods of treatment, and the peculiar nature of mental illness that differentiates its victims from those with other diseases or disabilities. It would follow that *any national program against mental illness adopted by Congress and the states must be scaled to the size of the problem, imaginative in the course it pursues, and energetic in overcoming both psychological and economic resistances to progress in this direction.* We have sought to acquit our assignment in full recognition of these facts and judgments. ■

TABLE 4

Hypothetical Costs to Federal, State and Local Governments of Doubling Expenditures for Public Mental Patient Care in Five Years and Tripling Costs in Ten Years Under Proposed Matching Plan (in Billions of Dollars)

Year	State Expenditure	Federal Grants Without Local Participation	Total	Local Participation to Extent of:	Federal Grants for Local Participation	Grand Total
1	1.0	0.1	1.1	—	—	1.1
2	1.0	0.2	1.2	0.03	0.17	1.4
3	1.0	0.3	1.3	0.04	0.26	1.6
4	1.0	0.4	1.4	0.05	0.35	1.8
5	1.0	0.5	1.5	0.06	0.44	2.0
6	1.0	0.6	1.6	0.08	0.52	2.2
7	1.0	0.7	1.7	0.10	0.60	2.4
8	1.0	0.8	1.8	0.15	0.65	2.6
9	1.0	0.9	1.9	0.20	0.70	2.8
10	1.0	1.0	2.0	0.25	0.75	3.0

NOTES ON IMPLEMENTATION

The function of the Joint Commission has been that of a study group. We have made a study and from it drawn recommendations for a national mental health program. This completes our job.

It is easy, however, to visualize the next two steps, and even a third. The first is the formation of public opinion for or against the program we propose. The second is the formation of legislative opinion pro or con. The third, and one which we urge the Congress to take immediately, is the formation of a Committee of Consultants who would concern themselves with standards and requirements for implementation of our program and with the kinds of enabling legislation that will be needed. Eventually, we can see that a comparable expert committee, forming an effective channel of communication between the legislature and the mental health professions, will be needed in every state.

In the matter of establishing priorities as they relate to the broad areas of patient care, recruitment, professional education, and research in mental health, we would sound a note of caution. Solution of the mental health problem can and already does pursue two courses. One course is to make better use of the knowledge and experience in the treatment of mental illness that we already have massed, the knowledge on which the broader concepts of treatment in this report are based. Another course is to intensify the search for new knowledge in the hope of mastering the terrain of unknowns to be traversed, and of finding by-passes or more direct routes resulting in preventive measures or treatment methods that are faster working and better adapted to mass application.

The question is not which course to pursue more intensively. In medicine, professional services, education and research move together insofar as they center on or relate to patients. Indeed, it is impossible to separate the patients who must be cared for from the persons who must be trained to care for them, and it is impossible to separate either patients or professional personnel from the search for new knowledge that is of vital concern to both.

Indeed, we can see only one matter that takes priority over all others in the program we propose and that is to obtain vastly increased sums of money for its support. Without adequate financial resources, we cannot take care of patients, we cannot educate professional personnel for public service, and we cannot pursue the basic knowledge needed for the prevention and cure of mental illness.

Printed in U.S.A.

OUTLINE FOR MENTAL HEALTH SERVICES STUDY

NEED FOR STUDY

Previous Community Council studies have shown that:

1. emotionally disturbed children are going uncared for because the services are so limited, as evidenced by waiting lists at Child Guidance Center, and Houston State Psychiatric Institute;

2. emotionally disturbed children, who need to be separated from family situations, and acutely ill and grossly disturbed children are not being cared for because residential care services and in-patient care services are so limited;

3. patients discharged from state hospital are returning to hospital frequently, because of the lack of such supporting services as out-patient clinics, half-way houses, sheltered employment, and counseling for families of patients;

4. emotionally disturbed adults are not able to secure out-patient services at fees which they can afford to pay;

5. there is a need for more extensive preventive services such as family life education, detection of emotional disturbances in the early stages, and education of the community at large about personal mental health.

The drastic changes and the tremendous progress that has been made in recent years in the treatment and care for mental illness emphasizes the importance of reviewing the problems and needs for services, and of planning for the best use of existing and new resources for treatment and care of mentally ill patients.

The Houston Mental Health Association has also called attention to these needs and has requested that the Community Council conduct such an overall study.

Consequently the Community Council Board has authorized the Health Section to conduct a study of Mental Health Services in Houston and Harris County that will assist this community in planning and developing needed services through the most appropriate use of resources.

MAJOR QUESTIONS INVOLVED IN THE STUDY

1. What are the nature and extent of the needs of mentally ill and emotionally disturbed people in Harris County? How many patients are there, what are their problems and needs, and what are the problems and needs of their families?

2. What services and what resources are now available to meet the needs of these patients?

3. What are the gaps between the services available and the needs of these patients?

4. What are the problems in providing services to these patients and their families?

5. What modification of existing services and what development of resources are required and feasible in order to solve problems and to provide needed services:
   a. more services,
   b. new services,
   c. different uses and arrangements of existing services?

