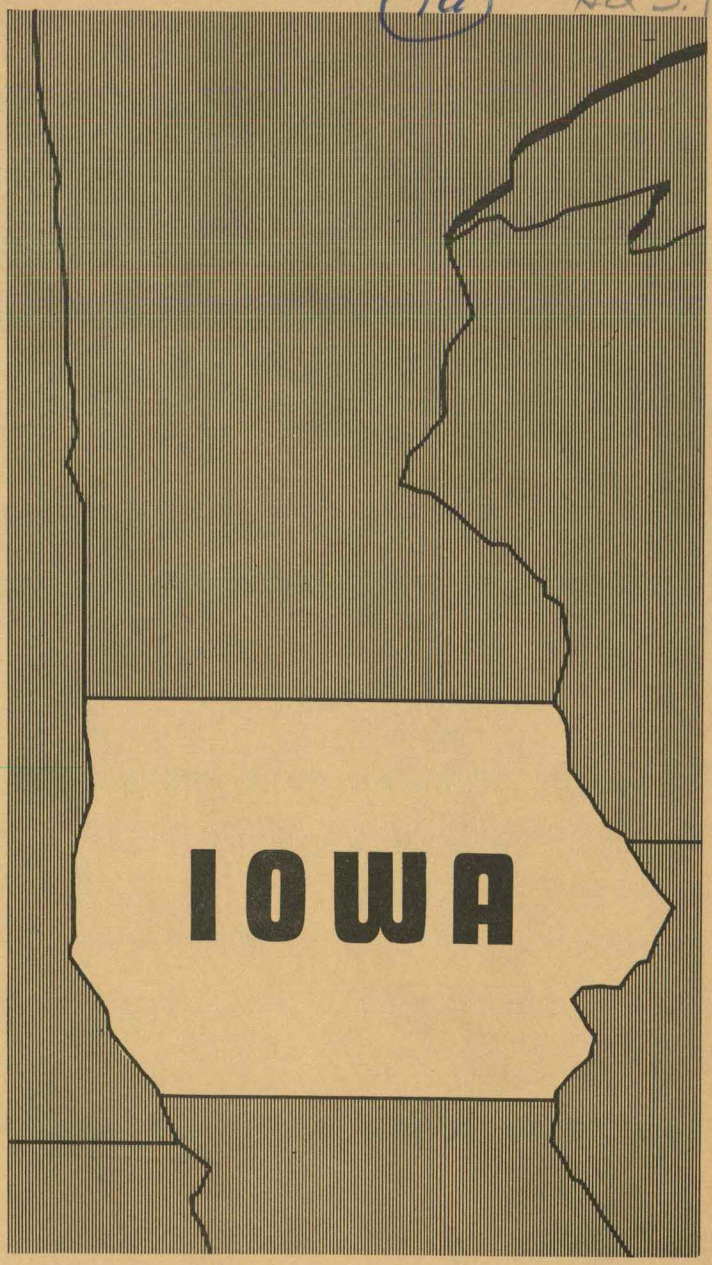
A Mental Health Program for IOWA

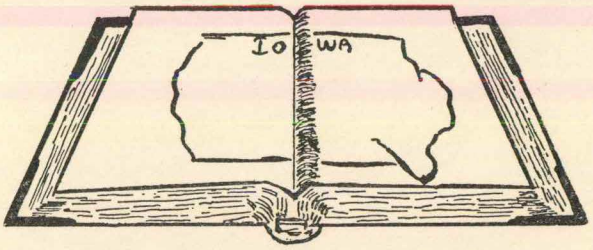


CHAPTER II: SUMMARY AND RECOMMENDATIONS

Submitted by the

GOVERNORS COMMITTEE
ON MENTAL HEALTH with the
AMERICAN PSYCHIATRIC
ASSOCIATION

DECEMBER 20, 1956



SURVEY OF
IOWA'S MENTAL HEALTH NEEDS
AND RESOURCES

SUMMARY AND RECOMMENDATIONS

Presented to His Excellency Governor Leo A. Hoegh

by

The Governor's Committee on Mental Health

assisted by the American Psychiatric Association

December 20, 1956

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SUMMARY AND RECOMMENDATIONS

The Survey Report presents a detailed and comprehensive analysis of a wide range of mental health needs and services in the state. Familiarity with the details is imperative for those who wish to use the report as a basis for action. This Summary is presented to provide a brief statement of the data and the reasoning which underlies the recommendations.

The recommendations which are presented here represent a consensus of expert judgment, adapted to the particular needs of Iowa. They are not final answers. Psychiatry is in a state of rapid growth; great advances have been achieved in methods of prevention and treatment in recent years, and research results are encouraging. Under these circumstances, the state should proceed as far as possible along lines which have been demonstrated to be successful, and experiment with new approaches in areas where progress is apparently being made. It should expect to reevaluate the whole program at regular intervals to determine whether a new direction is indicated.

GENERAL CONSIDERATIONS

Nationally and in Iowa interest in health and related matters is growing. Evidence of this is in such projects and events as the President's Commission on the Health Needs of the Nation, the White House Conference on Children and Youth, increased participation in voluntary health insurance, growing appropriations by Congress to the National Institutes of Health, growing recognition of national and international health movements, and the concomitant interest of various states and territories in these subjects.

In the field of mental health there have been the recent Governors' Conference on Mental Health, the Special Juvenile Delinquency Project, and the development of the National Institute of Mental Health, which has broadened and intensified interest in research, training of specialized personnel, and community services throughout the nation.

In Iowa indications of progress are the gradual increase in legislative backing which has raised appropriations to some degree, the special interest of the Governor, and the increasing strength of the citizens' movement led by the Iowa Association for Mental Health, the Iowa Association for Retarded Children, the Iowa State Medical Association, and other groups.

POTENTIAL FOR GROWTH

There is a solid potential for growth in Iowa. The tradition of education and research at the State University and individual instances of outstanding accomplishment and progress at the state institutions are assets which stand out sharply. There are also discouraging aspects to Iowa's situation, particularly in the lack of leadership and professional knowledge in the state offices, and in the serious lack of personnel in the institutions. The Survey Committee's public hearings clearly showed the determination of those present to obtain professional leadership for the program, and to bring the standards of treatment in the state up to the level which Iowa has a right to expect.

I. INTRODUCTION

The aims of the survey are:

To determine what resources Iowa has for the pevention and treatment of mental illness, and for the development of mental health;

To determine existing needs for psychiatric services;

To develop a framework within which psychiatric services can be strengthened, expanded, and coordinated with non-psychiatric services to achieve more effective prevention, more rapid treatment, and proper and more permanent adjustment to community activity;

To provide the state government and the citizens with a body of technical material which will serve as a guide to continued program improvement;

To provide general information to the public.

FRAME OF REFERENCE

It is important to define the scope of "mental health needs," and to distinguish between "mental health resources" and those community services which serve the whole community in the course of its ordinary activities, and the "trouble shooting services" which stand by in case of serious, but non-psychiatric, difficulties. The Survey presents a Zonal Classification of People and their Needs, which sets up a system of four zones, for purposes of convenience and clarification.

Zone I is the area of prenatal life and embryonic growth and development, with its genetic implications and the period of child birth. Zone II includes

those who are essentially healthy, influenced by the cultural climate with its schools, family life, spiritual development, opportunities for work, etc. Zone III includes those who, under special stress and strain, or with constitutional defects, need special assistance and who are aided by welfare, legal, special educational and non-psychiatric medical services. Finally, Zone IV is the area of psychiatric clinical services and specially trained personnel in the field of mental health. Zone IV has linkages with each of the other zones. Its relation to Zone I is primarily in research, to prevent the incidence of brain damage that sometimes occurs in infants. Its relation to Zone II is in the development of consultation services. Its relation to Zone III is in the provision of psychiatric consultation to the trouble-shooting agencies and assistance in training personnel so that they can better discharge their own responsibilities. The result should be fewer cases of adjustment failures passed on into Zone IV, and a greater readiness by these services to take up the care of psychiatric patients who are released from psychiatric treatment.

DEFINITIONS

The Survey used the terminology of the Standard Nomenclature of Health and Diseases of the American Medical Association, section on Disorders of the Psychobiologic Unit. The mental illnesses are: acute and chronic brain disorders, mental deficiency, psychotic disorders, psychophysiologic autonomic visceral (psychosomatic) disorders, psychoneurotic disorders, personality disorders (psychopaths), and transient situational disorders. The term "prevention" is used in two ways, as early treatment to prevent hospitalization and chronicity, and as preventing the occurrence of a disorder. The latter is "true" prevention, but the Survey used the term in both senses.

BASIS FOR ESTIMATING NEEDS

The incidence and prevalence of mental illness have not been established for any community or state. Nor is the ratio of needed services to population established. Estimates of the number of hospital beds needed per thousand of the population have been in general use for a number of years, but they were developed at a time when community services were unknown. The most widely used figure is that a state needs 5 public mental hospital beds per thousand of the population. This compares with Iowa's present figure of 2.2 beds per thousand. The ratio of 5 beds per thousand may be much too high, if other services are developed. In the case of a state which has substantially fewer beds, the development of community services should be a goal of high priority.

A number of factors enter into the estimates of services needed. First is the broadening of the field of mental illness and health, once restricted to the "insane," to include the seven groups of illnesses described in Definitions, above. Besides these illnesses, there are psychological components in all forms of illness. Research into the causes of illness and methods of treatment,

training of necessary personnel, and prevention are important aspects of the field. Second, treatment techniques have improved markedly and extend into all phases of the diseases, acute and chronic. They demand a development of community services and treatment while the patient is at home. Patients are leaving hospitals faster, and many who would once have had to be hospitalized now can be treated in out-patient clinics. There are many methods of handling various groups in such facilities as branch hospitals, day and night hospitals, and psychiatric units in general hospitals (see Chapter III, New Ideas).

The increased number of beds needed also depends on the extent to which existing beds are "approved," i.e. whether they meet professionally established criteria of space, safety, and personnel. In most of the United States, personnel is still well below acceptable standards, but many beds are unacceptable also because of overcrowding and inadequacy of plant.

Clinic services are measured by the number of clinic teams in relation to the population. The commonly accepted statement of adequacy is one clinic team per 50,000 of population. The number needed will be markedly affected by the extent of other services, such as welfare agencies, private psychiatrists, and the ability of general practitioners to handle certain forms of mental illness.

Planning should also recognize that clinic teams must have a certain amount of psychiatrist's time. The judgment and authority of a psychiatrist licensed to practice in the state is needed for proper diagnosis and treatment of the patient, and for legal reasons. Clinic teams without an adequate amount of psychiatrists' time cannot properly be called psychiatric clinics, and should be regarded as social work clearing centers.

ALTERNATE WAYS OF MEETING NEEDS

In developing psychiatric services, a state may go to the extreme of devoting all of its resources to community clinics, day services, follow-up care, foster homes, branch hospitals, community mental health centers, subsidizing private facilities and private practitioners, stimulating more private hospitals and psychiatric units in general hospitals and spending more on research and training, all in an effort to eliminate new hospital construction.

Or it can revert to the old pattern and constantly build to meet the increasing number of admissions as if there would be no change in releases.

Or it could compromise between these two extremes, replacing obsolete and dangerous buildings, and slowly converting unapproved to approved beds, but otherwise curtailing building pending experience with expanded training and research programs and community services.

All three of these alternatives apply both to mental patients and to mental defectives. Community services are equally important to both groups. The lag of services for mental defectives behind those for mentally ill persons, however, may require larger construction in this field to achieve minimum standards for the hospital-schools.

III. NEW IDEAS

A number of new devices are being tried out in various parts of the world which offer themselves as practical ways to improve patient care, relieve overcrowding, prevent readmissions to institutions, and to take the load off state hospitals and schools for mental defectives.

These are singled out for special mention as they often are a quick, easy and inexpensive approach to a local situation without waiting for major construction of new facilities and offer the possibility of giving better service with the present shortage of trained personnel.

COMMUNITY MENTAL HEALTH CENTER

This is a non-residential center where may be brought together administration and coordination of all resources in any locality and where the state program and voluntary agencies might unite to pool their resources. Overnight accommodations should be provided in nearby general hospitals. The center should include out-patient treatment, home visits, screening and referral and some preventive program and follow-up for hospital patients. This center may be started in a rented building with the part-time services of many people living nearby. By providing under its roof for a wide range of personnel and training, it may well prove to be the answer to local needs and take the place of a multi-million dollar institution that was thought to be necessary.

BRANCH HOSPITAL

As demonstrated in two provinces of Canada, this is a simple residential unit providing a less complicated life and more socializing therapeutic benefits at a less expensive cost for selected groups of patients. An important element here is the administrative connection with the main hospital which provides for the high standard of care through supervision, rotation of staff, and the immediate handling of complications requiring true hospital facilities without administrative obstacles.

DAY AND NIGHT HOSPITALS

Chiefly developed in Montreal, the day hospital provides an all-day supervised activity and treatment program close to a complete hospital. This has

been found to be far more useful for certain patients than the brief appointment hour of the standard out-patient clinic. The reverse of this idea occurs in the night hospital, where instead of sleeping at home, and spending the day in the hospital, certain patients who are employed may receive treatment and special help, particularly needed in the night hours when the protective activity of the day is not available.

SHELTERED WORKSHOP

These do not now exist for psychiatric patients who need a place to live. A certain number of patients could be prevented from readmission by having a chance to earn a living in a protected environment of this type.

