

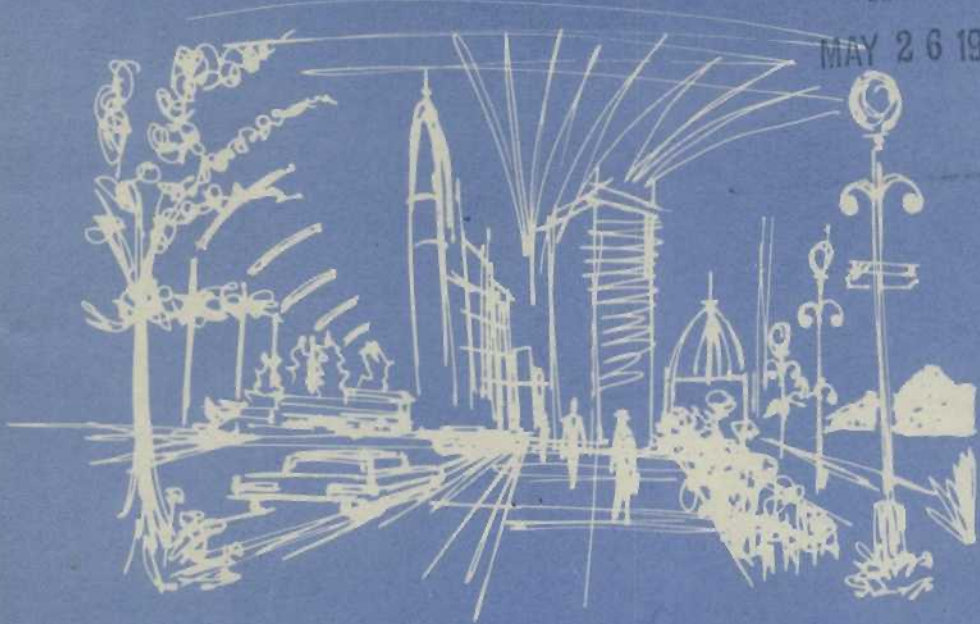
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COMMUNITY MENTAL HEALTH ADVANCES

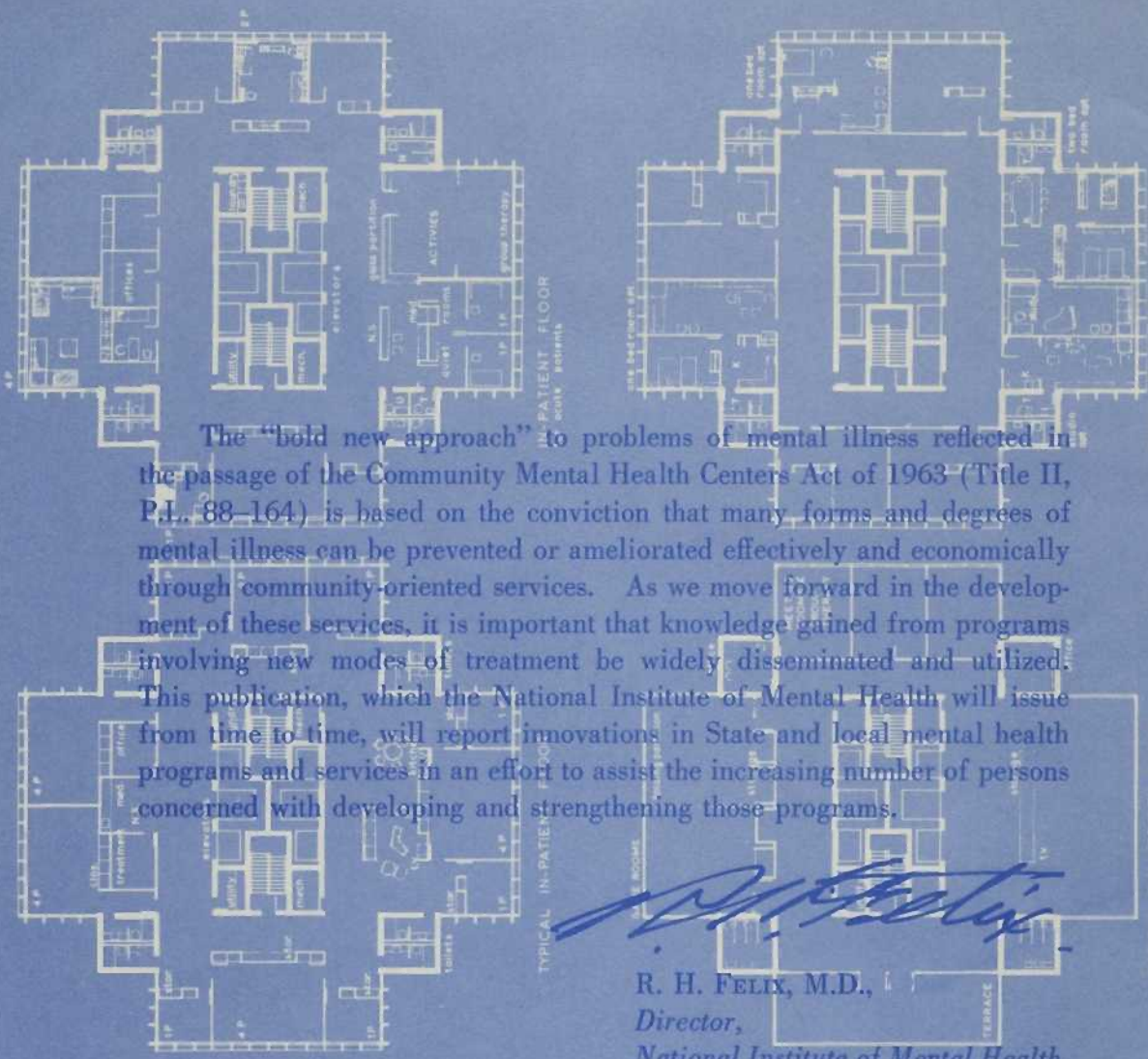
LEGISLATIVE REFERENCE
SERVICE

MAY 26 1964



- COMMUNITY MENTAL HEALTH CENTERS ACT USHERS IN NEW ERA
- NEW LEGISLATION IN THE STATES
- 'CRISIS UNIT' RETURNS MOST PATIENTS TO COMMUNITY
- DAY HOSPITALS SHOW RAPID GROWTH
- CALENDAR OF EVENTS
- CURRENT READING: 'THE PREVENTION OF HOSPITALIZATION'

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service



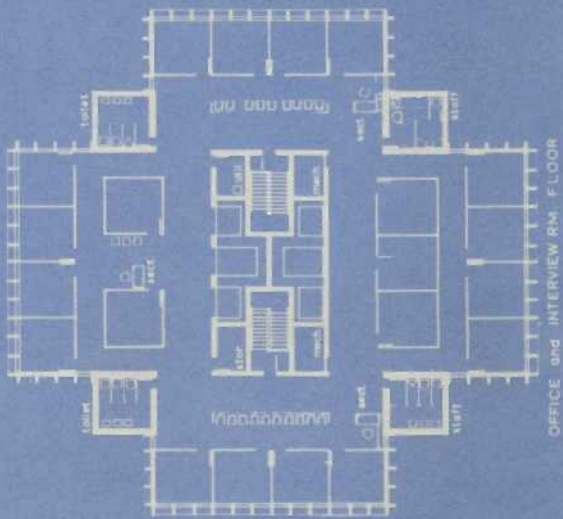
The "bold new approach" to problems of mental illness reflected in the passage of the Community Mental Health Centers Act of 1963 (Title II, P.L. 88-164) is based on the conviction that many forms and degrees of mental illness can be prevented or ameliorated effectively and economically through community-oriented services. As we move forward in the development of these services, it is important that knowledge gained from programs involving new modes of treatment be widely disseminated and utilized. This publication, which the National Institute of Mental Health will issue from time to time, will report innovations in State and local mental health programs and services in an effort to assist the increasing number of persons concerned with developing and strengthening those programs.