6. How can these modifications be achieved and these resources be developed?

PLAN OF PROCEDURE

This study is to be conducted under the supervision of a steering committee representing broad community interests and the professions and facilities involved in providing mental health services in this community. Segments of the survey will be assigned to subcommittees to complete a general survey of needs and existing resources. Then, when key problems and needs are recognized, appropriate study committees will be assigned specific responsibility under the guidance of the steering committee.

The following segments of the general survey have been proposed for subcommittee assignment:

1. preventive services for children;
2. preventive services for adults;
3. therapeutic services for children;
4. therapeutic services for adults;
5. after-care services for adults;
6. services for aged.

It is suggested that steering committee members accept assignments to one of these six areas for this general review.

ACTIVITIES OF THE STEERING COMMITTEE

1. Direct the subcommittees to review and refine that part of the assessment of needs and services which applies to the assigned area of each subcommittee and to note the gaps in service and problems in providing service.

   This assessment draft should be brought up to date by a survey of the amount of services now being provided and an examination of the best opinions available as to the extent of need. This can be done by surveying the existing facilities with suitable questionnaires, and by consulting with the professional societies for an estimate of private care service and extent of need.

2. Coordinate subcommittee results, determine the special lacks or problems which should be assigned for further subcommittee exploration, and sponsor such studies.

3. Draw conclusions regarding needs and possible solutions.

   By reviewing the results of study committees, conclusions can be evaluated and priorities for action can be set.

4. Make recommendations regarding solutions and the implementation of solutions. After evaluating possible solutions and setting priorities, the steering committee can make recommendations to the Community Council Board, agencies and facilities, and the community at large regarding specific action and ways of taking action.

HJL:sam
4/11/62

COMMUNITY COUNCIL
CITIZEN PLANNING FOR BETTER COMMUNITY LIVING

1209½ CAPITOL AVENUE ◘ HOUSTON 2, TEXAS ◘ CApitol 4-1701

June 26, 1962

MEMORANDUM

TO: Members of the Mental Health Services Steering Committee

FROM: Mrs. I. H. Kempner, Jr., Chairman

Attached are the minutes of the meeting of May 2 for your review. Each of you has accepted responsibility for serving on a subcommittee according to the plan proposed at the meeting on May 2. Attached is a list of the assignments to committees.

These committees are holding meetings and will be preparing reports for review by the overall steering committee in the near future.

MK:sam

Set up file

Photocopy — George Bush Handwriting

MINUTES

MENTAL HEALTH SERVICES STUDY COMMITTEE
COMMUNITY COUNCIL
HEALTH SECTION

Y.W.C.A.
MAY 2, 1962
12 NOON

PRESENT

Mrs. I. H. Kempner, Jr., Chairman
Miss Ruth Angelus
Dr. Spencer Bayles
Dr. Lee D. Cady
Dr. Laurie Callicutt
John Cooper
H. Harlan Crank, M.D.
Miss Nina Cullinan
Miss Louise Dollittle
Dr. L. D. Farragut
Dr. Nicholas Gerren
Dr. Sanford Goldstone
Dr. Francine Jensen
Dr. Harry Little
Dr. Alex D. Pokorny
Mrs. J. Newton Rayzor
Dr. Richard Slater
Mrs. Nelson Turner

ABSENT

Mrs. Leland Anderson
Dr. Alberta Baines
James Bayless
Dr. Dawson Bryan
George H. W. Bush
Mrs. Theo W. Cooper
Mrs. Wilfred S. Dowden
Judge William Elliott
Dr. W. H. Hamrick
Bishop John E. Hines
William P. Hobby, Jr.
Paul Kayser
George Markins
Tom McGown
Dr. C. A. Pigford
Mrs. Ben Schnapp, Jr.
Marshall Wells
Willoughby C. Williams

STAFF

Mrs. Helen J. Lewis, Community Planning Associate
Miss Shirley Mikes, Secretary

Mrs. Kempner, Chairman, opened the meeting at 12:35 P.M. and thanked everyone on behalf of the Community Council for serving on this committee. She introduced the members present, noting the representation from organizations concerned with mental health, and representatives from the community at large.

Mrs. Kempner commented as follows.

"It is probably obvious to all of us, even without a study that our needs in the mental health field are many and great. Our resources are limited, and in relation to the needs, likely to remain so in the foreseeable future. Therefore it is doubly important to make skillful and careful use of what we have and to plan wisely for any additions.

"It would be my idea to make only a broad outline for the far future and concentrate on the present and immediate future with realistic goals in mind but never losing sight of the broad outline. I think we can proceed with optimism and imagination without ending up with what amounts to a letter to Santa Claus that we know couldn't possibly be answered. I'll be very disappointed if a committee such as this doesn't produce a report that will be of real and lasting benefit to the community and the agencies concerned.

"As for procedure, you have read in the outline which was mailed to you that we plan to divide this steering committee into subcommittees. Later we shall ask you to indicate your first and second choice of those. After the subcommittees are organized, I hope they will do their job as quickly as is consistent with careful work. Otherwise, I think there is apt to be loss of interest and efficiency."