REHABILITATION HOSPITAL

The techniques of rehabilitation have never been applied in any appropriate scale to the field of psychiatry. With the assistance of all the imaginative ideas coming from Dr. Howard Rusk and his group, physically crippled people with psychiatric components and those disabled chiefly by their mental conditions could profit by an institution set up in any city where many people and services are available. With an objective of returning patients to the community and taking those who have some hope, a longer training period of one to two years rather than a few weeks would be envisioned. Such an institution would bring to the mental health field the benefit of magnificent developments in rehabilitation which have arisen since the war.

PSYCHIATRIC UNIT IN GENERAL HOSPITAL

This idea, by no means new, is new to a surprising number of localities even in the most advanced states. The reasons for creating such units are well stated in medical literature; the obstacles to their development are receding, but this change has not been so fully documented. Every community with a general hospital without psychiatric services should examine the reasons why that hospital is thus limiting its functions. A general hospital should be a hospital for all kinds of illness, including mental illness. Last year saw 276,000 psychiatric patients admitted to general hospitals in the U.S., which is about the same number admitted to all state hospitals, VA hospitals, and private mental hospitals. This may turn out to be the most useful, in point of numbers, of new devices to relieve state mental hospitals.

IV. SCOPE OF A STATE MENTAL HEALTH PROGRAM

An Iowa mental health program which is adequate to meet the demands properly placed upon it includes a steadily broadening range of services. Services in Iowa lag well behind what is recognized to be successful and necessary, in the light of expanding knowledge about prevention and treatment.

In most states services are not organized in such a way as to realize their full potentialities. Many individuals, groups, and state and local agencies are in fact an active part of the mental health activities of the state, but are not so recognized or organized.

In order to establish an adequate organization, several things are necessary. One is a general recognition on the part of the public and the legislature that the mental health problem is a large one, with unusual difficulties standing in the way of solution. Enormous efforts and large expenditures will be required, though much can be done without additional expense. Funds allocated for mental health by Iowa should be more efficiently and effectively expended. The cooperation of state and local groups, financial support by state, local, and private groups, and professional leadership of the highest order will be needed to make best use of all resources.

The difficulties standing in the way of success include: acute national shortages of personnel; the lag in psychiatric knowledge behind that in other health specialties; the large inherited load of chronic patients; the size and expense of hospital facilities; and the expense involved in hiring skilled personnel in the numbers needed. Solution of these problems will not come quickly, and will require brains, money, experience, and devotion to the public interest.

COMPONENTS OF AN IDEAL PROGRAM

On the general principle that the state takes responsibility where voluntary and individual efforts are inadequate, but that a state program must be assisted by and coordinated with efforts of voluntary agencies and individuals, the components of an "ideal" program for Iowa are suggested. The program must rest on a dual foundation:

1. The simplest and most efficient administrative and organizational structure possible, including adequate financial controls, records, and statistics.

2. An effective legal structure relating to administrative authority and organization; to admission, release, and eligibility of patients; and to activities of other departments relating to mental health.

The parts of the mental health program which a state organization must be prepared to direct, supervise, and develop, include:

1. Diagnosis, treatment, rehabilitation, and consultation. The state must provide services which deal directly with the public; it must also collaborate with privately and locally financed services to extend the coverage of the available services to the mentally ill and mentally defective.

2. Prevention services. The state must offer consultative services to agencies in non-psychiatric fields, as a contribution to improved mental health.

3. Training and recruitment of personnel. (*) Only the state can coordinate the training operations of the educational centers in the state, to build up the supply of psychiatric personnel, to recruit them where they are needed, and to provide the incentives required to keep them there. In-service training is a requirement in each state institution and service, and these should operate in collaboration with educational institutions.

4. Administration and finance. (**) Equality of treatment, economy, and adequate planning for growing needs require that there be a state organization charged with developing long-range plans for improvement and construction of buildings, and for hiring the necessary staff. Budgets for all hospitals, hospital-schools, clinics, institutions for psychotic criminals and delinquent defectives, and for clinics and other community services should be presented together, by an administrator professionally qualified to discuss the emphasis to be given different parts of the program in each year.

5. Inspection, supervision, and licensing. The state must be responsible for determining which public and private institutions are maintaining adequate standards in the diagnosis and treatment of mental illness, and which are not. The standards should cover not only physical plant, as they now do, but also the number and training of staff available for patient care and the treatment program available. (***)

ORGANIZATION OF STATE SERVICES

The form in which state services are organized affects their ability to perform their functions. Some individuals, particularly gifted in administration, can make even a cumbersome and awkward system work. But such a system hampers them unnecessarily, and the state as a whole suffers from their lowered effectiveness. Sound organization, built around a competent, well-trained, and experienced staff, is not only desirable but imperative to operate a program as complex and expensive as that required for mental health.

The system must fulfill three requirements.

1. It must make possible the recruitment of qualified personnel in sufficient numbers, as members of a career service.

(*) See also Chapter X.

(**) See page 12.

(***) An abridged version of the reports of the Central Inspection Board appears in the Appendix.

2. It must be flexible so that it can experiment with new forms of service, in order to select from the devices being developed in the state and elsewhere, those which offer promise of cheaper, more effective service under particular circumstances.

3. It must be able to get full cooperation from scientists and professional people in fields related to mental health, and to arouse the enthusiasm of citizens so that they participate fully in the program.

4. It must afford competent professional judgment, in order to plan effectively for services and structures, weighing the comparative costs and advantages of alternative solutions.

ORGANIZATION IN OTHER STATES

State organizations follow one of four broad patterns: operation under a board of control, either limited to mental hospitals or including other types of institutions; operation under a department of welfare, health, or health and welfare; operation under a department of institutions; and operation as a separate agency.

Board of control. In 10 states, a board of control operates mental health services only. In 12 states, the board also operates non-psychiatric institutions. The latter is Iowa's pattern.

Department of welfare or health. In 9 states mental hospitals are administered by departments of welfare or health and welfare. Progess in mental health matters in these states has not been outstanding. Many vacancies have existed in their staffs over long periods, treatment services have lagged behind developments in the most progressive areas, and many aspects of mental health have remained unexplored.

Department of institutions. In 5 states the psychiatric institutions are a part of the responsibility of a department which also manages penal and other institutions.

Department of mental health. In 11 states, among them some of the most progressive in mental health, with populations totaling 55,000,000, mental health services are in a separate department of state government. The department head (usually called Commissioner) is a highly qualified psychiatrist, well-trained in administration. These states appear to be making the greatest progress in the treatment and prevention of mental illness. The Council of State Governments reports that there is a growing trend in the nation toward autonomy of mental health programs. A number of large states have separated the departments in which mental hospitals are located from larger operations, and in line with public demand appear to be going to set up a separate mental health department in the next two to four years. We recommend that this plan be considered for Iowa.

In the last two years three states--Connecticut, Tennessee and Kentucky--have developed separate and independent departments of mental health. The advantages of this kind of department, headed by an experienced psychiatrist with administrative skill, lie in professional leadership and planning, unity of direction to coordinate and develop an over-all approach, and ability to secure the best professional personnel and to work with other professionals. In other states the commissioner or his equivalent, even though not at the head of the department, has special recognition and direct access to the Governor.

No central organization. One state has no central organization.

FUNCTIONS OF THE CENTRAL OFFICE

There are a number of functions which the central office must be prepared to direct and coordinate in a modern mental health program.

Diagnosis, treatment, rehabilitation, and consultation. These services should be placed under one division in organizational planning. To carry out these services, the state must provide:

a. Diagnostic, screening, and referral centers convenient to all areas.

b. Consultative services to other government agencies which operate institutions or similar services.

c. Out-patient and day-care services for adults and children.

d. Residential psychiatric units for treatment, rehabilitation, or permanent care of the mentally ill, including the mentally defective, and other special groups, such as alcoholics and sexual psychopaths. Such units would include: mental hospitals with branch units; hospital-schools for the seriously mentally defective and outposts for supervision of those going out for employment; hospital units for maximum security patients, and new types of residential units (see Chapter III, New Ideas) for the tuberculous mentally ill, and for mentally defective adults and juveniles under court jurisdiction; foster homes for selected patients; sheltered and rehabilitation workshops, etc.

Training and recruitment. These are closely connected, and should be carefully integrated.

In-service training is necessary to improve clinical services. Specialist training provides the additional personnel needed from year to year. An

atmosphere of professional advancement as well as the presence of top-grade skills in any profession increases the attractiveness of any hospital or clinic, from the viewpoint of new recruits. In the past, recruitment has been spasmodic and individualistic, often left to the personnel departments of state governments, and rarely the result of a professionally planned and consistently pushed campaign. Yet the latter is necessary. Personnel practices are directly related to recruitment. In Iowa it would be logical to fit a training program to the deficits in recruiting.

Carrying out such a program demands technically trained personnel in appropriate educational fields, and in public relations. To assist in the various professional programs the Commissioner of Mental Health should have in his office a consultant representing each of the major professions. These advance the quality of the work of each professional group, represent the state program to their particular professions in the state and nation, and are useful in recruiting.

Consultants in psychiatric nursing, social work, clinical psychology, occupational therapy, rehabilitation, volunteers, dietetics, special education, chaplaincy, tuberculosis, etc., should be included. They may be part-time or full-time, and more than one may be needed. They work with their professional confreres, but have no administrative responsibility.

Prevention and liaison. A close association must be established with all departments of the state government whose functions in any way are related to the mental health program. A device found very useful is the State Mental Health Council, with the Commissioner of Mental Health as chairman (as in New York state) and with representatives from other departments such as Public Assistance, Justice, Education, Labor, Public Health (if separate), Welfare (if separate), and others. Similar coordinating councils of private groups are suggested. Most preventive services will be performed by other agencies or departments of state government, community services, the medical profession, etc. For this reason, it is vital to establish an adequate system of cooperation with these groups.

Research. If research is expanded in line with best current thinking in all fields, it will constitute a far greater part of the program than ever before. Studies and surveys in social, physical, and medical sciences, etiology, treatment, and rehabilitation, administration, business, and a host of other areas all need careful exploration.

Administration and finance. The development, organization, and presentation of a budget providing for an adequate mental health program is the primary responsibility of the central office. Expenditures for all purposes must be weighed in the light of their effect on treatment, and a professional decision reached as to the relative merits of different programs. Presentation of a combined budget for all mental health services, by a professionally qualified

administrator, constitutes the best guarantee available that the money is needed and will be spent in the most effective manner. Further, the management of hospitals and schools is so large as to constitute a substantial part of the state's total operations. It requires careful business management, under professional guidance and supervision, so that all institution expenditures contribute to therapeutic values. It should also be a responsibility of the central office to plan capital improvements to implement the mental health program.

Inspection, supervision, and licensing. This is necessary to carry out the state's responsibility toward non-state institutions, which by law must hold to certain standards. Inspection of both the professional care of patients and of the physical plant is needed. It requires the attention of a competent professional, assisted by someone trained in safety, elimination of fire hazards, improvement of structural conditions, etc.

V. ORGANIZATION OF IOWA'S MENTAL HEALTH FUNCTIONS: POLICIES

Administratively, Iowa's mental health functions are split into three parts. The hospitals and schools for mental defectives are operated by an independent Board of Control. Clinics are partially supported by the Iowa Mental Health Authority, which is the Director of Iowa Psychopathic Hospital in Iowa City. The budget of the Mental Health Authority, which comes entirely out of Federal funds, is about $60,000. Administrative offices of the Authority are in Des Moines. Research and training in psychiatry are carried on largely at the State University, through the Medical School's Department of Psychiatry and the Psychopathic Hospital in cooperation with other departments of the University. By far the largest part of this total program is that administered by the Board of Control; the Board's operations are the fourth largest in the state. The hospitals and the state schools expend about $10 million annually.

BOARD OF CONTROL

The Board of Control supervises the four state hospitals, the two state schools, two penal institutions, three training schools, an orphanage, and a soldiers' home.

The Board is bi-partisan, appointed for 6-year terms, staggered to provide continuity of experience and policy. Qualifications for appointment are political and geographical.

Director of Institutions. The 6 mental institutions are by law under the direction of the Board which hires the "Director of Institutions" as an advisor.

The position, which pays $12,000, has been vacant for a year. The Director's duties, as stated in the law, give him sharply limited direct authority and responsibility.

They include assisting the Board of Controls in seeing that the institutions carry out their stated functions, supervision of the operations of the hospitals and schools, establishment of suitable standards of performance in the institutions, and standards of qualifications for all employees, and the preparation of budgets which will provide adequate treatment of all patients. If these duties were in fact as they are stated, it would be difficult to find a man competent to discharge them at $12,000. The post should carry at least as much salary as is paid to the superintendents of the hospitals. In fact, however, the Director has no real authority or responsibility. He is subject to the authority of the Board, serves at their pleasure, and his salary is fixed by them.

Achievements of the Board of Control. The Board of Control during its administration of the institutions has established a fairly high standard of custodial care and an atmosphere of humane and kindly handling of patients. In recent years, higher patient-personnel ratios have been achieved in the institutions, and some improvements have been made in salary levels, particularly at the top. Hospital superintendents' salaries, for example, now rank very high in relation to other states. A beginning has been made at bringing psychologists, social workers, and activity therapists in to the state hospitals as part of the therapeutic team, but the number of trained persons is insignificant. Much remains to be done in all these lines.

IOWA MENTAL HEALTH AUTHORITY

The Mental Health Authority, which disburses Federal funds for mental health, has, according to the custom which names one individual as the Authority, been designated as the Director of Iowa Psychopathic Hospital. The Authority partially supports 9 clinics, covering 11 counties in the state, and helps to organize and staff such clinics. Plans are going forward for the establishment of clinics which will cover five additional counties. Its operations are entirely independent of the Board of Control, or of any other department in the state government. Physically, it is housed in the State Office Building in Des Moines.