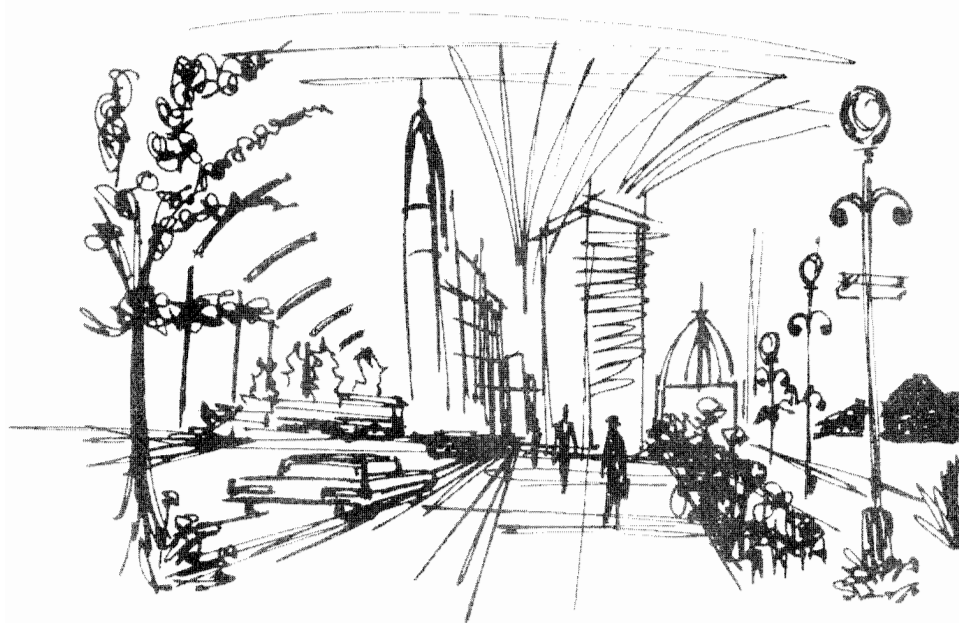
R. H. FELIX, M.D.,
 Director,
 National Institute of Mental Health.



TYPICAL FLOOR PLAN OF TOWER
 clear floor area 6,525 sq ft
 stairs, supports 585 sq ft
 elevator, core 1,153 sq ft
 total floor area 8,263 sq ft



COMMUNITY MENTAL HEALTH ADVANCES



April 1964

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
National Institute of Mental Health
Bethesda, Md. 20014

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A Bold New Program



A new era in the treatment of the mentally disabled of the United States has been ushered in by actions of the 88th Congress. Focused in the community, the bold new program will provide facilities and services to prevent and ameliorate the waste and tragedy of mental illness and mental retardation.

As enacted by Congress, the program authorizes Federal funds to:

1. Assist in the construction of comprehensive community mental health centers.
2. Aid the States in broad planning for the mental health needs of their citizens.
3. Help State mental hospitals and institutions for the retarded improve their therapeutic services.
4. Provide inservice training for personnel of State mental hospitals and institutions for the retarded.
5. Provide expanded services and research programs related to the mentally retarded (including grants for the construction of mental retardation centers), and aid the States in planning for mental retardation needs.

COMMUNITY MENTAL HEALTH CENTERS ACT

The Community Mental Health Centers Act of 1963 (Title II of P.L. 88-164) authorizes a total of \$150 million for fiscal years 1965

through 1967 for the construction of community mental health centers, which will form the core of the new national program.

The authorized Federal grants—totaling \$35 million in the fiscal year ending June 30, 1965, an additional \$50 million the following year, and \$65 million the third year—are to be allotted to the States on the basis of population, financial need, and extent of the need for community mental health centers. The Federal share will range from one-third to two-thirds of the cost, with a minimum allotment of \$100,000 to each State for each of the 3 years.

When fully developed, a comprehensive community mental health center will include the following elements:

- Inpatient services
- Outpatient services
- Partial hospitalization, including day, night and weekend care
- Community services including consultation to community agencies and professional personnel
- Diagnostic services
- Rehabilitative services including vocational and educational programs
- Precare and aftercare community services including foster home placement, home visiting, and halfway houses
- Training
- Research and evaluation

Within 6 months after enactment of the law, or by April 30, 1964, the Secretary of Health, Education, and Welfare was to issue regulations governing the new program.

States seeking to qualify for center construction funds must submit, for the approval of the Secretary, plans that among other things: (1) designate a single State agency for administration of the plan, (2) provide for a State advisory council, (3) set up a program for construction of the centers, and (4) provide for a system of determining priorities among center projects.

After the State plan has been approved, individual project applications may be submitted by local public or private agencies (or a combination) through the State agency. At that time reasonable assurance must be given that adequate financial support will be available for the construction of the project and for its operation when completed.

Funds for the first year of the center construction program are included in the President's budget for fiscal year 1965. Administration of the program will be the joint responsibility of the National Institute of Mental Health, NIH, and the Division of Hospital and Medical Facilities, Bureau of State Services, both of the Public Health Service.

PLANNING GRANTS

Closely integrated with the community mental health centers legislation are the appropriations made by Congress in fiscal years 1963 and 1964—over \$8 million in all—for grants to the States to aid in the preparation of State-wide plans for comprehensive mental health programs.

Applications for planning grants from all the State Mental Health Authorities have been approved by the Public Health Service, thus enabling all the States to use these matching, grant-in-aid funds.

For the first time in the history of our country, each of the States is thus being helped to formulate a comprehensive approach to the problems of mental illness as they affect its residents.

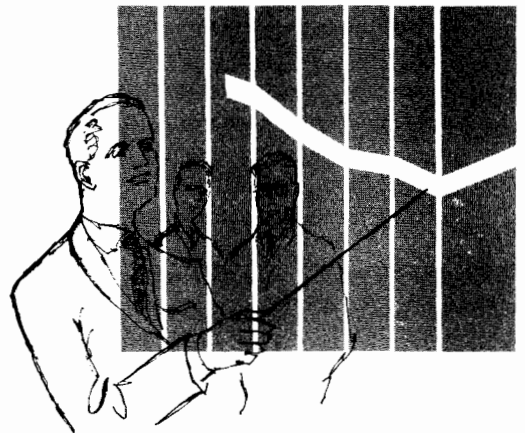
Funds have been made available for such activities as the development and use of means for gathering data, the integration and analysis of information, the determination of needs, the selection of goals, priorities, and methods, and the allocation of available resources to achieve the selected goals.

The planning grants program is being administered by the Office of the Director, National Institute of Mental Health.

HOSPITAL IMPROVEMENT PROGRAM

Funds for a new program to improve therapeutic services in State mental hospitals and institutions for the mentally retarded were included in the 1964 appropriation for the Department of Health, Education, and Welfare. During the first year of the program, \$6 million will be awarded by NIMH in the form of Mental Health Project Grants to support the new program.

The grants, accompanied by consultation and technical assistance, are designed to stimulate the institutions in initiating a sequence of



improvements which will spread throughout their entire program. They are also designed to help the hospitals and institutions achieve a more positive role as an integral part of the comprehensive community-based effort against mental illness and mental retardation.

The \$6 million will make possible at least one grant in each State which submits an approvable project for fiscal year 1964; an individual hospital or institution may receive a maximum of \$100,000 in any one year for a project or series of projects. Funds to assist additional hospitals and institutions will be requested in the future.

By the December deadline, 101 of the 289 eligible State mental hospitals and 65 of the 134 State institutions for the mentally retarded had submitted applications. In all, applications from 48 of the 54 States and Territories were received. The proposals are being reviewed initially by a special committee of persons selected for their experience in the operation of mental hospitals and institutions for the retarded and later will be reviewed by the National Advisory Mental Health Council.

Among the project proposals are: specialized intensive treatment programs for emotionally disturbed children and adolescents, for the aged, or for the seriously regressed chronic patient; hiring key staff to develop alternatives to full inpatient care; and developing pre- and post-hospital services which will bring about more effective use of inpatient facilities.

This grant program is being administered by the Community Research and Services Branch (formerly Research Utilization Branch) in cooperation with the regional offices of DHEW.

INSERVICE TRAINING PROGRAM

A total of \$3.3 million will support a new program of inservice training of personnel in

State mental hospitals and institutions for the mentally retarded during fiscal year 1964. Approximately 225 hospitals and institutions have applied for the NIMH grants, funds for which were included in the 1964 appropriation for the Department of Health, Education, and Welfare.

The new program will enable about one-third of the State mental hospitals and institutions for the retarded to receive up to \$25,000 each during the first year of the program, with at least one grant in operation in each State. It is hoped that funds to expand the program will become available in succeeding years.