APPROACH TO THE STUDY

At the Chairman's request, Mrs. Lewis commented that the Health Section leadership, planning for this study, considered Houston ready to move directly to specific activities that need attention. Many communities have conducted such studies by doing a general survey of mental health needs. Some communities have sought the help of outstanding professional consultants from other localities to make a study of their needs.

The leadership that developed this committee, however, felt that our citizen and professional leaders were already aware of a number of problems. This community also contained a supply of professional experts. Specific studies have been done in several areas. As had been noted, Houston and Harris County have a quantity of services, but the extent of need is considerably greater than the services available; and emphasis must be placed on the possibilities of making better use of services or putting some services together in more effective ways. This committee, with its representation, should be able to designate key problems and make recommendations for action for some immediate progress, and then to define some of the areas which need further study.

DISCUSSION OF SUBCOMMITTEE AREAS

Mrs. Kempner then opened the discussion for ideas on key problems and suggestions. Committee members began by discussing the area subdivisions which had been suggested as a convenience for comprehending problems and potential action. These are:

preventive services for children,
preventive services for adults,
treatment services for children,
treatment services for adults,
after-care services for adults,
services for aged.

Dr. Goldstone expressed concern about what he considered the lack of community attention to research and training in the field of mental health. The fact that facilities were training personnel and then losing these professional people to other communities was of great concern to Dr. Goldstone. He suggested that there be a special subcommittee on research and training, so that this area would have the attention which it deserved. He stated that one-half of the mental health services, now provided in this community, were being provided

by students in the programs of training and research. He felt that there should be direct support from the community for training institutions. He commented that there had been the accusation that educational institutions pay too little attention to service; and conversely there was an accusation that the community paid too little attention to the institutions providing training and research.

Discussion clarified that training and research should be considered an integral part of clinical services. Training is also a key element of the whole area of professional personnel. There was some discussion about whether or not training and research and the need for personnel would be among the elements considered across the board in all the areas suggested for subcommittee attention at this time.

It was agreed that "treatment services" would be changed to "clinical services", thereby obviously including both diagnosis and treatment.

In response to inquiry, it was affirmed that preventive services would include the activities of character building agencies, churches, etc.

It was suggested that attention be given to realistically financing services beyond a demonstration period. For example, a Denver, Colorado, school services project may have some difficulty being financed beyond the demonstration period.

RELATION TO OTHER STUDIES

There was some exploration of studies now underway or being developed in the near future. This committee would be concerned with mental health services for the entire community, while the juvenile delinquency study would be concerned with all kinds of services, including mental health services, for a selected area. Through Council structure the activities of this committee and the juvenile delinquency project would be coordinated, and, hopefully, would be mutually helpful. The experience of the Child Welfare Study, in providing information about troubled children, would be of use in pointing up problems for attention. The activities of this committee would also be related to the Study of Special Education Services now underway by representatives of the nineteen school districts in Harris County.

It was clarified that this committee would be concerned with all mental health services in this community regardless of auspices or source of financing. Consequently, the committee would be concerned with the duplication or ordering or coordination of service.

PROCEDURES

Mrs. Kempner explained that the division into subcommittees, however they were organized, would be an immediate and convenient way of assigning our energies

to specific areas in the broad field of mental health. Then chairmen of the various subcommittees could serve as an executive committee to relate and coordinate the results of subcommittees' reviews.

Since each agency or special interest group tends to emphasize the need for its services, it was proposed that the committee postulate that there was no certain truth regarding the care of children, and that there would be no firm commitment to the existing ways of doing things. We would hope to find some approaches and some ways of coordinating resources that may be different than current practice.

In response to inquiry, Mrs. Lewis affirmed that it would be possible to compare Houston's needs and resources with those of other communities so that we could benefit by their experience.

It was suggested that a subcommittee be formed to explore community resources which would cover the areas of research and training. However, further discussion clarified that another such subcommittee would not be a neat fit with the six being considered. It was suggested that one possible division might be services for children and services for adults.

Discussion further clarified that this steering committee could be subdivided in various ways in order to start the exploration of problems and suggestions for specific action. Results of such exploration could be brought back to the steering committee, and these results would provide guidance for further and different approaches as feasible. This committee would prepare a series of reports depending upon action taken and studies indicated.

ACTION PROPOSED

There was general agreement to start with the six conventional areas originally suggested for the purpose of enumerating problems and making suggestions for immediate action. Mrs. Kempner advised that chairmen for the various subcommittees would be chosen, and meetings would be held by these various subcommittees to experiment with this approach. In six weeks the steering committee would meet again to hear reports from the various subcommittees. Using the results of subcommittee activity, the steering committee would then determine next steps. All members present filled in cards indicating their preference for subcommittee assignments.

Mrs. Lewis briefly described the Inventory and suggested that committee members review it in order to decide whether or not it should be brought up to date and if so, how?

Meeting adjourned at 1:35 P.M.

Respectfully submitted,

Helen J. Lewis sam

(Mrs.) Helen J. Lewis,
Community Planning Associate

HJL:sam