The responsibility of the IMHA is limited to financial support, and aid in recruitment and administration. The clinics get the largest part of their support from local sources, and operate according to policies determined locally.

IOWA PSYCHOPATHIC HOSPITAL

Iowa Psychopathic Hospital and the Department of Psychiatry in the University School of Medicine constitute a major resource for teaching, training, and research. The hospital and the department are under the direction of a single

individual, who is also the Mental Health Authority. The staffs of the hospital and the department are identical. The University must approve hospital and department budgets, but does not include them within its own.

Collaboration between the University and the state institutions has for many years been almost entirely lacking. Under present administration, there appears to be a real possibility of developing a joint program. This possibility, however, depends on development of a professionally sound program in the institutions, on the recruitment of more personnel at the University, and on the strengthening of the University's program so that it can carry on more training and research.

NEED FOR INTEGRATION OF SERVICES

The possibilities of expanding training and research services in Iowa depend to a large extent on the possibilities of greater collaboration between the University and the state institutions. The training and research functions of the institutions must be built up if treatment services are to improve, and this can be done only through University cooperation. Unless this occurs, Iowa medical school graduates will continue to be drained off to other states.

The integration cannot be achieved at University expense; it is equitable that the mental health services of the state contribute a reasonable amount to the costs of training and research. The present gulf which separates the University and the state services must somehow be bridged.

POLICIES

A number of policies now in effect in Iowa are detrimental to the treatment of mental illness. Some work directly, by limiting the care and treatment which are afforded, and some indirectly, through unnecessary hobbling of the state services.

ADMISSION PROCEDURE

Admission to state hospitals is largely by commitment, although the law provides for voluntary admission. Commitment is handled by the County Commissions on Insanity appointed by the District Court and composed of a lawyer, a physician, and the clerk of the county court. Applications are submitted by the patient's family, by police officials, by some welfare agency, or lately by some other individual or agency. If, in the Commission's opinion, the patient is "insane," he is sent to the state hospital on a "warrant of admission." There he is diagnosed, and if the psychiatrists there agree, he is accepted for treatment. Many are treated and discharged for whom a warrant of commitment is not issued. Some who require prolonged treatment are, on recommendation of the hospital staff, committed. Some are transferred to the County Home, committed for custodial care.

This procedure eliminates the possibility that a person who is not mentally ill will be kept in the state hospital. It has several adverse effects, however.

Under modern practice, more and more patients are admitted voluntarily. In many states, committed patients constitute a third or less of the total. Where admissions are largely voluntary, patients are usually given prompt intensive treatment and the discharge rate is high. As a result, the stigma attached to hospitalization declines.

Iowa law should be revised. Greater dependence should be placed on voluntary admission and admission by a physician's certification. The Commission on Insanity should be called a Commission on Hospitalization. The warrant of admission should be called a "certificate of admission," and the "order of commitment" should be the "order of admission." One basic law should govern both voluntary and involuntary admission, and the several existing statutes revised or repealed.

TRANSFERS

Iowa has a policy of hospitalizing certain mental patients, and transferring others to county homes or other county non-psychiatric institutions. Under a law dating back to 1860, when the hospital system was established, superintendents are instructed to transfer "incurable and harmless" patients to county care.

The patients so transferred may be arteriosclerotics who were admitted in old age and whose symptoms have receded, or they may be psychotic patients who have grown old in the hospital.

When the law was passed, it was probably true that these patients were incurable, and to a degree it still is. But in a properly staffed and operated hospital, they could then and can now benefit from treatment. Modern medicine can do a good deal to improve the condition of arteriosclerotics and schizophrenics, many of whom become social cures.

The policy is in opposition to currently accepted medical practice. It results in a dual and inequitable system of treatment for Iowa's mental patients. The determination as to whether a patient is to continue to receive hospital treatment is based not on his condition, but on whether under county care he will be docile and undemanding, or provide a cheap source of labor at the county home. In recent years, due to economic pressures, the hospitals have been reluctant to transfer such patients for they need them to operate their own facilities. This is a tragic commentary on the mental health situation. The policy is based not on the needs of the mentally ill, but on a desire to keep hospital populations and budgetary demands down.

Even at the point in chronic psychosis where the patient seems tractable and quiet, there is a chance that his symptoms will again become severe. Transferring him to a county home is technically a reversible procedure, and some

patients are returned to the hospital when they become disturbed. But the pressure of policy and the need for hospital space for new admissions tend to keep them in county care. In November a Survey Team member who visited 6 county homes saw a dozen or so seriously sick patients whom the hospital superintendent felt should go back to the hospital. In none of the county homes is there any psychiatric supervision of the patients. Iowa has approximately 2600 patients forgotten in county homes. With proper care and treatment a considerable number of these could be rehabilitated.

BUDGET AND PERSONNEL RESTRICTIONS

Staffing and maintenance of hospitals is difficult under the best of circumstances. Personnel is in short supply all over the country, and hospitals are located at a considerable distance from educationl and professional centers. Buildings are overcrowded and many of them are in poor repair, so that emergency replacements must be made, and major changes are often necessitated.

Yet the superintendents are hampered by artificial barriers in their ability to manage their funds which make the problems more complex and difficult.

Recruitment. Hiring is limited by law not only to the numbers which could be obtained with the sums appropriated, but also to specific numbers at designated salaries in each department or division. The numbers authorized in each skill are well below the levels which are recommended by the American Psychiatric Association. Yet, if the superintendent is unable to fill a vacancy in, say, the pyschological staff, he cannot use the unexpended funds to hire more nurses or activity therapists. Each of the superintendents has commented that when nurses come in asking for jobs, in the face of severe nurse shortages in the hospital, and even though other staff vacancies have existed for a long period, they cannot hire them.

Approval of applications. Further, all applications for employment must be approved by the Personnel Officer in the Comptroller's Office in Des Moines. The regulations of this office state that all jobs paying over $156 per month must be approved, which under present conditions essentially means all jobs. If the provision is used as a veto on the hiring of particular persons, the hospital administration is being unduly limited in its choices. If the provision is merely another check on expenditures, as is more frequently the case, it slows down hiring, which is already very difficult.

Maintenance and repairs. When buildings are as old as those in many of Iowa's institutions, and when they are seriously overcrowded, it is difficult to predict where repairs will be needed, and how large they will be. A strict line-by-line budget is difficult to set up in the first place, and hard to operate under. Considerable operating leeway would be gained by making a lump sum available, and permitting the superintendent to shift items about within categories to meet emergencies.

These restrictions, in total, mean that the professional judgment of the superintendent is being limited, and decisions affecting the patients are being made by non-professional personnel located far from the hospital, who do not know or understand the problems of hospital treatment and administration. The inevitable result is damage to the therapeutic program of the institution.

RECOMMENDATIONS

1. The state hospitals, schools for mental defectives, institutions for psychotic criminals and delinquent defectives, state operations in the field of out-patient clinics, and the new services proposed should be placed in a single department. In the same department should be training and education of professional personnel, prevention and liaison, inspection and licensing of psychiatric institutions and homes, and the administrative and financial services necessary to these functions. These changes should be brought about as rapidly as possible.

2. The services should be headed by a well qualified psychiatrist with administrative experience, at a salary slightly above that now paid to hospital superintendents.

3. The department might be organized in various ways, provided the director (or commissioner) has the authority and responsibility to guide the mental health programs of the state along professional lines. It should be counseled by an advisory board.

4. The functions of such a board should not be administrative. It should advise the Governor and the Commissioner on policy, and should also be charged with keeping the public informed of policy matters.

5. The line of authority should run from the Commissioner to the superintendents of the hospitals, schools for defectives, and heads of other institutions.

6. The Commissioner should be supported by a deputy commissioner and consultants in psychology, psychiatric social work, nursing, rehabilitation therapy, and other specialties.

7. The present policy of transferring unrecovered mental patients out of state hospitals as a means of providing space for new admissions should be stopped. Space can best be provided through more rapid turnover resulting from prompt intensive treatment.

8. Crippling budget and personnel restrictions should be removed. The commissioner and superintendents must be allowed to make their decisions on medical grounds, within the framework of the resources which the state can make available.

VI. TREATMENT SERVICES

The mental hospital system began very early in Iowa's history. The first hospital, which was also the first west of the Mississippi, was established in 1860, at Mt. Pleasant, Iowa and was a leader in the treatment of mental illness for many years.

Treatment services in Iowa today include:

4 mental hospitals (called mental health institutes), with 5,000 patients.

2 institutions for mental defectives, with 3,000 patients (treated in a separate chapter).

Psychiatric services in the general hospitals and private psychiatric hospital beds, totaling 650 beds. Iowa Psychiatric Hospital has 60 beds.

County homes housing some 2,400 mental patients, chiefly chronic schizophrenics and seniles (arteriosclerotics), and 200 mentally deficient patients. Most of these were transferred from the hospitals under the legal designation "harmless and incurable." A few were committed directly as insane by the County Commissions on Insanity, without going to the hospital.

The Men's Reformatory at Anamosa, housing about 70 psychotics in its "criminally insane section." Undoubtedly some undiagnosed psychotics and some defectives are still in the general prison population.

Nine out-patient clinics, operated on private funds with assistance from Federal funds through the Iowa Mental Health Authority.

Out-patient services in each hospital.

Services for children, including the long-established Des Moines Child Guidance Clinic, some beds for children at Iowa Psychopathic Hospital, and the beginnings of a children's unit at Independence Mental Health Institute.

About 90 physicians practicing psychiatry, counting all members of the psychiatric medical staff in the state hospitals and physicians in private practice, the University, and the clinics. The American Psychiatric

Association has 64 of these as members. Of these, 13 are in state hospitals and 4 in Veterans Administration facilities. The remaining 29 are in private practice. A few of them have part-time assignments in state-operated or state-supported services.

STATE HOSPITAL PATIENTS

The four mental hospitals together have room for about 5,100 patients. Resident populations in December were:

Mt. Pleasant	1183 patients
Independence	1102 "
Clarinda	1310 "
Cherokee	1293 "

In addition, the county homes house 2,400 patients who by medical definition are mental patients. Thus, Iowa has 2.8 beds per thousand of the general population. For the nation as a whole, the figure is 4.4. For Oklahoma it is 4.6, and for Kansas 2.4. (Beds for mental defectives are not included in this calculation.)

Beds per thousand of the population is a very crude measure of the adequacy of treatment services. It is available for all states, and is in general use; therefore it is used here. However, it says nothing about the quality of treatment services, and hence tells nothing about how many patients per year can be treated in the available space.

It also tells little about the incidence or prevalence of mental illness, except in an indirect and inaccurate way. Presumably the pressure to hospitalize mental patients is strong, and the existence of a large number of unhospitalized patients would result in increasing the number of beds.

There is no evidence indicating that the states differ in the incidence or prevalence of mental illness. Such differences as exist between bed-to-population ratios may be much more readily explained by a greater tolerance of mental illness in some communities, or by a state's failure to provide adequate treatment servides, so that people hesitate to use existing custodial beds.

No figures are available on the number of ill persons in the general population --those, for example, who are in the early stages of mental illness, or whose illness takes a non-disturbing form, so that they have not yet come to the attention of the authorities. There have been some small studies in limited areas which indicate that the number of psychotics outside hospitals is as large as the number in residence. There is good reason to believe that larger numbers are maintained at home in rural areas and small communities, however inadequately, than is possible in urban communities.

DISCHARGES

The discharges from all hospitals in fiscal 1956 totaled about 2,000. This is a substantial advance from the previous year, though it is not very high in proportion to the resident population. For this purpose the 2,000 discharges should be compared to 5,100 plus 2,400 (the number of patients in hospitals and the number in county homes), or 7,500. The discharges, then, were about 26 percent of resident population. Hospitals which offer more adequate treatment are able to discharge between 30 and 60 percent of the total patients yearly.

The four hospitals differ substantially in the numbers discharged, and in the rate of discharge:

	Numbers discharged	Discharged patients as percent of resident patients (*)
Mt. Pleasant	367	20.3
Independence	808	43.1
Clarinda	508	27.2
Cherokee	507	25.5
	2190	

(*) This percentage is calculated using the 1956 resident population as a base, plus 600 added for each hospital to cover those residing in county homes.

BUDGETS

The budget for each state hospital is fixed at $1,520,000. Since the number of patients is different for each hospital, and staff numbers and qualifications also differ, as does physical plant, it is apparent that some rigidity exists in the budget structure.

PERSONNEL

The ratio of total employees to patients in the hospitals is fairly high. In the category of attendants, particularly, the hospitals are close to (and in one hospital slightly above) APA minimum standards. In the more highly skilled ranks, however, the staffing is severely inadequate, and the personnel available in the state is on the whole not well trained.

Staff has increased over the past 10 years. The number of physicians has increased from 18 to 39, psychologists from 0 to 10, registered nurses from 11 to 31, and social workers from 6 to 12. While there has been some improvement, the numbers are still far below the minimum standards established by

the American Psychiatric Association, and little psychiatric treatment is offered. Most of the staff is untrained in psychiatry.

The number of psychiatrists on hospital staffs is difficult to establish. This is because the definition of psychiatrist is not uniform. The table of organization for the hospitals establishes a number of positions, but does not set up qualifications which would insure hiring only psychiatrists in these spots. On the other hand, in at least one case a physician working in his professional capacity is listed on the rolls as an attendant.

The total number of physicians provides a ratio of 1 to each 125 patients. The number of physicians with at least a year of psychiatric training provides a ratio of 1 to 385. The number with 3 years of training provides a ratio of 1 to 456. APA standards of 1 physician to 94 patients contemplate that the physicians will be fully trained psychiatrists.