The long-range objectives of the program are to increase the effectiveness of staff in these institutions and in other community mental health-centered agencies, and to translate rapidly increasing knowledge into more effective services to people. Because personnel such as psychiatric aides, attendants, house parents and others involved in direct patient care constitute such a large and important treatment resource, the first major support is being extended to this category.

Grant requests are being considered initially by a new subcommittee of the Mental Health Training Committee and will later be reviewed by the National Advisory Mental Health Council.

In connection with the new program, seven regional conferences were held throughout the country in which more than 700 State leaders including governors, legislators, heads of mental health and mental retardation agencies, and university heads and staff participated. Conferencees discussed program planning for inservice training and broad questions of current thinking and practice in this area. They also explored ways in which State mental health agencies, colleges and universities, and the NIMH can work together to formulate more adequate inservice training programs.

This program is being administered by the Training Branch of NIMH in cooperation with HEW regional offices.

FACILITIES AND SERVICES FOR THE RETARDED

Two important pieces of legislation which will benefit the mentally retarded were enacted by the 88th Congress.

Titles I and III of the Mental Retardation Facilities and Community Mental Health Centers Act of 1963 (Public Law 88-164) authorize \$126 million for the construction of research centers and facilities related to mental retardation between fiscal years 1964 and 1967 and \$53 million for the training of teachers of handicapped children and for research and demonstration projects in this area between fiscal years 1964 and 1966.

Under Title I, \$26 million is authorized for the construction of research centers, \$32.5

million for the construction of university-associated facilities, and \$67.5 million for grants to the States for the construction of facilities for the care and treatment of the mentally retarded. In order to receive the construction grants, the States must present a construction program based on a Statewide inventory of existing facilities and survey of need. It must also indicate the priority order of projects.

Title III authorizes \$47 million for training teachers of handicapped children—including the mentally retarded, emotionally disturbed, and physically handicapped—for fiscal years 1964 through 1966, and \$2 million a year for the same period for research and demonstration projects relating to the education of handicapped children.

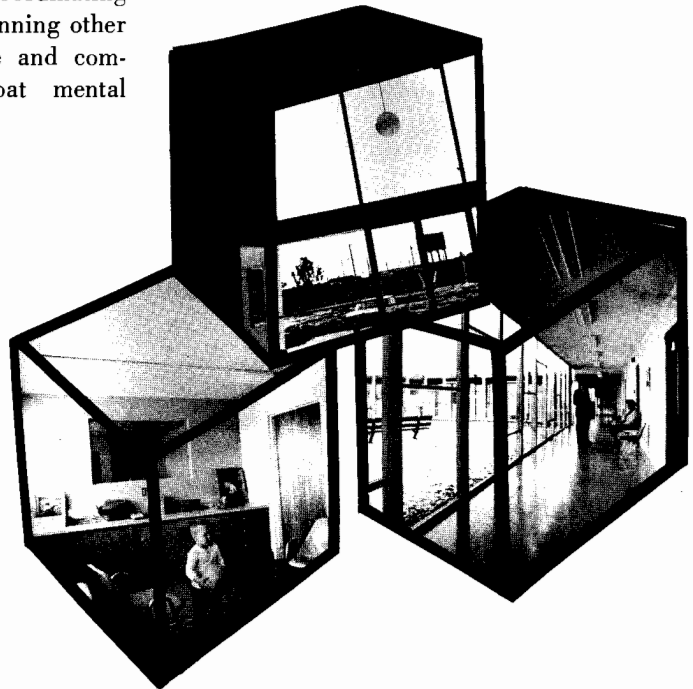
The 1964 supplemental appropriation for the Department of Health, Education, and Welfare included funds for the first year of the new program, for which the following units of the Department of Health, Education, and Welfare have administrative responsibility:

<i>Program</i>	<i>DHEW Unit</i>
Construction of research centers.	Division of Research Facilities and Resources, NIH, in cooperation with National Institute of Child Health and Human Development, both Public Health Service.
Construction of university-affiliated facilities.	Division of Hospital and Medical Facilities, Bureau of State Services, PHS.
Construction grants for facilities for mentally retarded.	Division of Hospital and Medical Facilities, Bureau of State Services, PHS.
Training of teachers of handicapped children.	Division of Handicapped Children and Youth, Office of Education.
Research and demonstration projects in the education of handicapped children.	Division of Handicapped Children and Youth, Office of Education.

The Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (Public Law 88-156) encompass four programs related to mental retardation:

1. Expansion of existing programs of maternal and child health and crippled children's services, with funds to be increased by steps from \$50 million in fiscal year 1964 to \$100 million in 1970 and afterwards.
2. A new \$110 million program of grants for maternity care projects designed to prevent mental retardation.
3. A new program of \$8 million a year in grants or contracts for research in maternal and child health and crippled children's programs.
4. A one-time grant to the States to encourage planning. A total of \$2.2 million is authorized to assist in developing public awareness of the problems of mental retardation, coordinating existing resources, and planning other activities leading to State and community action to combat mental retardation.

The 1964 supplemental appropriation for the Department of Health, Education, and Welfare also included funds to get these programs under way. The first three programs will be administered by the Division of Health Services of the Children's Bureau, Welfare Administration, and the planning grants by the Division of Chronic Diseases, Bureau of State Services, Public Health Service.



In The States

COMMUNITY MENTAL HEALTH SERVICES ACTS

Three States—Michigan, North Carolina, and Colorado—passed Community Mental Health Services Acts in 1963, raising the total number of States with such laws to 18. Several other States amended their acts.

MICHIGAN's new law provides for State matching grants to localities ranging from a minimum of 40 percent to a maximum of 60 percent of local expenditures. The grants may not exceed \$1 per capita of the population served by the local program. Over a 5-year period, State-administered clinics are to be turned over to local control and so eventually will become eligible for participation in the State matching program.

State grants to localities may be used to help support inpatient and outpatient diagnostic and treatment services; rehabilitative services; consultative services to courts, public schools, and health and welfare agencies; information and education services; and cooperative preventive services with public health and other groups.

NORTH CAROLINA's law provides for joint operation of local community mental health clinics by the new State Department of Mental Health and the local mental health authority, representing the local governmental unit. State funds will pay for two-thirds of the first \$30,000 of the approved budget of the local mental health authority and half of the remainder.

The North Carolina law is unusual in the

amount of authority it gives to the State Mental Health Department. According to the law, the local participating clinics will operate under the "supervision" of the department, and the appointment of a clinic director requires the approval of the State Commissioner of Mental Health.

The COLORADO law, which differs even more from the typical Community Mental Health Services Act, makes it official policy for the State Department of Institutions to purchase services from local community mental health clinics, thus giving legal sanction to a subsidy program already in effect. During the first 3 years of clinic operation, the State may pay 75 percent of hourly costs of services, and afterwards, 50 percent. The State Department of Institutions was also authorized to set standards for participating clinics.

Among the States amending their Community Mental Health Acts was NEW YORK, which became the first State to remove the per capita ceiling on State reimbursement for local community mental health expenditures. Under the revised law, the State matches local expenditures, dollar for dollar, without limit. Safeguards are provided to insure that the additional funds will expand local programs in accordance with the State Mental Health Commissioner's plan for State-local mental health services.

In CALIFORNIA, State reimbursement to local mental health programs (Short-Doyle Act) will be raised from 50 to 75 percent in those counties which expand their programs to specified levels. NEW JERSEY raised the

ceiling on State matching of local expenditures from 20 to 25 cents per capita.

CONNECTICUT's Community Mental Health Act had been limited to psychiatric clinics for children; the 1963 law expands State support to include clinic services for adults.

ILLINOIS legislation authorized localities to levy an annual tax of one-tenth of 1 percent of their taxable property, to be used to establish and operate community mental health facilities. Approval of the tax through a referendum is required. Under previous legislation the State Department of Mental Health already had authority to make grants-in-aid to localities.

SERVICES FOR CHILDREN

Two State legislatures approved programs which will benefit special groups of children.

In CALIFORNIA, special educational services will be provided for "culturally disadvantaged" children. The State Department of Education was authorized to provide grants to local school districts for "compensatory education" programs, including broadening of cultural experience, stimulation of educational and cultural interests, guidance and counseling, work with community agencies, individualized instruction, and remedial assistance.

The ILLINOIS legislature approved a \$6.8 million matching program to encourage school districts to develop special programs for gifted children. Current plans call for establishing demonstration centers and experimental projects and for training specialists who will become experts in counseling gifted children.

NEW FACILITIES AND SERVICES

A 1963 law in MISSOURI authorized the establishment of three mental health centers: Western Missouri Mental Health Center in Kansas City, Mid-Missouri Mental Health Center in Columbia, and Malcolm Bliss Mental

Health Center in St. Louis, all to be operated by the Division of Mental Diseases of the State Department of Health and Welfare. The facilities are to serve as receiving and intensive treatment centers. When they are in operation, it is planned that all patients in the State will be admitted to one of them, with the State hospitals receiving only those patients who do not respond to treatment at the centers. The legislation was accompanied by a \$9 million appropriation.

Legislation in OHIO provides for outpatient services at all State mental hospitals. The new law states that any person, including ex-mental hospital patients, may apply to the hospital for "therapy and medication." Services will include individual and group therapy, day care, medication, activity and industrial therapies, and vocational rehabilitation. In several hospitals Community Services Units have already been established and staffed. Gradually, all outpatient services of the mental hospitals are being consolidated in these units.

ALCOHOLISM

The trend to strengthen State organization of alcoholism programs was reinforced by action in four States. The MONTANA legislature set up an Alcoholism Service Center as part of the Montana State Hospital. There had been a small alcoholism program at the State hospital, and the State Board of Health had been responsible for alcoholism education. In TENNESSEE, legislative action created an alcoholism program in the State Department of Mental Health and provided an appropriation of \$25,000. Under the new program, arrangements have been made in four of the State hospitals to accept and treat alcoholic patients, and mental health clinics have also agreed to treat such patients.

In WEST VIRGINIA, a new law created a Division of Alcoholism in the Department of Mental Health and appropriated \$25,000 for

its activities. Formerly, the Department had had legal responsibility for such a program but no clear mandate. The ILLINOIS Department of Mental Health was authorized to make grants-in-aid for the care, treatment, and rehabilitation of alcoholics and for educating the public about alcoholism. Grants-in-aid for alcoholism had previously been limited to research.

DRUG ADDICTION

CONNECTICUT passed a law providing for the admission of narcotic addicts to separate facilities in State mental hospitals. Admission may be voluntary or by court commitment. A new OKLAHOMA law directs the State Department of Mental Health to establish a

room or ward for the treatment and rehabilitation of minors who are drug addicts.

In MASSACHUSETTS, the legislature authorized the establishment of a Drug Addict Rehabilitation Board. The Commissioners of Correction, Mental Health, and Public Health are administering the program which will be in—but not under—the Department of Public Health. The board has power to appoint a Director of Drug Addict Rehabilitation and to establish a State center in any public or private institution by contracting for services. Addicts may enter the institution on a voluntary or civil commitment basis or through the courts. The sum of \$93,000 has been appropriated for the first year's operation of the program.



What's Going On

HOSPITAL POPULATION DROPS AGAIN

For the eighth consecutive year, the resident patient population in the Nation's State and county mental hospitals decreased, according to the NIMH Biometrics Branch. The 1963 figure of 504,947 resident patients in these hospitals represents a decrease of 2.1 percent from the 1962 figure.

Since the downward trend began in 1956, there has been a reduction of 53,975 or 9.7 percent in the hospital population—an average decline of 1.2 percent per year.

Admissions, on the other hand, continued to rise—from 267,068 in 1962 to 285,244 in 1963—a jump of 18,176 patients or 6.8 percent of total admissions. This upward trend began in the mid-1940's.

Also rising was the number of net releases (live discharges from the hospital to the community or to other inpatient facilities). Between 1955 and 1963 the number of net releases almost doubled—rising from 126,498 to 247,228.

The number of full-time personnel in the State and county mental hospitals stood at 194,516 at the end of 1963—a ratio of 2.6 resident patients per full-time employee. This compares with 146,392 full-time personnel in 1955, a ratio of 3.8 resident patients per full-time employee.

Maintenance expenditures for the public mental hospitals have also continued to climb during this 8-year interval—from \$618,087,247 (\$3.06 per resident patient per day) in 1955 to \$1,084,713,931 (\$5.81 per resident patient per day) in 1963.

COMPENSATED WORK AS THERAPY HELPS PATIENTS IN VARIOUS SETTINGS

The success of a number of work therapy programs in which the patient is paid for his work was documented at a recent workshop at the Institute of the Pennsylvania Hospital, Philadelphia. This workshop was one of a series being held with support from Smith Kline and French Laboratories.

The program at the Brockton, Mass., Veterans Administration Hospital was described in detail as a means of stimulating interest among mental health professionals in initiating compensated work therapy programs in other settings.

The Community-Hospital-Industry Rehabilitation Project (CHIRP) at Brockton was started early in 1961 following a trip to Europe by two Veterans Administration psychiatrists who were impressed with the effectiveness of compensated work programs there in aiding the rehabilitation of long-term mental patients.

A specialist in physical medicine and rehabilitation was assigned to make contacts with private industry in the area to secure sub-contracts for work to be done in the hospital by patients. The type of work found most suitable has been assembling, burring, simple grinding, inspecting and wrapping. Often a factory does not have enough space or personnel to perform these operations on its own and welcomes an opportunity to subcontract the work.

All CHIRP candidates must be referred by a physician. After starting in the program, they usually reach the production standard in 1 to 14 days. When this is achieved (or approached within 80 percent) the worker is paid an hourly wage of \$1.25, the prevailing minimum in the area. A realistic factory setting is created, including time clocks and coffee breaks, and factory discipline is expected.

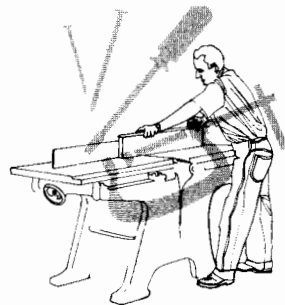
Each patient accepted in CHIRP continues in the program for 60 days. If he is not ready for discharge, he may continue for another 60 days. In the first 21 months of operation (through March 1963), 192 patients were assigned to the program; there were 24 remaining in it as of April 1, 1963. A total of 121 patients had been separated from the hospital with medical approval; only 6 of these were readmitted.

Several other compensated work programs were also described.

At the Veterans Administration Mental Hygiene Day Care Center, Providence, R.I., a program similar to CHIRP is in existence as part of a day care program. An average of 25 patients participates three times a week. Designed to help people who are "salvageable," the program includes males with chronic psychiatric conditions who have not worked for at least 3 months. The emphasis is on preventing hospitalization of the patients. At the same time, an effort is made to improve their home situation. Once the patient has

met the production standard, efforts are begun to place him in a job.

Rosewood State Hospital in Maryland, an institution for the mentally retarded, began a new contract work program more than a year ago. It was found that a planned sequence of learning was necessary, and only contracts without a time factor were accepted. In addition, Rosewood has been sending out women patients to work in factories in the community. In one such instance a rush call for 10 factory workers was received, and the staff accepted it with a great deal of apprehension. An instructor was sent along to the factory with the women to give them initial assistance and support. After the first few days, the women in the program were able to manage the time clock and other details, and after a week they behaved like the other employees. After a few months, the hospital was able to recall the instructor, and by the end of a year the women had lost their "retarded" behavior and had been completely assimilated in the jobs. At present, Rosewood has 60 women who have been "cleared" for day work in the community, and 25 go out each week.



The program at Philadelphia State Hospital includes a PREP (Preparation for Return to Evaluation and Production) shop for patients who need to reinforce work habits and overcome dependency feelings before returning to the community. After a 2-week trial period, the patients are evaluated by the medical staff

and if found qualified, are transferred to the production shop. Patients usually meet production norms on the subcontract factory work in 2 to 3 months.

The Jewish Employment and Vocational Service, Philadelphia, had a job placement program of long standing but found that many of the people it placed could not keep their jobs. To solve this problem it set up a short-term sheltered workshop to enable participants to learn social skills. The workshop occupies a floor of an industrial building, and the people consider themselves workers. During the first 4 weeks the worker is given work samples, graduated in difficulty, to discover his preferences and his achievement level. At the beginning there is a very benign atmosphere but later it is firmer, with an insistence on adequate interpersonal relationships. Of 339 persons referred, all of whom had previously been judged unemployable, 55 were placed in positions and still were holding their jobs at a 3- or 6-month followup.