Psychologists. There are now 18 psychologists working in the hospitals. This is an average of 1 for each 500 patients, which is close to APA standards. However, only 4 have the Ph. D. in clinical psychology which the APA standard contemplates. There are 9 with MA degrees, 2 with BA's, and 3 in training.

There are 16 social workers, as against a requirement of 40. Only 1 or 2 of these have as much as a master's degree in social work, and none have psychiatric sequences in their training.

The total number of positions for registered nurses in the system is 47. (There are 8 vacancies.) The budgeted total is 14 percent of the 338 required by APA standards. These are located as follows:

	Number	Percent of APA standard
Mt. Pleasant	4	4.4
Independence	24	33.3
Clarinda	7	8.3
Cherokee	12	14.5

The difference in the degree to which the hospitals have been able to attract nurses is very marked. Independence's high figure is clearly related to its nurse training program, and indicates the value of training programs generally. Each of the superintendents has commented, however, that he could recruit more nurses if he had more positions in his table of organization.

No trained persons are employed in physiotherapy, occupational therapy, or recreational therapy.

INSPECTION REPORTS ON STATE HOSPITALS

As a part of the Survey, the 4 state hospitals were inspected by the Central Inspection Board of the American Psychiatric Association. These reports are briefly summarized at the end of this Summary chapter, to provide an indication of the Board's findings, and to suggest the nature of the revisions that are needed. The Central Inspection Board Report will be delivered separately to the Board of Control. More complete summaries are included as part of Chapter VI, Treatment Services, in the Survey Report.

IOWA PSYCHOPATHIC HOSPITAL

Iowa Psychopathic Hospital is a 60-bed hospital established as a training and research institution. It has never received an appropriation to carry on a research program. Its staff is too small to properly carry out its training, research, and service functions. Admissions are confined to cases which fit into the teaching or research programs of the hospital. The hospital is well regarded in the state and admissions are frequently sought because of its superior medical standing. The hospital has withstood this pressure, and should continue to do so, since only thus can it maintain its status as a teaching institution.

Salaries at the Psychopathic Hospital are low. All positions are part-time, and are important enough to require full-time work. They are intended to be full-time positions. Under what is known as the "Iowa plan" the Medical School recruits top-level men on a part-time basis, allowing those who have status as assistant professors or above to add to their income to a specified amount by accepting private patients. In effect, then, the University has only part-time men in its upper brackets. This is a realistic approach to the problem of getting good men, but it results in spreading their work very thin.

Also, there are a number of vacancies on the staff.

It will be difficult to build up a fully qualified teaching staff in the expanded program unless it is possible to recruit men who can devote full time to the work. In order to do this, salaries must be raised to the point where they are competitive with the hospital superintendent's salaries and with incomes available in private practice.

INSANE DEPARTMENT, ANAMOSA

Psychotic criminals and individuals held for observation pending court action are housed in the Insane Department of the Reformatory at Anamosa. This Department is under the administration of the warden of the prison and a steward, neither of whom has formal professional training for the management of psychiatric patients.

The only staff available is a male nurse and a guard for each floor. They are assisted by prisoners who are called "psych attendants." No treatment is available. The physical plant is unsatisfactory for psychiatric purposes. The men are kept in cells or cell-like rooms, and the space is unattractive. No rehabilitation therapy is available.

Some of the men have been confined to the cells for a period of years. The possibilities of recovery or even improvement are practically nil.

Patients who are now sent to Anamosa should go instead to a maximum security unit designed and constructed for the purpose. It should be staffed by psychiatrically trained personnel, with special training in handling psychotic criminals.

Adequate provision must be made for periodic re-examination of patients, with transfer to the proper institution as their condition improves.

TUBERCULOSIS

Since the beginning of the state mental hospital systems in the U. S., tuberculosis has been a formidable problem. The incidence of this disease among mental hospital patients has always been higher than in the general population, although perhaps not higher than in other chronic disease hospitals.

Treatment of tuberculosis in general has advanced remarkably in the last two decades and particularly since World War II. Active treatment requires adequate anti-contagion measures, the attention of a physician skilled in tuberculosis, use of modern drug therapies, and the availability of chest surgeons.

None of the state hospitals now provides adequate treatment of tuberculous patients. The physical space is ill adapted to modern treatment; isolation is not always achieved; there are no tuberculosis specialists available; and surgery is at too great a distance. However, routine x-rays are carried out on patients and staff, and the incidence of the disease is not as great as previously.

Quarters assigned to the patients need to be modernized and improved to care for suspected and inactive cases. Very few additional beds will be needed.

Active tuberculous cases are not getting adequate treatment. Under accepted modern practice, these cases should be sent to a common center where a specialist in the disease and other medical and surgical assistance are available. It should be near a medical center.

The location of such a center is somewhat controversial. Some say it should be primarily a tuberculosis hospital, with a neuropsychiatric wing attached.

Others say that psychosis is the more difficult problem, and the center must be part of a mental hospital. The weight of opinion and actual practice favors the latter view. Psychiatric cases with tuberculosis are almost universally treated in mental hospitals.

It is true that tuberculosis hospitals as such usually do not want to take mental cases. Psychiatrists, on the other hand, do not want the responsibility of handling active tuberculosis unless they have a specialist who can be responsible for the tuberculosis treatment.

With progress in the control of tuberculosis and a decline in chronic cases, the total is unlikely to increase. At present it appears that accomodation for 75 would be sufficient, if the division of space between men and women were flexible.

A new unit of 75 beds should therefore be established for active cases, leaving to each hospital the responsibility of routine case finding, isolation of suspected cases, and the care of those whose tuberculosis has become inactive who are returned from the active treatment center.

None of the state hospitals is suitably located. The choice seems to lie between the state tuberculosis hospital near Iowa City or in the Des Moines area, alongside a general hospital. (See discussion on Polk County services).

PSYCHIATRIC SERVICES IN GENERAL HOSPITALS

Psychiatric services constitute an important part of the services offered by a true general hospital. The number of such units is increasing rapidly in the nation. Altogether, such units treat as many patients as are treated in all other types of mental hospitals put together. The availability of psychiatric services in a local hospital does much to relieve the pressure on other community services, serves to provide prompt treatment under conditions which are far less traumatic than admission to a state hospital, and afford psychiatric consultation to illnesses with a large psychiatric component. They constitute a major attraction to private psychiatrists seeking a place to practice.

Iowa is now making good progress in the establishment of such services in its general hospitals, and in private mental hospitals.

There are now some 600 such beds in the state, with current active plans for over 200 more. These current plans should be carried ahead promptly.

COUNTY HOMES

Some 2400 mental patients and 200 mental defectives are now being cared for in county homes, and an undetermined number (perhaps as many as another thousand) in other types of county care such as nursing homes. These patients are not being given psychiatric treatment or rehabilitation

services, though in many cases they are being given adequate custodial care. In some cases, the county homes are no better than poor-houses.

It is not possible now to remove all mental patients from county homes. Space does not exist in the hospitals for them, nor is staffing adequate for existing patient loads. But the law should be changed so that mental patients are treated according to medical considerations rather than to make space available in the hospitals. The seriously sick patients should be returned to the hospitals, and further transfers to the county homes as now constituted should be discontinued.

Needed space for new admissions should be achieved by improved staffing of the hospitals, to provide for prompt treatment and early release.

The better county homes might be used for the rehabilitation of certain patients, if they were operated under the authority of the hospital superintendent. It might be possible, with sufficient medical and nursing help, and some rehabilitation staff, to make branch hospitals or rehabilitation hospitals out of the homes with adequate physical plant and good management.

CLINICS

Iowa now has 9 clinics operating with the support of the Iowa Mental Health Authority, which distributes Federal funds. Most of these take both children and adults, and two are child guidance centers. Slightly more than half of the patients are children.

Few of the centers have adequate psychiatric direction. Each is served by a part-time psychiatrist, and the time available runs from 4 to 20 hours per week. Ordinarily the administrative director is a psychiatric social worker, and the social workers are employed full-time.

The clinics are financed largely from local sources.

Most of the patients are diagnosed as "transient situational personality disorders" and the treatment afforded is generally that which would be offered in a social-work agency. This is a service which has great value, but in most instances it is not properly designated as a psychiatric clinic.

There is a large need for more clinics, and for more psychiatric time in existing clinics. State support in addition to the Federal support now being made available, is probably needed to get the clinics started.

SPECIAL PLANS FOR POLK COUNTY

The largest county in the state, Polk County, containing largest city (Des Moines) is short of psychiatric clinic facilities. State hospital cases have to go 150 miles to Clarinda. There is no adult psychiatric clinic. Children are looked after in the child guidance clinic but the demand is not met. The recent 25-bed unit at Broadlawns is a distinct step forward but should be enlarged.

Private facilities are more nearly adequate. Since 1949, 6 psychiatrists have entered private practice and all are busy. The only qualified psychoanalyst in the state is in Des Moines. Private beds in Hillcrest Hospital totaling 58 and the 22-bed unit at Iowa Methodist Hospital have been added in recent years.

There is no residential unit for child psychiatric cases, and no training in psychiatry in nursing, social work, occupational or recreational therapies and no clinical psychology.

This situation in the state's largest city calls for special attention and remedy. Testimony at the hearings in Des Moines calls for treatment facilities for adults and children, and consultation service for schools, both public and parochial, for increases in special education classes, consultation and help at the county level, and private welfare agencies and assistance with cases coming back from Clarinda. The nearby school for mental defectives at Woodward is in need of help for its cases coming from and returning to the city.

NEW STATE HOSPITAL IS NOT THE ANSWER

There has been some talk of a new state hospital at Des Moines. For many decades, in the face of overcrowding, long waiting lists and an increased demand for services by an awakened public, the answer has been, "Build more beds." This is no longer the only answer, and it is not the answer for Iowa now.

The hospital census has gone down in recent years. It has been reduced in part by the transfer of life-time patients to county homes--a medically unsound solution. The hospitals need to be improved to the point where they can properly care for their present number of patients. When this is done, they will be admitting and discharging substantially larger numbers, and the effect will be the same as the construction of new beds.

The county homes can properly be used as rehabilitation units if they are put under the supervision of the hospital superintendents, and are staffed to provide the rehabilitation services needed. They can also be used as old age centers for non-psychiatric patients. If properly set up, they could

operate as real centers for the prevention of senile decay.

It would cost at least $10 million to construct a new 1,000-bed hospital, and would add $1.5 million to annual operating expenses. This money would be used more effectively if it were turned into salaries for new personnel, and the addition of certain important community activities.

A BETTER SOLUTION

The city has many assets that need to be brought together and expanded. Private resources are available and are going to grow with plans which are already under way. The county hospital can be utilized, and the county home can be developed into an active progressive prevention and rehabilitation center. Since county residents are financially responsible for all expenses, whether by state or county taxes, there should be no insoluble difficulty in arriving at the best combined uses of state and county resources. Given leadership, organization and full cooperation of all parties, the situation is hopeful.

GENERAL PSYCHIATRIC SERVICES

All municipalities need a psychiatric treatment unit. This is true even where the state hospital is close by as in Boston, Indianapolis, New York, Washington, D. C., etc. In these cities the psychiatric unit handles emergency cases, alcoholics and others who may need brief treatment, and those who may after screening go on to a long-term hospital. In many of these places the city and the county are essentially the same. Des Moines and Polk County have a similar relationship. The Polk County Hospital, therefore, is the logical place for development of psychiatric treatment services.

The present ward of 25 beds should be made as efficient as possible with added professional and non-professional personnel. More psychiatric time must be obtained and more professional direction and voice in the conduct of this highly technical treatment program.

Affiliate psychiatric teaching for student nurses, refresher courses in psychiatry for the medical and allied professions, and courses to clinic workers in follow-up of discharged patients should receive consideration in planning.

Enlargement of this unit to 50 beds for adults should be given a high priority.

Since the city lacks treatment facilities for those who cannot afford the high cost of private care, the county should furnish beds at least partly subsidized by county funds. Any legal changes necessary to provide a flexible financial rate should be inaugurated promptly.

Private treatment facilities now consist of 58 beds at Hillcrest Hospital, and 22 at Iowa Methodist Hospital. Des Moines could use approximately twice as many. Enlargements are proposed in both institutions. Because of the high cost of psychiatric beds and treatment services every effort should be made to provide in these private facilities a substantial number of low-cost beds without lowering the quality of service.

The most acceptable financial assistance is the Blue Cross type of insurance against hospitalization cost. Strong pressure to include psychiatric cases on a par with other medical infirmities has been exerted in Iowa for some time. It is hoped that these efforts will be successful. They deserve the strong support of all citizens. Blue Cross will make private resources in the city more available to the average family. Further extension, e.g., of Blue Shield, will help in non-residential treatment services.

The principle of state or county aid to pay bills of certain citizens who qualify for public support and who are treated in private facilities is well worth considering. In one mid-western state most of the patients who would be taken care of in clinics at reduced rates or free are seen by private psychiatrists; the bills are paid by state or county. One state sends 24 percent of its mental defectives to private institutions, because state institutions were full and this method was better than further building. This principle is worthy of consideration in Polk County, or elsewhere in the state.

OUT-PATIENT CLINICS

Clinics for adults should be opened as soon as possible. Possibilities include an all-purpose clinic associated with the psychiatric unit of Broadlawns Hospital. Since needs include diagnosis and treatment of adults and children with all 7 groups of mental disorders, the clinics should endeavor to cover all these. Especially needed is screening and diagnosis of mental defectives. Some patients would need the attention of neurologists, some of pediatricians, some of clinical psychologists, etc. Other groups as well should be made part of the clinic, particularly the fields of social work and nursing, including public health nursing.

Such a clinic could be started by voluntary agencies with assistance from Community Chests, from federal funds through the Iowa Mental Health Authority, etc. It could be related to one or all of the private psychiatric hospitals.

The Des Moines Child Guidance Clinic is an excellent base on which to build additional services for children. Treatment for a number of hours each day, as in a day-care center, is obviously needed. To a great extent the development of a high order and wide range of child welfare and treatment services will cut down the need for residential treatment centers for children.

RESIDENTIAL CENTERS FOR CHILDREN WITH PSYCHIATRIC DISORDERS

A number of beds for children are needed in this area. Space in existing private institutions may be available and efforts should be made to assist in developing a small unit as soon as possible. Des Moines is the logical place to develop a program of some proportions for children.

In addition to a small private unit, the state should develop a larger public residential unit for psychotic and psychoneurotic children and children with personality and transient situational disorders. This should be for 25 children at first, with plans for extending the size to 50 as required. About 60 percent of space should be planned for boys and 40 percent for girls. This unit would demand a high ratio of personnel because of the individual attention needed. Schooling could be arranged in a nearby public school.

The child guidance clinic should be expanded to include (1) diagnosis and screening of mentally defectives; (2) consultation to court, maternal and child welfare agencies, and schools; (3) a 4-8 hour day-care center for children, with perhaps a nursery school, as a part of a preventive preschool program; (4) a residential unit for children for short and possibly long-term treatment; (5) other preventive or educational programs.

ORGANIZATION OF PSYCHIATRIC SERVICE IN POLK COUNTY

State needs as described earlier

1. 75-bed unit for maximum security patients (criminals with psychoses).
2. 75-bed unit for psychotics with TB.
3. 25-bed unit for children (to be later raised to 50 beds), in addition to children's services at Independence and Cherokee.

County needs

1. 50-bed unit for adults, brief treatment cases.
2. 25-bed unit for children.
3. All-purpose out-patient clinic.
4. Consultative services to city agencies.
5. Day hospital for adults and children.
6. Night hospital for adults.

All these services would be best operated under single organization and single director, with an assistant director for each section.

A community mental health center is proposed for eventual construction on the grounds of Broadlawns. There should be also a tuberculosis unit to house tubercular patients from all state hospitals, a maximum security section, a children's section, extensive out-patient service for adult and children, and special services for special groups. Each of these divisions should face away from the center, with separate entrances, but built around a central core containing central services, staff offices, administration, etc., all as close as possible to the Broadlawns General Hospital.

A rehabilitation section of the county home should be organized, with vocational training, employment supervision and other features. This section should be under supervision of the Director of the Community Mental Health Center. This type of psychiatric supervision and active rehabilitation program would produce a suitable place for many patients ready to leave the hospital at Clarinda.

Referrals to Clarinda may be markedly cut down, as many would be carried by the clinic and day service, and many would be treated briefly by the psychiatric unit at Broadlawns and either returned home, or to day care, or the Rehabilitation Section of the County Home.

With such a large establishment, consultation should be available to the city sufficient to supplement the services of the private practitioners.

Staffing of this Community Center would be greatly aided by part-time employment of physicians in all specialties in the city, and by social workers and clinical psychologists.

A broad-scale teaching and research program would find ample clinical material in the several services.

Such an organization would be unique in the United States. It would require unusual ability and leadership in its director. It would demand both central office and county support.

The first step is for a demand by interested citizens for such an organization and such a center. The second step is pressure by professional leadership in the central office. The third step is appointment of a Director for the Polk County Project to create a community Mental Health Center and bring about the cooperation of all forces in the county to make it a reality.

RECOMMENDATIONS

1. Fundamental to progress in Iowa's provisions for psychiatric treatment services is a policy decision that proper treatment will be made available to all who require it. This is a goal which cannot be achieved immediately, but a beginning can be made, and progress can be expected as a result of the policy decision and the necessary implementing steps.

2. Improved treatment should be sought by all possible methods (including more intensive treatment in the hospitals, which makes more efficient use of available space), the provision of auxiliary services such as branch hospitals, colonies, day and night treatment centers, wider use of community resources such as general hospitals and psychiatric clinics, improved social service work to facilitate discharge, improved screening of patients, etc.

3. Buildings listed in the CIB reports as unsatisfactory should be replaced as rapidly as possible. Those which are dangerous should have first priority for the necessary structural changes, fireproofing, etc.

4. Addition of new beds should be limited to the number that would relieve existing overcrowding and provide for all patients sent in, many of whom now are returned to county care as "harmless and incurable." Provision for additional patients should depend on the results of more effective use of beds as a result of improved staffing.

5. The vocational rehabilitation program of the state should be expanded to permit collaboration with hospital staffs in the pre-discharge rehabilitation of patients, and in provision for post-discharge assistance.

6. A unit for psychotic criminals, and one for delinquent defectives, should be established away from the correctional institutions and under psychiatric guidance.

7. A unit for active tuberculosis cases should be set up, separate from the four hospitals, and near a medical center.

8. Assistance in planning and recruitment of staff should be given to general hospitals wishing to set up psychiatric services.

9. Assistance from state funds should be provided for mental hygiene clinics, and assistance in recruitment of psychiatrically trained personnel made available.

10. Those directing clinic policy should strengthen the psychiatric orientation of the clinics.

11. Close coordination between in-service and extra-mural facilities should be provided. The effect will be to limit hospital admissions to patients in actual need of psychiatric help, to provide for earlier planning for discharge, and to arrange for supportive services to promote discharge possibilities. An extra clinical director may be needed in the hospitals for this purpose.

12. A follow-up service should be established in each hospital, with the assistance of local clinics.

13. Plans should be undertaken to develop the better county homes as branch hospitals or rehabilitation units.

14. Patients should no longer be discharged to county homes, except as the homes become rehabilitation units. Patients now there should be screened to determine whethery they should be returned to the hospital.

15. A modern department for the care of mentally ill criminals, defective delinquents, and dangerous patients from the Mental Health Institute, should be established at the proposed mental health center in Des Moines.

16. The facilities provided should be so planned that classification of different types of patients is possible. Facilities for work and recreation should be provided in addition to those for all forms of modern psychiatric treatment.

17. The services of a visiting psychiatrist should be provided at the present unit as soon as possible.

18. The non-psychotic aggressive and hostile inmates of Anamosa should be carefully examined and if possible recommendations for other disposition made.

19. When the new department becomes available the population of all of the penal institutions should be carefully screened and all discovered mental cases transferred to it.

20. The complex of services described in the section on Polk County needs should be established, and its results tested before any plans are made for construction of a new state hospital.

21. Employees should be assigned from the hospital to the County Welfare Board to assist in follow-up of patients and in liaison with county homes.

VII. MENTAL DEFICIENCY AND RETARDATION

Services for mental defectives and retarded persons are a part of the state's treatment services for the mentally ill. They are discussed separately for two reasons. They lag far behind the other treatment services in the extent to which they meet the needs now being expressed. There is good reason to believe, as well, that the expressed need is by no means as large as the real need. New cases are constantly being uncovered. In the second place, the range of services is somewhat different from that for other types of mental patients. Psychiatric service is needed as a fundamental part of the program, since mental deficiency is a mental illness, and one which is frequently accompanied by emotional disturbances both in the patient and his family.

Mentally defective individuals are classified in four groups:

Borderline	IQ 70-90
Mild	IQ 50-70
Moderate	IQ 20-50 (*)
Severe	IQ 0-20 (*)

(*) The National Association of Retarded Children makes the division between moderate and severe at IQ 30. Ohio practice is to put it at 25. Pennsylvania uses the divisions shown here.

"Mild," "moderate," and "severe" correspond to the terms "moron," "idiot," and "imbecile" in use in Iowa. The former are generally regarded as more accurate and less invidious designations. The outmoded terms should be abandoned.

INCIDENCE

No studies have been made on incidence over any large area. The figures generally used derive from an estimate that 3 percent of the total population is below 70 IQ. In Iowa, this number would be 78,000. Much the largest proportion of these is in the higher IQ levels.

The distribution, according to widely used estimates, is:

IQ range	Percentage distribution	Numbers in Iowa
Total under 70	3.0	78,000
50-70	2.5	65,000
20-50	.4	10,400
0-20	.1	2,600

WIDE RANGE OF SERVICES NEEDED

This wide range of deficiency requires a wider range of services than now exists in Iowa.

The multiple subprograms which come within a program for mental defectives include the care of disturbed, tuberculous, and delinquent defectives; care of all ages of defectives, from a few days to 80 and over; diagnosis, screening, and referral services throughout the state; and training and education of all grades of mental deficiency, plus the diagnosis and treatment of cases of pseudo-deficiency where children have been admitted as defective but who are in fact under-functioning and disturbed.

PRESENT PROGRAM

The number in state schools is 3,500. It is clear from the testimony presented at the hearings, and from an examination of patient statistics, that this number includes some who should not be there, and excludes some who would benefit from a good state school program.

Woodward, for example, takes both mental defectives and epileptics. In recent years, with advances in the medical managment of epilepsy, most of the epileptics admitted were taken because they were also mentally defective. There is still a substantial number of patients who could be returned to their communities.

Some mentally defective children have gone to the training schools at Eldora and Mitchellville. This point was the subject of extended comment in the 1937 report on mental institutions, and it still presents major difficulties in the operation of all four institutions. Careful diagnosis is required to determine which institution is best suited to the care and training of an individual.

No provision is being made for the management of delinquent defectives. Commonly these individuals create a problem in state institutions. When they are kept in prisons they are likely to be victimized by other inmates, and when they are kept in state schools they are likely to be disciplinary problems. They should be in a separate institution, preferably alongside the recommended unit for psychotic offenders in Des Moines.

The schools are located at Glenwood, near Council Bluffs, and Woodward, near Des Moines. The districts for the two schools divide the state approximately in half from east to west. The northern half of the state, except for the westernmost tier of counties, is in the Woodward District; the southern half plus the northwestern tier of counties, is in the Glenwood District.

Glenwood is intended solely for mentally defective patients, and Woodward takes mental defectives plus epileptics.

GLENWOOD STATE SCHOOL

The school houses 1900 patients and 230 employees in buildings on the institution grounds. The plant consists of nearly 1200 acres, with two large and a number of small patient buildings, dining and kitchen space, power plant, laundry, and farm and out buildings of various kinds.

The school was established in 1867 in a converted orphans' home. Some of the buildings date from that period.

Many of the patient buildings are over 50 years old, not fire resistant, and inadequately ventilated. Lacey and Mogridge Halls are nearly 50 percent overcrowded, and present real hazards to the occupants. The other buildings are also badly overcrowded. Plumbing is old and much too scantily supplied. The best of the buildings were characterized by the Survey Consultant as fair. The defects noted were buildings non-resistant to fire, inadequate toilet and bath facilities, unsatisfactory ventilation, and insufficient space to permit classification of patients.

The hospital building, which is only 10 percent overcrowded, is not fire-resistant and has no fire alarm system. The outside fire escapes are of metal. According to the registered nurse in charge of the hospital:

> "Dishwashing facilities are inadequate. On third floor the kitchen has no sink and dishes must be taken across the hall, to be washed in a bathroom. First and second floor kitchens have sinks, but no way to sterilize dishes. Badly in need of an elevator. Patients on stretchers must be carried upstairs to x-ray. This is dangerous for patients, and difficult for stretcher carriers. There is a need for isolation units to take care of communicable cases. The laboratory is in a crowded, poorly ventilated room, with no windows. The lab is opened into surgery, and is considered a source of contamination to the operating room. A space on second floor is available for a laboratory with a moderate amount of reconstruction. This would provide a way for out-patients to come and go to lab without entering the ward of the hospital. The heating system is poor; constant leaking radiators cause damage to floors."

PATIENTS

There is available no complete statement as to the condition of the patients. The Biennial Report of the Board of Control classifies the patients according to the outmoded terms "idiot," "imbecile," and "moron," but adds a classification "not mentally deficient or epileptic." The Survey Consultant who visited the schools listed the patients as ambulatory or non-ambulatory and

custodial, trainable, or educable. These classifications would almost certainly be sharply changed if enough trained personnel were available to develop the full potentialities of the patients. What is clear is that the proportion of crib cases is growing, and that a growing but still very small number of the higher IQ cases are being prepared to leave the institution.

PERSONNEL

The Superintendent, now 80, is retiring. He is a general practitioner who was staff physician at the School before he became superintendent. The full-time medical staff consists of two unlicensed European physicians who are permitted by the Board of Medical Examiners to practice in the institution. Two local general practitioners make regular ward rounds and respond to emergency calls. Patients who need surgery go to Iowa City. Those with psychosis are transferred to Clarinda.

The nursing service consists of an attendant supervisor of male and female attendants, and a registered nurse in charge of the hospital, with another registered nurse as assistant. Twelve attendants are available to perform nursing service, and a registered nurse is in charge of the t.b. annex.

In recent months two psychologists have been employed. Each has an M. A. degree. The program is too new to be accurately evaluated, but it offers considerable promise, if it is properly coordinated with other school functions.

The social service work of the hospital is carried on by two workers. The size of this staff is completely inadequate for the work required in a modern institution.

The formal teaching staff consists of 19, including the director, or school principal. Most of the teachers are not certified by the state, and no professional qualifications are required for employment. Two teachers have BA degrees, and a few others have some college training.

SALARIES

Generally, pay scales are low. Translating maintenance into equivalent dollars, the top level for the superintendent can be figured at about $14,000. For physicians the top figure is about $10,000 or $11,000, and some are hired at a figure comparable to $6,500 in cash. Social service workers may make $4,000 or $4,200, and psychologists get between $4,500 and $6,500.

Further, these salaries are maximums, the top of the range. Also, they require that the employee live on the institution grounds. If he prefers not to do this, the sum which is paid him in lieu of maintenance is so small as to penalize him severely for his choice.