"CRISIS UNIT" RETURNS MOST PATIENTS TO COMMUNITY

A high percentage of patients admitted to the intensive treatment unit at Northern State Hospital, Washington, are able to return to the community after an average stay of 22 days. Treatment in the unit is based on encouraging the patient to be as self-sufficient and self-directing as he can.

The unit admits all patients under the age of 60 entering the hospital from Snohomish County. The first phase of the treatment program is characterized by rapid service: the patient is greeted by a receptionist who serves coffee and calls the doctor, who usually arrives within 10 minutes. The doctor interviews the patient and does a physical examination. The patient then goes with a nurse to choose a room. In almost all cases, somatic treatment is begun within 2 hours of the patient's arrival.

He is told to rest, sleep, eat, and postpone any effort to solve his problems until he feels better.

When acute symptoms have subsided, the patient is transferred to the readjustment section. Here he abruptly enters a quite different situation, one which attempts to approximate living in the community. The program is designed to convey to the patient the expectation that he is a responsible, capable, self-respecting person. The patients keep and take their own medicines. They are expected to go home every weekend and to make their own arrangements for doing so. They decide whether they wish to participate in industrial or occupational therapy and hospital recreational activities. Each patient is assigned a counselor with whom he discusses plans and problems related to returning home. In the counseling, emphasis is placed on working jointly with the patient and his family, and most families have participated in this planning activity.

After the patient has returned home, a detailed report of his hospital treatment is forwarded to his family physician, and an early appointment with the family physician is recommended. The Snohomish County Health Department has a social worker who acts as a mental health consultant for the community, and a resource coordinator who is in touch with the public health nurse, public assistance department, vocational rehabilitation facilities, etc. When necessary, the resource coordinator arranges for the use of the appropriate service to the patient returning to the community.

Of the 72 patients admitted to the intensive treatment unit during a 6-month period, 66 returned to the community and 6 were transferred to other facilities, including other sections of the State hospital.

This project is an example of the use of Mental Health Project Grant funds to test out innovations in treatment programs.

INSURANCE COVERAGE FOR MENTAL ILLNESS

FEDERAL PLANS IMPROVE BENEFITS

Five of the health insurance plans participating in the Federal Employees Health Benefits Program began offering some benefits for psychiatric disorders for the first time November 1, 1963, and four other plans improved such benefits on that date, according to an announcement by the Civil Service Commission, which administers the program.

Among the plans with expanded psychiatric coverage is Group Health Insurance, Inc., of New York City, which now provides both inpatient care and care outside the hospital, including individual and group psychotherapy. The feasibility of insuring this kind of coverage was demonstrated in a 30-month research project at Group Health Insurance, completed in 1962 and supported by NIMH funds. The Kaiser Foundation Health Plan of Southern California, in addition to new benefits while the patient is hospitalized for psychiatric illness, also provides 75 percent of the first \$120 of charges for outpatient evaluation.

The Government-wide Service Benefit Plan (Blue Cross-Blue Shield) increased its inpatient benefits for nervous and mental disorders to 120 days under the high option and 30 days under the low option, the same number of days allowed for other illnesses.

The fourth contract year for the program began November 1 with 38 different plans participating, including 2 Government-wide, 13 sponsored by employee organizations, and 23 direct-service plans. Most of the employee organization plans and the two Government-wide plans (Blue Cross-Blue Shield and Aetna) have offered substantial benefits for mental illness since the inception of the Federal employee program.

The Civil Service Commission, in announcing the new psychiatric coverage, said it was gratified at the progress made in this area, which came about in response to the late President John F. Kennedy's Special Message on Mental Illness and Mental Retardation. The Commission anticipates that psychiatric benefits will be improved in future years as carriers gain experience.

AVERAGE LENGTH OF STAY 10 DAYS

Reporting on experience under the Government-wide Service Benefit Plan (Blue Cross-Blue Shield), "Inquiry," a Blue Cross Association publication, noted that under the high-option plan for the period November 1, 1961 to October 31, 1962, the average length of stay for mental disorders was 10.0 days compared to 6.7 days for all conditions. Mental disorders accounted for 2.6 percent of all admissions, 3.8 percent of all hospital days, and 3.1 percent of the total amount of hospital charges.

CLEVELAND BLUE SHIELD UPS IN-HOSPITAL PAYMENT

What may be the first Blue Shield plan offering premium benefits for intensive psychiatric care in the hospital is now in effect in Cleveland after several years of negotiations between the Cleveland Academy of Medicine and Blue Shield. Under the new agreement, Blue Shield will reimburse subscribers for physicians' services for treatment in a general or private mental hospital for major mental disorders in the following amounts: \$25 for the first day and \$10 for each subsequent day, up to 30 days. Reimbursement then reverts to \$4 a day for the remainder of the benefit period, which is usually 120 days.

To cover hospital expenses, Blue Cross in Cleveland offers full reimbursement for a maximum of 120 days if the patient is treated in a general hospital and \$10 a day towards the costs in a private psychiatric hospital.

DAY HOSPITALS SHOW RAPID GROWTH

The emerging importance of the day hospital in the treatment of mental illness was emphasized at a Day Hospital National Workshop held in Kansas City, Mo., September 16-18, 1963, by the Greater Kansas City Mental Health Foundation under an NIMH Mental Health Project Grant.

In a day hospital program, the patient lives at home but goes to the day hospital for treatment and planned activities from Monday through Friday (or sometimes fewer days), usually from 9 until 4 or 5 o'clock.

Reports on a number of such programs already in existence suggest that roughly half the mental patients who formerly would have been admitted to a 24-hour treatment facility can be treated in a day hospital. This kind of care is less expensive than 24-hour treatment, decreases the tendency toward dependency and regression, and retains the patient's ties with family and community.

"Once a day hospital is established, the door to the community seems to open more easily, and it never closes," Milton Greenblatt, M.D., Superintendent of Boston State Hospital, noted in his lead-off speech at the workshop.

A report to the workshop on the first national survey of psychiatric day-night services revealed that as of May, 1963, there were 114 such programs in the U.S. in which a psychiatrist assumed medical responsibility for all patients. The major growth in the number of day hospitals has taken place in the past 3 years; only 37 were in existence prior to 1960.

The study, undertaken by the NIMH Biometrics Branch, showed that half of the centers were located in four States—California, New York, Ohio, and Pennsylvania. Of the 114, 85 offered day services only, 27 both day and night services, and 2 only night services

(where the patient goes to the hospital in the evening for treatment and activities and sleeps there, but carries on his normal activities away from the hospital during the day). Almost 3,600 patients were under care in such services during the week of May 19, 1963—2,900 in day care and 700 in day-night care.

Forty-eight of the facilities were connected with a mental hospital and 16 with a general hospital. In addition to 7 centers affiliated with a community outpatient psychiatric clinic, 4 with a community mental health center and 7 with other community agencies, there were 19 day centers associated with Veterans Administration outpatient clinics.

Among the reports at the workshop was one by Alan M. Kraft, M.D., Director of the Fort Logan Mental Health Center, part of the Colorado mental hospital system serving residents of Denver. Dr. Kraft told of a study of 235 patients admitted to the center from July 1 to December 31, 1962. Of the 235 patients, 116 (49 percent) were admitted as 24-hour patients and 119 (51 percent) as day patients, suggesting that about half the patients entering a State hospital can be admitted to a day setting. A study of the characteristics of the two groups of patients revealed that while those admitted as inpatients were more disturbed and more severely impaired than the day patients, many who were very seriously impaired could be treated in the day hospital.



Among the other speakers at the workshop was H. Douglas Bennett, M.D., physician of the Bethlem Royal Hospital and Maudsley Hospital, London, England, who reported on the sharp acceleration in the growth of day hospitals in Great Britain in the past few years. The first day hospital in Great Britain opened 15 years ago and in 1959 there were only 38. But by 1961 there were 116 and by the end of 1962 there were 153, treating a total of 8,840 patients during the year.

Great Britain is planning to reduce the number of inpatient beds for mental health services from 30 per 10,000 population to 18 per 10,000 population within 15 years. Much of this planned reduction is based on the increasing use of day hospitals and day centers. The latter are independent of the hospital but offer a limited amount of medical supervision. It is expected that 103 day centers, which will provide a "sheltered workshop" type of setting, each with a capacity of 30-40 patients, will be built by 1975.