It is not to be expected that well-qualified, competent professionals can be recruited for substandard salaries. Until this problem is faced and dealt with, there is little reason to believe that the school can move out of a custodial pattern, and become a modern hospital-school.

PROGRAM

Besides the general program of the institution, which revolves around the housing, feeding, and care of 1900 patients, there is a small school program. It is based on the philosophy that many of the children will never master reading, writing, and arithmetic, but that many of them can become self-sustaining in the personal sense, and in some cases economically self-supporting.

Pre-school classes handle 45 children, with activities generally characteristic of nursery school classes for normal children. The kindergarten has 40 children in 3 classes. Customary kindergarten activities are undertaken. One group has a morning session, and the afternoon is divided between the other two classes.

The trainable group of older children is divided into primary, intermediate, and older groups, each attending school about a quarter of the day. Each teacher has four similar groups. These children work at many tasks intended to teach obedience, following directions, keeping clean and neat, acquiring acceptable social standards, and working to the extent of the individual's ability.

Three teachers handle the educable group, each teacher working with a different group each half day. The primary group is about on a first-grade level, and their chronological ages run to about 10. The intermediate group (10-14) is about on a second or third-grade level, while the upper group is on a fourth-grade level. The older group includes 18 year olds, who are removed from these classes at the end of the term in which they become 18.

Music, industrial arts, gym classes, home economics, ceramics, shoe repair, woodworking, basketry, and recreation are also a part of the school program.

On-the-job training is offered to over 1,000 boys and girls who have achieved the maturity of which they are capable, and can perform simple tasks. In 1954 fewer than 100 children were discharged from Glenwood, while over 160 were admitted. The figures for the previous year were much the same.

WOODWARD STATE SCHOOL

The school houses nearly 1,600 patients. It admits defectives from the northern half of the state, and epileptics from the whole state. The number of epileptics admitted in recent years has been declining, and should continue to

do so. Medical advances have made it possible to manage most epileptic cases in the community.

Overcrowding is estimated at 35-40 percent; there is a waiting list of 165. Overcrowding has broken down the system of classification of patients, and one result is an increase in the workload of attendants. Four buildings now being constructed, with a total of 250-300 beds, will ease this situation considerably, and may also eliminate the waiting list. The new buildings are poorly planned two-story buildings for infants and small children, chiefly of the lowest grade.

The other buildings fall so seriously short of modern standards as to require immediate modernization or replacement. All of the buildings are fire-resistant. None has adequate toilet or bath facilities. The common quota of toilets is 6 per floor, though the number of patients per floor varies from 40 to over 100. Most of the buildings have two tubs per floor; the newest one, for male patients, has six tubs per floor. Dormitory and day-room space is also inadequate.

Housing is available for non-professional personnel who wish to live on the grounds. Housing for professional personnel is seriously lacking, and Woodward shares the disability common to all state institutions of having to penalize those staff members who live off the grounds.

PERSONNEL

The superintendent is a physician who has been continuously employed at the School for many years. She is well-trained in all aspects of mental deficiency, and is active in the American Association of Mental Deficiency. The assistant superintendency is vacant; it is expected that the assistant superintendent will also be clinical director. The educational director resigned some months ago to take a better-paying position; the acting director has been on the job only since September 1, 1956. She has a B.S. in elementary education.

The medical staff consists of four European-trained physicians. One of these has had 15 years in the United States, with service in three general hospitals. A second interned at a Minneapolis hospital and is now in charge of tuberculosis work; a third served as medical technician in Philadelphia. The fourth came over in May 1955, and almost immediately began service at Woodward. None of them is licensed.

No registered nurses are employed in the patient buildings. There is an Attendant Supervisor, with an assistant, for male and for female patients. Nursing services in each building are directed by an Attendant III or licensed practical nurse, with Attendants I and II assisting in the care of patients. The hospital has 23 beds for female and 25 for male patients; registered and practical nurses provide care. The hospital is sometimes unable to care for acutely ill patients because it is used for crib cases.

The Social Service Department of the School has operated an intensive rehabilitation program since 1948. In the past 6 years some 500 patients have been released as capable of self-support. The number on vocational placements each month stands at about 50. The Department is attempting to cut down the number of patients in the School diagnosed as neither mentally defective nor epileptic, and has had some success.

There are strong religious and volunteer programs.

The staff consists of sociologists rather than social workers. They have done considerable research on defective delinquents, psychopaths, social adjustment, criteria for vocational placements, group placement concepts, rural-urban admission rates, psychomotor epilepsy diagnosis, placement supervision techniques, parental attitudes, epileptic behavior patterns, merit wards, and problems of communication between lay persons and professionals.

The chief psychologist has an MA in psychology, and 45 points in advanced courses. The assistant psychologist has a B. A., and has almost finished her M. A. This Department does diagnostic testing and interpretation, psychotherapy and counseling, and research, besides consulting with other departments, and participating in educational programs for staff and visiting students.

Understaffing is serious. The table of organization provides for a superintendent and assistant superintendent, 4 physicians, a clinical psychologist, a psychologist and an intern, 4 psychiatric social workers, 8 registered nurses, 18 practical nurses, and 183 attendants. Two music therapists and a recreation director and 3 therapists are also authorized. The positions of assistant superintendent, the psychologist and intern, one social worker, 8 attendants, 6 RN's, 6 practical nurses, and the recreational director are vacant. Comparison with APA minimum standards shows that understaffing is far more serious.

The teaching staff consists of 13 teachers, most of whom have high school or normal school educations and certificates, but who have also taken a good deal of additional university work and have had some experience in teaching.

SALARIES

Pay scales are not high. Physicians get from $375 to $500 per month, plus maintenance, which means that the top pay in real terms is between $8,000 and $9,000 per year. The top of the clinical psychologist's range is the same as that for physicians. This is not unreasonable for clinical psychologists, but will not result in recruiting physicians of higher qualifications.

PROGRAM

Of the 13 teachers, 5 are for educable children, 6 for trainable, 1 for homemaking, and 1 for nursery children. The educable group includes 90 children, half boys and half girls. The trainable group is 83, and there are 15 girls in homemaking. The nursery class consists of 21 boys divided into two groups. The children in school, then, number 209 of the total of 1,600.

SPECIAL CLASSES IN PUBLIC SCHOOLS

Iowa now has about 1600 children in special classes in the public schools. This is a good beginning, but includes only a fraction of the children who could be so handled if special teachers were available. The IQ group from which these children come totals 65,000; not all of them are physically or emotionally fit for this type of education, but many more than the present number could be served. In addition, there are 11 classes for trainable and 147 for educable children. Capacity of these classes is about 1600.

Such classes in the community, either in conjunction with public schools or in separate facilities, could serve substantially larger numbers of children in the IQ group 20-50. These children are capable of a good deal of training and socialization, in the absence of other handicapping factors. Provision of training service, plus a day-care program which frees the mother for other tasks, is very valuable. More classes are authorized but teachers are not available. In the past 2 years Woodward has offered 6 weeks of training to 33 teachers. No other special training is available in Iowa.

STATE PROGRAM NEEDS

The state needs to provide a high level of professional leadership in:

the diagnosis of mental deficiency;

diagnosis and treatment of associated mental illness either in the child himself or in his family;

training, education and rehabilitation of the individual and his adjustment to community living;

and the establishment of a continuing guardianship over mentally defective individuals to permit assumption by the state of responsibility in case of crisis.

The central office should have a well-qualified psychiatrist experienced in the problems of diagnosis, treatment, and research in mental deficiency, in charge of the whole program for mental defectives. He should be assisted by

an educator who understands the problems of educating and training mental defectives, as well as the training of special teachers, and the administration of the school functions in the hospital schools. The psychiatrist-administrator should be equipped to develop a program of collaboration between state and community services which will greatly extend the network of resources.

Centers will have to be provided at various cities in the state for diagnosis, screening, and referral to provide prompt local service for families and agencies. In some cases the psychiatric clinics can be used for this purpose; as the clinics improve their allotment of psychiatrists' time, this part of the work can be extended. The clinics should also extend their activities to provide counseling for parents and treatment for mental illness in both parent and child as indicated. (It would be possible to set up special clinics for these purposes, but it would provide a more efficient division of the physicians' time to combine with existing psychiatric clinics.)

The state schools need to be substantially improved. Plant needs extension and improvement, with elimination of substandard conditions, including overcrowding.

Staffing needs to be much improved, as to both numbers and training. The medical staff needs to be substantially enlarged, and attention should be paid to the problem of replacing untrained physicians with those trained in psychiatry and neurology as rapidly as possible. The superintendents should be psychiatrists, and should have adequate psychiatric assistance. The education and rehabilitation staff also needs to be expanded and its qualifications raised.

COMMUNITY PROGRAM NEEDS

Modern medical and social thinking favors keeping defective children at home, rather than in institutions, if their presence is not too disturbing to the family or community. In Iowa, the emphasis is still on institutions. Approximately 700 children now in the state schools are in an IQ range which normally permits successful adjustment to community life. These 700 are among the 65,000 estimated to be the state total in the upper IQ range. They would have to be carefully examined to determine whether they could in fact adjust to community life, or whether they had complications which would make rehabilitation unlikely.

Among the community services which would help to keep children at home, without detriment to their families or the community, are:

special classes in the public schools;

day-care centers;

diagnosis, consultation and guidance to defectives and their families;

vocational training and guidance;

temporary care during family emergencies, or to permit families to take vacations;

sheltered workshops;

foster-home care;

supervised residences.

Iowa's system of special classes has developed well, but there is a need for more and better-trained teachers, to reach substantially larger numbers of children.

There are a very few day-care centers offering nursery or kindergarten programs. A major addition to these would be a system of after-school recreation, possibly in the public schools as an extension of the program of special classes.

The other items listed are almost entirely lacking. A further lack that has been mentioned to the Survey Team is transportation to and from classes. Some sort of religious education would also be helpful.

RECOMMENDATIONS

1. A chief of services for mental defectives should be established immediately in the central office. He should be responsible for coordination of all services for mental defectives in the state, and for administration of the state-supported services aside from those in the Department of Education. The individual chosen for this position should not be responsible for the operations of any institution. Ideally, he would be trained in psychiatry, psychology, and education, and would have worked in an institution for mental defectives.

2. Psychiatrists should be required as superintendents of the state schools. The vacancy at Glenwood should be filled immediately with a qualified psychiatrist; when the present superintendent at Woodward retires, she should be replaced with a psychiatrist. Each superintendent should be given adequate assistance by an educator skilled in the administration of an education and training program, as well as in the training of special teachers. In addition, all staff at the schools should be brought up to APA standards.

3. A series of diagnostic centers for mental defectives should be set up, either separately or in connection with diagnostic and screening centers for all mental patients, distributed throughout the state. Preferably, they will be established as part of the system of mental hygiene clinics. The

specialized training required for this type of diagnosis will necessitate additional staffing.

4. In connection with the diagnostic work, counseling should be available for parents and for continued guidance of the patient himself.

5. Classes and day-care centers for the mentally retarded under community sponsorship should be expanded, and a program of expert guidance established in the central office. This program is showing good results both in Iowa and elsewhere.

6. A residential center should be established at Iowa City for training and research.

7. The Department of Education should be urged to expand special classes in the public schools. Assistance in the way of consultation, training of personnel, etc. should be available in the central office.

8. An aggressive policy of rehabilitation, vocational training and release should be inaugurated in both schools, with the objective of returning to the community all patients with IQ's over 50 who are without psychosis.

9. To this end colonies should be established in population centers in which patients can live under supervision while beginning employment and self-support.

10. Epileptic patients at Woodward should be carefully re-examined and screened, if necessary by a task force organized out of Iowa City, with a view to sending the patients back to their own homes, to colonies, or to county homes. Medical supervision for these patients must be available in nearby clinics, general hospitals, or from private physicians, as a condition of discharge. Some of the patients may have to go to mental hospitals.

11. A special institution for delinquent defectives should be established at Des Moines, alongside the maximum security unit for psychotic offenders recommended elsewhere.

12. A system of home teaching should be set up.

13. The two schools should be rapidly staffed with well-qualified professionals: psychiatrists, general physicians, psychologists, psychiatric social workers, nurses, rehabilitation workers, and teachers.

14. Physical plant should be improved on an accelerated schedule to eliminate overcrowding and substandard structures. Necessary plumbing and other facilities must be installed.

VIII. SPECIAL PROBLEMS: CHILDREN AND ADOLESCENTS; AGED; SEX OFFENDERS

Two major fields of mental health programming have so large a psychiatric component and are so troublesome that they must be given special attention in this report. These are problems of children in need of psychiatric treatment, and aging persons. In addition, the problem of sex offenders, while not large in terms of numbers, requires special attention.

The non-psychiatric aspects of these problems can and should be handled by Zone II or Zone III services. To the extent that they are lacking, an unduly heavy burden falls on Zone IV (psychiatric) services. Standing all alone in an isolated area, a mental health clinic or children's unit or treatment center for aging persons may be smothered and is likely to fail.

PSYCHIATRIC SERVICES FOR CHILDREN AND ADOLESCENTS

Psychiatric treatment of children is a special skill. This is recognized in the training program for child psychiatrists, which provides 3 years of training in a clinic. Residents in child psychiatry must have 2 years of residency in general psychiatry before specializing in work with children. Only 40 child psychiatrists are trained each year in the nation. Competition for them is intense.

Children have special needs, which may involve considerable personnel; they are in their most formative years, when psychiatry can do the most for them, and the investment in help is most worth while. All children need adequate public health services, including sanitation, prevention of infectious diseases, etc. They also need a satisfactory family, religious, and early social life, and good schools. Many also need emergency assistance, such as maternal and child welfare services and residential care for special problems.