Some of the issues and questions raised at the workshop were:

1. Organization structure and its implications for the kind of patient to be treated and the orientation of the treatment program—day programs as part of established general and/or mental hospitals vs. physically and administratively separate facilities.
2. The modification of traditional roles of the various mental health professionals in the day hospital program.
3. Homogeneity vs. heterogeneity of patients according to age, diagnosis, and socio-economic status.
4. Role expectations of patients in a "hospital without beds."
5. Optimum size of patient groups.
6. Advantages and disadvantages of combining day patient and inpatient activity programs.

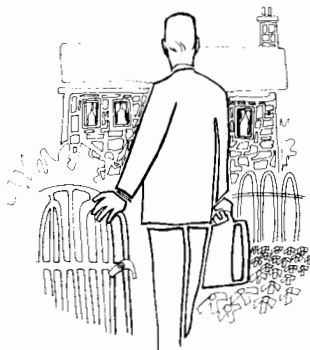
Attending the workshop were about 275 mental health professionals from 32 States, some of whom are now actively engaged in day hospital programs and others representing institutions or agencies contemplating day hospitals. The proceedings will be published this year.

HERE AND THERE IN THE STATES CALIFORNIA PSYCHIATRISTS MAKE HOME VISITS

A recent survey of 266 psychiatrists in northern CALIFORNIA revealed that 90 percent had made a home visit at some time in their private practice and that nearly half had made two or more home visits in the year prior to the survey.

Private psychiatrists made most of their home visits to patients they were seeing for the first time. These were usually patients who were markedly disturbed and whose family or family physician requested a psychiatric evaluation at home.

The survey indicated that when a patient—particularly an acutely ill one—is seen at home, a more complete and accurate evaluation of his condition and his environment is obtained than in the psychiatrist's office. In the cases studied, it appeared that most of the patients being seen for the first time and most of those already in office treatment avoided hospitalization as a result of the visit.



FLORIDA EMERGENCY SERVICE PREVENTS HOSPITALIZATION

Impressive results in preventing hospitalization as a result of a county-wide Emergency Psychiatric Service are reported by the Pinellas County (FLORIDA) Health Department. Several emergency teams, each consisting of a physician and a public health nurse, with psychiatric consultation available, have been organized and answer requests for aid any hour of the day or night.

During the first year of operation, 1,215 emergency calls were received, the majority from the patient's family, a neighbor or friend, the police, or a physician. Results included the following:

- Forty-seven percent of patients receiving emergency care remained at home, receiving treatment at a clinic or from a family physician. Eight percent were referred to nursing homes, and 44 percent received evaluation and/or treatment in local general hospitals.
- New admissions to State hospitals from Pinellas County were reduced by 15 percent, although the population of the area increased.
- The team found it was not unusual for other family members to be in need of psychiatric help. Home visiting proved to be a new, relatively inexpensive, and effective case-finding technique.
- Jail detention of the mentally ill was virtually eliminated.

AVERAGE COST OF TREATING MARYLAND PATIENT FALLS

The MARYLAND Department of Mental Hygiene reports that despite rising daily costs for maintenance expenditures, the total cost of treating a mental patient in the State hospitals has dropped 40 percent in the past 10 years.

This dramatic drop is due to the increased discharges and shorter periods in the hospital resulting from improved treatment methods. The average total cost of treating a patient from admission to discharge was cut from \$5,207 in 1952 to \$3,109 in 1962.

"TEACHER-MOMS" AID NEW YORK CHILDREN

The public school system in suburban Elmont, NEW YORK, is using "teacher-moms"



to educate and treat severely emotionally disturbed children who cannot be handled in regular classrooms. The "teacher-moms" are warm, emotionally stable mothers who are willing to contribute two mornings a week to working with the children. A local synagogue and Kiwanis Club provide classrooms and financial support.

The key to progress in the special classes appears to be the one-to-one relationship with the children and the communication by the "teacher-mom" of warmth and affection; for example, she holds the child on her lap when she thinks this is necessary.

Of the 21 children in the program during its first 3 years, 11 have been returned to regular classrooms. Because of the relatively low cost of the program—\$680 per pupil for one school year—it has a potential for use on a widespread basis.

MANHATTAN AFTERCARE CLINIC SHOWS DAY CARE EFFECTIVENESS

Day hospital treatment was as effective as inpatient treatment for relapsing ex-hospital patients, a recent study at the Manhattan Aftercare Clinic, NEW YORK City, indicated. A group of acutely disturbed relapsing ex-patients was treated in the day hospital as part of a research project and the results compared with those from a similar group returned to the State hospital for treatment.

Among the findings of the study, which was financed by an NIMH grant, were:

1. Acutely psychotic symptoms can be brought under control in a day hospital and remission of symptoms achieved within 7 weeks.
2. Day hospital patients are able to return to gainful employment or home responsibilities as soon as, or sooner than, inpatients. After 2 months of treatment, 40 percent of the day hospital patients were employed as compared with 10 percent of the State hospital patients. Day hospital patients did not give up their job; they took sick leave instead.
3. Remission of symptoms among the day hospital patients lasted as long as for the group which received inpatient treatment.

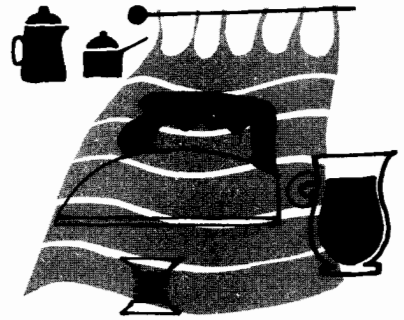
RHODE ISLAND HOUSEWIVES GET HELP FROM REHAB SPECIALISTS

The RHODE ISLAND State Division of Vocational Rehabilitation and the University of Rhode Island have teamed up to assist mentally ill housewives in the critical period of transition from hospitalization to home life. More than 300 women have participated in the new program thus far.

Just prior to discharge, women patients from the Neuropsychiatric Department of Chapin Hospital are given one or more demonstrations

on how to simplify their housework by the university's home management specialist. Topics range from ironing to household budgeting. Another faculty member discusses problems related to child rearing, family relationships, and meeting emotional needs. Films and small group discussions accompany the talks.

After the patients return home, they are provided with individual homemaking instruction and other services such as vocational training, job placement, and demonstration marketing trips.



TEXAS HOME TOWN PROGRAM EXTENDED

An experimental program of treating a large proportion of mental patients in their hometown (El Paso, TEXAS) instead of in a distant State mental hospital has proved so successful that the 1963 State legislature appropriated \$546,000 for the next biennium to extend the program to other communities.

The El Paso County Hospital is used as a treatment facility for many patients who previously would probably have been sent to Big Spring State Hospital, 400 miles away. The county furnishes the beds, nursing care, medicine, and outpatient clinic space; the State pays for professional services, particularly psychiatrists' fees. Local psychiatrists decide which patients should be treated at the county hospital and also carry on their treatment.

In a 7-month period, only 97 patients from El Paso were admitted to Big Spring State

Hospital, although based on previous experience at least 324 patients would have been expected. Stay in the county hospital averaged 9 days. Through the outpatient clinic, many more patients were reached than formerly. Also, aged patients were maintained in their own homes and in nursing homes so that few had to enter the State hospital.

IDAHO FAMILY CARE PROGRAM SUCCESSFUL

An NIMH Mental Health Project Grant assisted IDAHO to develop a successful family care program at its State Hospital, North, and the program is now being financed from State funds.

During the pilot phase of the project 93 patients, of whom 12 were mentally retarded, were involved. All were considered ready for discharge but still in need of fairly close supervision. After placement in family care, only 18 of the 93 had to return to the hospital for continued care; all the rest were reported to have made successful adjustments in the community.

Often two or three patients were placed with the same "sponsor" family. It was found that when placed in the same home with other ex-patients, most of the patients made a better adjustment than when living completely apart from ex-patients.

CONNECTICUT DEVELOPS MENTAL HEALTH SERVICE CORPS

As an outgrowth of the CONNECTICUT project in which students from six colleges participated in a student-companion program at Connecticut Valley Hospital, the State Department of Mental Health last summer developed a Mental Health Service Corps.

Thirty-three carefully selected students, after special training, served for a month at a State hospital and a month at Camp Laurel, the Department's camp for mental hospital patients. Paid only a modest amount, the students performed so well that Department officials are eager to expand the program next summer.

Calendar of

Apr. 8-10-----	National Council on Alcoholism-----	New York City
Apr. 9-11-----	American Medical Association: Conference on Mental Retardation.	Aurora, Ill.
Apr. 22-24-----	Academy of Religion and Mental Health--	New York City
Apr. 26-May 2--	NATIONAL MENTAL HEALTH WEEK	
Apr. 30-May 1--	President's Committee on Employment of the Handicapped.	Washington, D.C.
May 4-8-----	American Psychiatric Association-----	Los Angeles
May 5-9-----	American Association on Mental Deficiency.	Kansas City, Mo.
May 24-----	National Association of Social Workers: Annual Institute on Social Work in Psychiatric and Mental Health Services.	Los Angeles
May 24-29-----	National Conference on Social Welfare (Annual Forum).	Los Angeles
June 8-10-----	National Association of State Psychiatric Information Specialists.	St. Louis
June 15-19-----	American Nurses Association-----	Atlantic City
June 19-20-----	American Geriatrics Society-----	San Francisco
June 21-25-----	American Medical Association-----	San Francisco
Aug. 3-7-----	World Federation for Mental Health-----	Berne, Switzerland

Events—1964

Aug. 17-22-----	First International Congress of Social Psychiatry.	London, England
Aug. 24-27-----	American Hospital Association-----	Chicago
Aug. 30-Sept. 4--	American Sociological Association-----	Montreal
Sept. 3-9-----	American Psychological Association-----	Los Angeles
Sept. 28-Oct. 1--	American Psychiatric Association: Mental Hospital Institute.	Dallas
Oct. 5-9-----	American Public Health Association-----	New York City
Oct. 7-10-----	National Association for Retarded Children.	Oklahoma City
Oct. 9-10-----	American Medical Association: Council on Mental Health, National Congress (Theme: Community Mental Health Centers).	Chicago
Oct. 22-30-----	American Occupational Therapy Association.	Denver
Oct. 29-31-----	Gerontological Society-----	Minneapolis
Nov. 8-11-----	National Rehabilitation Association-----	Philadelphia
Nov. 18-21-----	National Association for Mental Health---	San Francisco
Nov. 19-22-----	American Anthropological Association----	Detroit
Dec. 1-2-----	National Social Welfare Assembly-----	New York

Current Reading

OF SPECIAL INTEREST

THE PREVENTION OF HOSPITALIZATION. A detailed report on the study "Prevention of Hospitalization of Psychotic Patients Referred to the Massachusetts Mental Health Center," by Drs. Milton Greenblatt, Robert F. Moore, Robert S. Albert, and Maida H. Solomon, Grune & Stratton, New York, 1963, 182 pages. \$7.50.

In the belief that large numbers of the mentally ill are accepted and admitted to mental institutions with too little attention given to the possibility of care in the community, NIMH grantees conducted a study among hospital referrals to determine how many could be successfully treated outside the hospital.

For this purpose a Community Extension Psychiatric Service was created at the Massachusetts Mental Health Center (formerly the Boston Psychopathic Hospital). The Service was staffed by psychiatrists, psychiatric nurses, psychiatric social workers, and research personnel. During the study, 128 patients came to the Service by way of the waiting list for admission to inpatient wards. Half of them were reported not to require hospitalization, and were managed by other means so that they remained in the community for at least a year.

Each patient had been referred for full-time ward care. Sixty-two were hospitalized after diagnosis and study by the Community Extension

Service. The other 66 were not hospitalized, and of those, 13 were treated in the Center's day care program 2 or 3 days a week. The other nonhospitalized patients were treated through such means as individual psychotherapy, drugs, electric shock therapy, social casework, and other specialized services, such as vocational counseling. The goals were to explore means of preventing the hospitalization of acute mentally ill patients by providing patients with prompt psychiatric, social service, and nursing attention, and to assess the value of those alternative techniques and resources.

When the Community Extension Service patients were compared with a sample of those either waiting for admission or being treated in the inpatient wards, no substantial differences were found in diagnosis or history.

As a result of the study, investigators concluded that similar units operating in connection with mental hospitals can provide a new focus of thought and energy on the pivotal question of who among the mentally ill require inpatient treatment.

Among recommendations were: a screening-plus-service program should be instituted as a part of every mental hospital in collaboration with social agencies and medical authorities in communities; hospital psychiatrists should actively participate in deciding on admissions;

family physicians who refer patients for hospital admission because appropriate alternatives are either not available or are not considered can benefit from the psychiatric orientation provided by a CES unit; and finally, such a unit can be a training milieu for psychiatric residents and nurses.

GUIDES TO PSYCHIATRIC REHABILITATION: A Cooperative Program with a State Mental Hospital. A report of a three-year project on rehabilitation of psychotic patients in a mental hospital, edited by Bertram J. Black, Altro Health and Rehabilitation Services, Inc., New York, 1963, 96 pages. \$2.50.

Initiated by Altro Health and Rehabilitation Services in 1958, this rehabilitation project was developed in cooperation with the Rockland State Hospital in the New York State Department of Mental Hygiene and with the New York State Division of Vocational Rehabilitation in the State Department of Education.

The book describes the problems the project team encountered in introducing the concept of rehabilitation into a traditional mental hospital program; states the approaches, both successful and unsuccessful, that the team took in its work; summarizes the results of the program; and presents a series of guidelines to the rehabilitation of psychotic patients based on the team's experience and analysis.

Pointing out that "no single service can be considered rehabilitation," the book declares that rehabilitation consists of "hospitalization, psychiatry, casework, vocational counseling, recreational services, employment agencies, sheltered workshops, residential arrangements, and financial support—not necessarily all working together with the same individual but all integrated into a program in which any, some, or all of them are available for an individual."

A major part of the report is devoted to the complex procedure involved in considering a

patient's readiness for discharge from the hospital. Case histories are used to throw light on the principles and guidelines derived from the human experiences described in the report.

Guides to Psychiatric Rehabilitation is intended primarily for use by administrators, psychiatrists, and nurses in mental hospitals; vocational rehabilitation counselors; occupational therapists; and social caseworkers and supervisors. It will also be useful to psychologists, educators, and others who help the mentally ill in their rehabilitation and in their return to the community.

BRIEFLY NOTED

BIBLIOGRAPHIES. A number of bibliographies have been prepared by the Research Utilization Branch of NIMH and published by the National Clearinghouse for Mental Health Information. Single copies are available free of charge from the Publications and Reports Section, NIMH, Bethesda, Md., 20014. The bibliographies include:

Bibliography on Planning of Community Mental Health Programs

Bibliography of Informational Publications Issued by State Mental Health Agencies

Selected Bibliography on Foster Home and Family Care for Mental Patients

Selected Bibliography on Halfway Houses

Selected Bibliography on Emergency Psychiatric Services

Selected Bibliography on Psychiatric Day-Night Services

Selected Bibliography on Mental Health Communications

Bibliography of Published Reports of Completed Studies Supported by Mental Health Project Grants

NEW APPROACHES TO MENTAL RETARDATION AND MENTAL ILLNESS. (November 1963 issue of *Indicators*, monthly

publication of the U.S. Department of Health, Education, and Welfare.) Fifty-four pages of informative articles, illustrated with graphs, relating to: (1) the recent White House Conference on Mental Retardation; (2) legislation recently passed in Congress relating to mental illness and mental retardation; and (3) programs and activities in these two areas. A limited supply of free copies of the issue is available from the Publications and Reports Section, NIMH, Bethesda, Md., 20014.

REHABILITATION IN DRUG ADDICTION, A Report on a 5-Year Community Experiment of the New York Demonstration Center (Mental Health Monograph 3) reports an NIMH demonstration project in which addicts discharged from the U.S. Public Health Service Hospital in Lexington, Ky., were counseled and referred to community health and welfare agencies. Project findings emphasized the importance of integrated, long-term community programs and services to provide the step-by-step support needed by the returned addict. Single copies of the 48-page pamphlet available free of charge from the Publications and Reports Section, NIMH, Bethesda, Md., 20014.