People who work in Zone II and Zone III services must recognize the natural emotional reaction to stress. If the problems are taken care of and the special stress relieved, the emotional aspects recede. Only if they do not, but progress beyond the ability of the social worker, teacher, doctor, minister or other available person to deal with them, should psychiatric consultation be requested. The emotions of children and adolescents are likely to be volatile; though quick to rise, they are also quick to subside. A child or adolescent should not be made a "psychiatric case," with all that this means to child and parents, unless it is necessary.

THEORY OF RESIDENTIAL TREATMENT

A residential treatment center is usually conceived as a small group setting whose purpose is to provide a 24-hour-a-day therapeutic environment for children with psychiatric disorders. Such centers are a recent development; the first beginnings were made about 30 years ago. In the last 10 years the development of units calling themselves residential treatment centers has been rapid. The term as now used is not precise; the centers vary widely in provision for schooling, intensity of treatment, type of children served, and auspices. Some units are parts of mental hospitals, some are affiliated with general hospitals, and some are independent units. Academic teaching may be arranged in the unit itself, or the children may attend community schools; sometimes there is a combination of both.

There are also differences as to the degree of participation required of parents and in amount of psychotherapy offered.

States today are providing residential treatment in a variety of ways:

mixing children with adult patients in state mental hospitals;

establishing separate wards or buildings in the hospitals;

establishing independent institutions physically separated from state hospitals but still under their jurisdiction;

establishing units in no way affiliated with adult state hospital administration;

adding clinical services to state institutions, or purchasing care from private institutions.

Most of the children now being given psychiatric treatment are in state mental hospitals, although there is conflicting opinion regarding this practice.

NEEDS FOR SERVICE IN IOWA

There is great pressure in Iowa today for residential treatment for mentally ill children. Attention was drawn during the Survey Committee's public hearings to the inadequacy of existing units and of the proposed center at Iowa City (which is planned as an out-patient center). Pressure also exists for additional clinics and for psychiatric consultation to schools and child-caring agencies. The pressure for residential treatment centers is strongest at the

present time, however, partly because the idea is new and appealing, partly because a few centers have had very good results, and partly because of the failure of alternative resources to meet the need, and to train personnel.

EXISTING FACILITIES

In 1954 the Children's Committee of the Iowa Mental Health Authority surveyed child care facilities in Iowa to determine the availability of residential space. Questionnaires were sent to 69 agencies and institutions. The responses indicated that very few institutions were set up to provide psychiatric treatment, although a number of them, for lack of better services, accepted psychiatric cases or found later that their patients had psychiatric disorders.

Eight public agencies with residential facilities had some disturbed children. These included two state hospitals, the state psychopathic hospital, two training schools, one state school, one state juvenile home and one other home. Sixteen private agencies with residential facilities also had some emotionally disturbed children. Three of these took such children only in emergencies since they had no special provisions for them.

The physical facilities available ranged from placement in adult wards with no special facilities to cottage unit plans segregating children by age, sex, or condition. The agencies had no uniform policies on education. Only 5 of the 24 agencies had a full-time psychiatrist; 4 others had a part-time psychiatrist. Eight had a full-time and 7 a part-time psychiatrist; 14 one or more full-time social workers and 4 part-time. Twenty of the agencies accepted children of both sexes, 2 only boys and 2 only girls.

Sixteen agencies reported that psychotherapy was available from members of the agency staff; one said that children were referred to the clinic for psychotherapy; and the remaining 7 agencies did not answer this section of the questionnaire. Psychotherapy was being done by psychiatrists, psychologists and social workers. The agencies in general showed little emphasis on work with parents, although this is considered very important and some of the most successful centers in other states refuse to accept children unless it is also possible to work closely with their parents.

A further document on this subject published in January 1955 indicated need for a 40-60 bed center for disturbed children. The following gaps in Iowa's provision for children were noted:

> Diagnosis for children's illnesses is not readily available, and commitment to training schools frequently occurs without diagnosis;
>
> private institutions generally regard their resources as far too limited to deal with disturbed children;

all the institutions are too small to provide the space needed over long enough periods to deal effectively with the symptoms;

the Iowa Annie Wittenmyer Home and the State Juvenile Home frequently receive dependent and neglected children with emotional problems who cannot be given the intensive individual guidance they need.

The Citizens' Committee commented that a children's center could provide diagnosis, sorting out quickly the children with psychiatric symptoms and avoiding unnecessary shuffling among institutions. It could also offer short- and long-term treatment and serve as a follow-up center for children discharged from state hospitals. As a result of the work of this committee, money was appropriated in 1955 for a children's center in Iowa City. The amount appropriated was only $130,000, to be divided between a center for emotionally disturbed children and one for mentally defective children. The amount is of course very small and does not permit rapid progress toward the goals set by the committee, but a start is being made. It is hoped that additional money will be made available promptly and that immediate steps will be taken to complete and staff the center. It should eventually provide in-patient treatment in accordance with the original plans.

The number of children needing service is still not known. The 1954 survey counted 1,800 in a 3-month period; this figure is subject to wide error but is the only measure available. Probably the total includes some duplications; on the other hand, such surveys usually fail to uncover some cases of need. Certainly only a small fraction of Iowa's psychiatrically ill children are being treated, the new out-patient unit at Iowa City is inadequate to meet the need, and in-patient services are needed. An in-patient training and research unit at Iowa City is essential.

Plans are going ahead at Independence to establish a true unit for children. A building is available, and a satisfactory treatment unit could be set up with a relatively small investment in alterations and improvements. New staff will of course be needed. As many as 50 children could be taken care of at first, and the unit could be expanded as experience indicated.

At least one more center should be established in the near future in the western part of the state.

PSYCHIATRIC ILLNESS AMONG THE AGING

One of the most serious problems of aging persons and their families is cerebral arteriosclerosis (hardening of the arteries of the brain), the psychosis of old age. It shows itself in confusion, irritability, loss of memory, inability to manage every-day affairs, hallucinations, apathy, and similar symptoms. This disorder ranges from mild to very severe and requires a comparable range of treatment and care methods.

In most states, mental hospitals are being pressed to admit more and more aging persons. A number of facts have led to this increasing pressure and to the concomitant pressure to discharge elderly patients to nursing homes, county homes or elsewhere. Not all of these facts are accurately interpreted.

The increase in the number of older people in mental hospitals has often been interpreted as largely due to the rising number of first admissions of persons 65 or older; actually, however, the deaths in this age group have consistently outnumbered first admissions. The phenomenon is due instead to the aging of the resident population; an increasing percentage of patients each year becomes 65. The resident population in mental hospitals consists largely of a slowly accumulated core of schizophrenic patients who are admitted during youth or early maturity and stay, in many cases, for the rest of their lives. The real answer, therefore, to the problem of aging in the mental hospital population will be found when a successful method of treating schizophrenia is found. This is a major reason for intensified research.

Hospital patients who have grown old in the hospital and who are beyond the point where standard hospital treatment can be expected to benefit them, can properly be discharged to a branch hospital (see Chapter III, New Ideas).

Iowa differs sharply from most of the rest of the nation because of its tendency to use county homes rather than mental hospitals for the care and treatment of aging patients. State law provides for the transfer of "incurable but harmless" patients to county homes. Under existing practice, the patients transferred are usually older people. Presumably those with acute symptoms are not returned to county care. In fact, however, a recent inspection of six county homes turned up about a dozen patients who were seriously withdrawn, catatonic, untidy, and in need of hospital treatment.

The present practice has grown up as a means of dealing with overcrowding in the hospitals and is based on a recognition that increased overcrowding will mean further deterioration in treatment, from which all will suffer. It is an unrealistic answer, however, and one which bases its present limited

success on discrimination between persons who are in need of in-patient treatment.

The most realistic way to deal with overcrowding is to provide more efficient use of bed space. This means prompt diagnosis and intensive treatment, with discharge services geared to return a much larger proportion of patients to an active life. This approach should be fully exploited before any plans are made to add new hospital beds, whether in existing institutions or in new ones. It involves substantial staff increases, and it would be unwise to try to staff new beds while these increases are being made.

INCREASE IN ADMISSIONS

While the over-all increase of aging persons in hospitals is due principally to the aging of the resident population, it is also true that admissions of people over 65 are increasing. This is due to a large number of problems surrounding the onset of old age and a general lack of services to handle these problems. Since 1900 the nation's population has doubled while the number of those over 65 has quadrupled. In Iowa the increase has been even more spectacular: Total population has increased 17 percent since 1900, but the number of those over 65 has increased 146 percent. Clearly, this puts a tremendous burden on general and psychiatric services which were planned for much smaller numbers and for different types of patients.

The processes creating an increased demand for services for old people include: Urbanization and the splitting up of families; lowering of retirement ages; and increase in the need for medical and nursing care with advancing age. If the latter needs are not met, the result may be a serious illness, perhaps complicated by depression, lowered vitality and a tendency to become house-bound. Under these circumstances the ordinary symptoms of age are aggravated. Finally it becomes necessary to provide specialized care and treatment, usually for a longer period than would have been required at the outset. It must be stressed, therefore, that one of the major needs in any group of old people is improved medical care. A clinic, attached to some other organization for old people, would meet a real need and do much to improve the outlook of aging individuals. Its staff should include physicians able to recognize and treat early mental illness.

Efforts should be directed toward maintaining the mental health of aging persons over longer periods and delaying, sometimes for many years, the onset of senescence. This approach depends on the effectiveness of a number of community services, all aimed at keeping older people active in the community. These might include day-care centers, volunteer work by older people, etc.

PROMPT TREATMENT

Many old persons admitted to mental hospitals are able to return home after relatively brief treatment. This is particularly true if they are admitted early but may be true even in advanced cases. Frequently, even when symptoms are not remitted, the illness becomes stabilized at a point where a much less highly organized environment is beneficial.

In order to discharge such patients, there must be a place to send them, and a system of pre-discharge social service and post-discharge supervision.

A social service unit should be attached to the hospital to prepare the patient for prompt release, and his family for his return. This preparation should begin at or even before the time of the patient's admission to the hospital. Relatives need to understand the process of aging and the type of specific adjustment problems which may arise. If these adjustment problems are taken care of before the relationships in the family deteriorate too far, the chances are increased that the patient will have an untroubled transition back into family life. In New York, the state hospitals have been given an additional clinical director in charge of preparing patients for release.

The social service department may evaluate the possibilities of various facilities or combinations of services and decide what kind of readjustments would be needed to make discharge feasible. They could also watch the patient's progress after discharge to see whether the solution had benefited him or whether an alternative type of care would be better.

Additional services such as home visiting by public health nurses, visiting nurses, social workers, or others, may make discharge to the patient's own environment more feasible. Montefiore Hospital in New York City has for some years had a very successful plan of home visiting and nursing care which has permitted them to maintain a large number of patients in domiciliary care outside the hospital. Assistance to the County Welfare Board would also be useful.

USE OF COUNTY HOMES

It is not possible to abandon the county homes. They represent a substantial investment, and in some cases they have a good physical plant, even though it is not adequate to treat mental patients. Yet the homes contain too much space to care only for the present number of indigent persons.

The homes could usefully be operated as rehabilitation centers for discharged mental patients--a sort of way station on the road back to community life. With a rehabilitation staff, skilled in vocational training and placement, and the necessary medical and nursing staff, under the supervision of the hospital administration, it would be possible to operate these county homes so as to

improve the patients' condition. Iowa is a rural state, and much agricultural training would be of real benefit to the patients. As industry develops in a community, attempts should be made to integrate industrial training into the therapeutic complex.

TREATMENT OF SEX OFFENDERS

The handling of sex offenders varies widely throughout the United States. This subject normally attracts very little attention, but when an incident occurs, the state and the legislature are likely to be stirred to act. The emotional content of the discussion is high, and the result is frequently a hastily drawn bill, which may be ineffective in regard to specific situations and at the same time damaging to individual civil rights.

A considerable amount of research is available as a basis for revision of state laws. The State of California authorized a study of sexual deviation in 1950; the final report, containing a summary of current studies on the subject, was issued in 1954. According to the survey, six states have asked their legislative councils or similar bodies to study this problem preparatory to a revision of the laws.

According to the report, 24 states have enacted some kind of special legislation regarding sex offenses. The older statutes usually provide that a state's attorney may initiate proceedings to determine whether a person charged with a sex crime or having dangerous propensities toward sex crime is a criminal sexual psychopath. If upon psychiatric examination the court finds a condition of criminal sexual psychopathy, it may suspend criminal proceedings and commit the individual indefinitely to a mental institution, with release depending upon recovery.

The Iowa law, passed in 1955, is of this variety. The definition is general: All persons charged with a public offense who are suffering from a mental disorder and who are not proper subjects for schools for the mentally defective or for mental hospitals, who have criminal propensities toward the commission of sex offenses and who may be considered dangerous to others, are declared to be criminal sexual psychopaths. If the court finds that the complaint offers sufficient proof of the defendant's criminal propensities, and if the examining physicians find that these are attributable to a mental disorder, a hearing is set. If the defendant is found to be a criminal psychopath the court may commit him to a state hospital or may order him tried on criminal charges "as the interests of substantial justice may require."

After a period of treatment, if he is found to have improved, he must return to the court for another hearing. He may then be put on probation for three years or returned to the hospital. If the latter, he must be held for another three years and after that may be discharged.

NEWER APPROACHES

Some states have tried to remedy defects in existing laws without giving up the idea of special legislation. These laws recognize, however, that psychiatry is not fully able to define "sexual psychopaths" in satisfactory legal terms, to predict potentially dangerous sex offenders, or to obtain permanent cures for all persons treated.