HIGHLIGHTS OF DEVELOPMENTS IN MENTAL HEALTH PROGRAMS, 1962, designed for persons concerned with developing and strengthening mental health programs, emphasizes major developments of nationwide significance and innovations in State and local mental health services. Among topics covered are treatment facilities, including community mental health centers, court decisions, State legislation, insurance coverage of mental illness and special problem areas such as aging and juvenile delinquency. Single copies of the 57-page pamphlet available free of charge from the Publications and Reports Section, National Institute of Mental Health, Bethesda, Md., 20014.

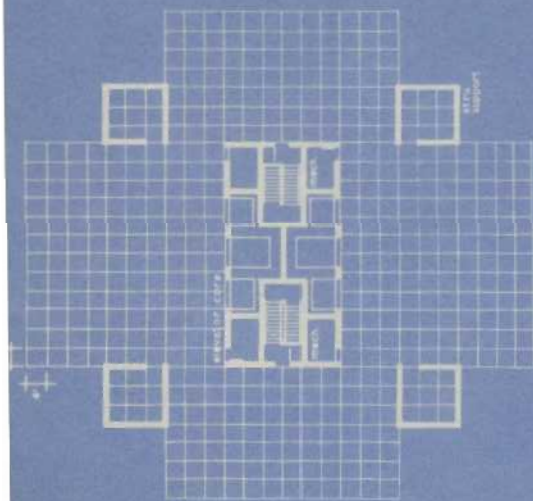
NARCOTIC DRUG ADDICTION PROBLEMS is the 212-page report of an NIMH sym-

posium which represented the first full discussion of this subject by all the professions concerned with addiction. Public Health Service Publication No. 1050, for sale at \$1.75 by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

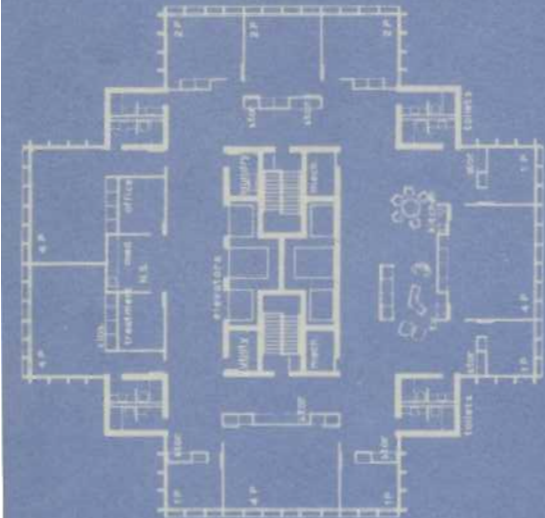
THEY RETURN TO WORK . . . The Job Adjustment of Psychiatrically Disabled Veterans of World War II and Korean Conflict, reports the results of a Veterans Administration study of the employment experiences of veterans with psychiatric disability. Of the sample group of 2,049 veterans studied, including those with major psychotic disorders, 1,421 were found to be employed. The 210-page report is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, at 70 cents.

DIRECTORY OF RESOURCES FOR MENTALLY ILL CHILDREN IN THE UNITED STATES, 1964, lists and describes 147 residential and day facilities that provide service to seriously disturbed children in separate units, distinct and apart from adult care. Both public and private resources are listed. The 96-page directory, published jointly by the National Association for Mental Health and the National Institute of Mental Health, is available for \$2 from the NAMH, 10 Columbus Circle, New York, N.Y., 10019.

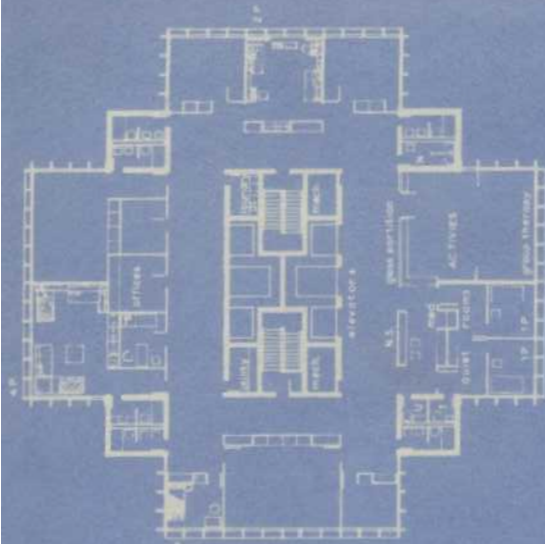
SALARY RANGES FOR PROFESSIONAL PERSONNEL . . . Employed in State Mental Hospitals and Institutions for the Mentally Retarded, September 1963. Report No. 10, Psychiatric Studies and Projects, published by the Mental Hospital Service of the American Psychiatric Association. Listed under type of position, data are presented concerning number of positions and annual salaries in each State. The 36-page study is available at \$1 per copy from the American Psychiatric Association, 1700 Eighteenth Street, NW., Washington, D.C., 20009.



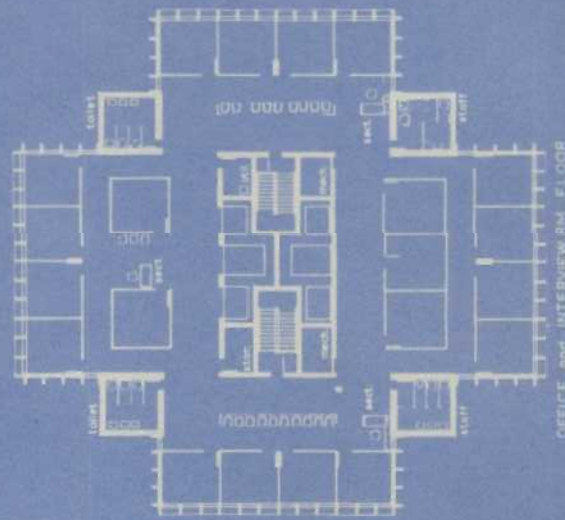
TYPICAL FLOOR PLAN OF TOWER
 clear floor area 6,525 sq ft
 85% support 566 sq ft
 elevator core 1,135 sq ft
 total floor area 8,226 sq ft



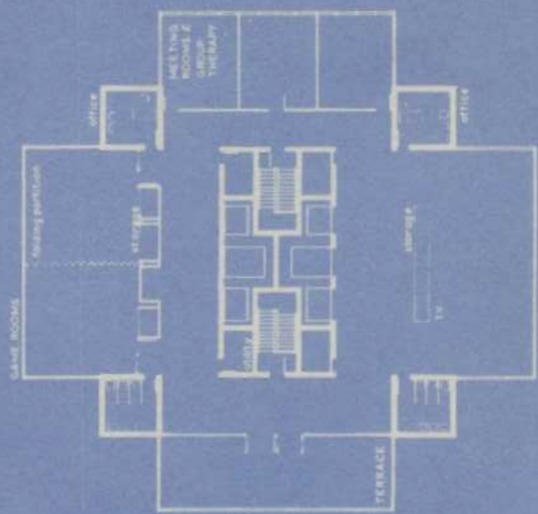
TYPICAL IN-PATIENT FLOOR



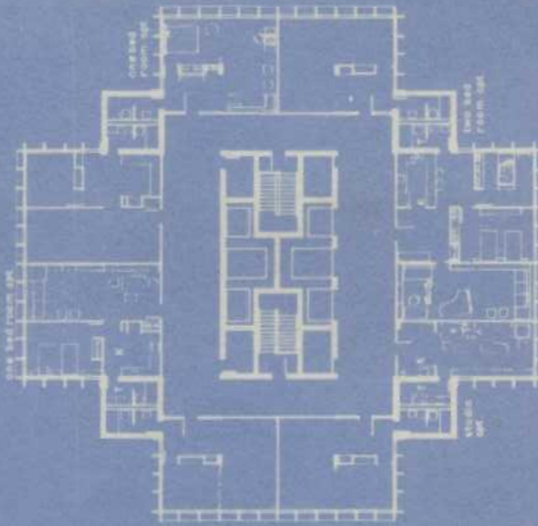
IN-PATIENT FLOOR
 for acute patients



OFFICE and INTERVIEW RM FLOOR



TYPICAL DAY-ACTIVITY FLOOR



STAFF APT FLOOR FLEXIBILITY OF IN-PATIENT UNITS

Public Health Service Publication No. 1141