Sex offenders are not a separate, homogeneous diagnostic group. Further, many legal definitions fail to reach such antisocial conduct as stabbings, sadistic murders, robberies and arson which in some cases may be motivated by sexual abnormality.

New York's statute was drafted in an effort to remove some of the most serious objections to existing law. The new law neither delays nor stops criminal proceedings nor tries to define, psychiatrically, a potentially dangerous person. Instead it requires a pre-sentence psychiatric examination of all persons convicted of any of seven specified sex felonies or of a misdemeanor subsequent to a sex offense. Two qualified staff psychiatrists, empowered to subpena and examine witnesses and examine documents, must submit a written report. Thereafter the court may impose any appropriate legal penalty or an indeterminate sentence of one day to life. As a criminal sentence it protects the individual upon release from further trial or sentence, and yet the person is not deemed civilly dead. Psychiatric examination and reports must be sent to the parole board two months prior to each review, which is mandatory after the first half year and biennially thereafter.

MEDICO-LEGAL CONSIDERATIONS

At the Survey Committee's public hearing in Des Moines, a representative of the Iowa County Attorneys Association noted that the 1955 state law on sexual psychopaths was passed because the problem of dealing with criminal sexual psychopaths in the state had become acute. He said that while in theory the law might sound like a good solution to the problem, in practice "we have found that the program does not work out as well as anticipated... There is a real need for an institution to handle the criminal sexual psychopath, where trained personnel could work with such an individual in hopes of gaining his recovery."

In general, individuals committed under special sex legislation are assigned to prison sections or to overcrowded mental hospital wards where treatment is almost wholly lacking, and the prisoner-patient waits out his indefinite term in idleness. This situation appears generally to exist in Iowa. Perhaps as many as half of the convicted sex offenders could be salvaged. The most effective method is intensive psychotherapy.

An effective legislative approach is one which demands no more medical help than experienced psychiatric opinion can at present render. Definitions

should be eliminated or revised toward less specificity. Psychiatric consultation and management are strongly advised for those criminals whose mental condition is in the trial judge's opinion questionable, with hospital commitment of suitable cases instead of sentence. A practical method is to assume that those who commit certain specified dangerous offenses require psychiatric consultation. This is done in New York. Psychiatric opinion is best obtained in established neutral court clinics.

A number of procedural safeguards should be inserted. It is important to make the statute applicable to convicted individuals only, and not to a class of persons. This is a step toward considering sex crimes one aspect of criminal deviation, and may well pioneer a significant advance in the penal treatment of all mentally abnormal criminals.

RECOMMENDATIONS

CHILD PSYCHIATRY

1. The state's deficiencies in child psychiatry need to be made up, starting with at least a part-time child psychiatrist in the central office, and the development of a broad-scale program for training of child psychiatrists at the University.

2. Preparations for establishing at the University in-patient services for disturbed children and mental defectives need to be speeded up.

3. The development of a children's unit at Independence should be encouraged by providing the necessary space and equipment. At least 50 beds should be set up promptly, and others added as experience indicates.

4. Consideration should be given to the establishment of a residential treatment unit in the western part of the state.

5. Out-patient diagnostic and treatment facilities need to be expanded at various locations throughout the state, under the direction of a trained psychiatrist experienced in work with children.

PSYCHIATRIC ILLNESS AMONG THE AGING

1. A policy change is needed, and the law requiring transfer to county care of "harmless and incurable" patients should be repealed. Patients should be transferred to county care only under the same type of circumstances as would justify release to foster-home care.

2. Unrecovered patients could be sent to branch hospitals under the supervision of the hospital superintendent; these branch hospitals could be

established in some of the best of county homes, but they must be adequately staffed for rehabilitation purposes.

3. Each superintendent should see that the mentally ill patients now in county care in his district are examined, and those who are seriously ill returned to the hospital.

4. Day centers should be established in and by local communities, as a preventive measure.

5. Local communities and agencies should set up programs for aging persons, aimed at keeping them active in community life as long as possible, a very successful preventive measure.

6. Coordination should be established with the State Committee on Aging.

TREATMENT OF SEX OFFENDERS

1. Iowa law on sex offenders should be revised to use a less specific definition, and to apply only to convicted individuals rather than to a class of persons.

2. Treatment space should be provided rather than custody; perhaps half the offenders could be salvaged with proper treatment.

3. A law similar to the New York law is recommended. Treatment facilities should be set up in connection with the maximum security unit recommended for Des Moines.

IX. PERSONNEL, TRAINING, AND RESEARCH

Iowa is far below American Psychiatric Association standards for professional staffing of its mental hospitals and schools for the mentally defective. Mental health clinics in the state are operating largely without sufficient psychiatrists and with high turnover of social workers and psychologists. Expansion of community classes or special classes for mentally retarded children in the public schools is hampered by the lack of special teachers. Trained occupational and other therapists are essentially non-existent.

Since these skills are also in short supply in other states, and Iowa cannot hope to recruit the number needed from outside the state, the only practical means of meeting its own needs is to develop adequate training facilities within the state. This will depend on recruitment of key personnel in the training and research institutions.

TRAINING

It cannot be emphasized too strongly that Iowa's principal personnel problem is one of training. Training in the state must utilize and expand the combined resources of the state hospitals and clinics, the state university, and such other facilities as can be brought into the program. To assist in this job, a central office chief of a division of education is needed to coordinate and expand all professional and attendant education and research.

In 1952 an effort was made to establish a cooperative training program between the University and the hospitals. The memorandum of agreement has never been implemented. The Survey Team believes that an opportunity now exists to start on a greatly increased training program which can turn out, over a period of years, substantial numbers of trained personnel.

ROLE OF THE STATE UNIVERSITY IN EXPANSION OF TRAINING

The Department of Psychiatry in the State University must provide the foundation for expanded teaching and training resources. It must also embark upon a program of collaborative teaching and research with other departments of the Medical School to assist the general practitioner, who is considered a first line of defense against mental disorder. In addition, it must promote research and expand its child psychiatry training facilities.

Additional professional staff will have to be employed, and new space provided. A 30-40 bed acute in-patient unit in the University Hospital should be established as a teaching facility and to promote research in psychosomatic disorders; a 30-bed residential treatment center is needed for emotionally disturbed children.

The Psychopathic Hospital has always furnished outstanding treatment, as well as provided for training and research. In recent years, however, it has become clear that the Department of Psychiatry, which staffs the hospital, is undermanned and inadequately supported. Higher salaries are needed, and the staff should be full-time.

Plan for training personnel. The Department of Psychiatry, which has divisions of psychology, social service, nursing, occupational and recreational therapy, and electroencephalography has, in collaboration with the hospital superintendents, developed a plan which would train more candidates for staff positions and provide in-service training for professionals and sub-professionals now employed.

The plan recognized that each state hospital and school for mental defectives should be a training and research center. Training should be related not only to the major professions (psychiatry, psychology, nursing, and social work) but to the rehabilitation treatment groups, ministers of religion, and others. Courses for general practitioners should be part of the curriculum. Full

development of the hospitals as training centers should be assisted by a director of training in the central office in Des Moines as well as a director of education in each institution.

Close connection with colleges and universities will also be required. Other states have found an agreement which lets a university accept responsibility for training and, if possible, for research, to be very satisfactory. The University of Iowa is the logical locus for this kind of training; other colleges should be used when the faculties have teachers who are qualified in the fields to be taught. Each of the affected divisions of the University will need increased staff in order to assist in an expanded training program and to work with state institutions. Qualified teachers in each institution should also be given faculty appointments in the university. Funds for increases in faculty could logically be included in the budget for state hospitals.

The following parts of this section will deal with shortages and training in the various professional personnel categories.

PSYCHIATRISTS

Psychiatrists in mental hospitals and clinics are responsible for general administration, policy-making, and diagnosis and treatment. They also explore the causes of disease and test new therapy methods and techniques. Psychiatrists competent in research and education teach medical students and psychiatric residents, general practitioners in post-graduate courses, and hospital and clinic staffs in in-service training programs. They also teach the principles of mental health to individuals outside hospitals and clinics who are concerned with the impact of mental illness on problems they encounter in their own fields.

There are 64 psychiatrists in Iowa, or 1 to each 48,000 of the state population. This compares with 1:19,000 in Pennsylvania, 1:7,200 in New York; and 1:25,000 in Ohio. A third of the 64 are concentrated in Des Moines and Iowa City; the eastern part of the state is better supplied than the west, but nowhere is the supply adequate.

In Iowa, 56.4 percent are 46 or older; the national average is 39 percent.

Board certification is an important index to the professional standing of a psychiatrist; in Iowa 22, or 34 percent of the total, are Board-certified, while for the United States as a whole 56 percent are certified.

PSYCHIATRISTS IN STATE SERVICE

Forty psychiatrists are listed as employed by the state hospitals. "Psychiatrist," as used in the state service, is a personnel designation. It does not imply that the individual has met stated educational or experience requirements. For the purposes of this section, the term "physician" will be

used to describe the doctors in the mental hospitals. It covers both trained psychiatrists and other physicians. Iowa is below standard both in the numbers of psychiatrists employed and in the amount of training which individual physicians possess.

For a number of years the state has made use of physicians trained in Europe and elsewhere who would work for the rather low salaries offered in the hope of making a place for themselves in this country. Some have been extremely well trained, others less so; most suffer from a language handicap. By the use of these doctors Iowa has been able to add appreciably to the medical staffs of the state hospitals. They are generally underpaid, however, and some are not even carried on the rolls as physicians. As they improve their language facility and gain licenses to practice, they will move out of the hospitals. Strong efforts will have to be made to fill vacancies, since no new supply of physicians similarly willing to work for low salaries appears likely to become available.

Only 6 of the 40 state hospital physicians are licensed to practice in Iowa, and only 3 are Board-certified psychiatrists. Twenty-two have had no residencey training in psychiatry; of these only 6 have had as much as 5 years of psychiatric hospital experience.

The average ratio of physicians to patients in the four Iowa state hospitals is 1:133. APA standards call for 1 to each 94 patients. (This does not count superintendents, nor assistant superintendents unless they also act as clinical directors.) It appears, then, that the hospitals need a total of 55 psychiatrists, in addition to superintendents and assistant superintendents, or 63 psychiatrists in all. The net addition needed is between 23 and 50, depending on whether physicians now in the hospitals are in fact psychiatrists.

The clinics also need additional psychiatrists. None of the 9 clinics now has a full-time psychiatrist, and each should have at least one. According to the calculation in Chapter VI, Treatment Services, Iowa should have between 26 and 36 clinic psychiatrists.

To recruit or train any such enormous addition to psychiatrists in the state service, or even to the total number of psychiatrists in the state, will take years of unremitting effort.

TRAINING OF PSYCHIATRISTS

Under the training plan of the University of Iowa's Department of Psychiatry, medical students will get their psychiatric training at the Psychopathic Hospital, the new children's center, the various out-patient clinics and the proposed psychiatric unit in the University Hospital. State institutions should also offer undergraduate medical training. The distances make it practical for students to work at the institutions during the regular school year, but summer

employment is useful to both the hospital and the student. Special appropriations for short-term jobs should be made available; each hospital should attempt to place at least five students the first summer and increase to 10-15 as soon as possible.

The Department of Psychiatry should organize and direct a training program for staff psychiatrists, with clinical instruction at Psychopathic and University Hospitals. Residents now in the state hospitals would rotate through the Department's residency program, and the university would assist in strengthening the institutions' residency programs. An ultimate goal should be a "package plan" residency program, rotating all state hospital and other residents through the university center and the state hospitals and clinics.

A program of regular weekly or bi-weekly in-service instruction should also be developed for physicians in the hospitals and clinics, along with workshops and demonstration clinics in the hospitals.

The Department of Psychiatry now turns out two psychiatrists a year. It could, by the means described here, turn out 6 a year. Such a figure would offer the possibility of meeting Iowa's needs in 17 years. This is not enough. Training facilities must be enlarged beyond this. As the program proceeds, it will be possible to step it up further, making adequate staffing possible within a shorter period.

Training in Child Psychiatry

The 1955 Legislature appropriated $130,000 (to which $30,000 has since been added) for a diagnostic, training, teaching and treatment out-patient center for emotionally disturbed and retarded children. It will eventually move into quarters in University Hospital. The staff will consist of a child psychiatrist as director, a pediatrician with special interest in mental retardation, psychologists and social workers, and will also have a representative of the College of Education who is competent in the field of special education.

The center will train physicians specializing in child psychiatry, pediatricians in the application of mental health principles to pediatric practice, and psychologists and social workers who wish to enter the fields of child guidance, family service, and mental retardation. Elementary and secondary school teachers will be trained in the recognition, understanding and classroom management of the emotionally disturbed child, and special teachers of mentally retarded children will have an opportunity to study their problems.

The center is being organized to meet national standards for accredited training. It will need additional staff to meet current service demands, nor can it adequately train all the professional personnel needed. Once it is in full operation, demands for service are expected to increase markedly. More

professional staff will be required; an additional child psychiatrist, a psychologist and two social workers will be necessary immediately.

The new center is for out-patients only. Some patients will need residential treatment; when this kind of service is added it would become an integral part of the clinic operation, in order to provide professional training and multi-disciplinary research.

CLINICAL PSYCHOLOGISTS

Clinical psychologists have three major functions in a mental health program. They do testing and diagnostic work; research; and, under the direction of a psychiatrist, assist in therapy. The directory of the American Psychological Association lists 145 members in Iowa. There are nine diplomates of the American Board of Examiners in Professional Psychology, 5 in clinical psychology and 4 in counseling.

The salary ranges for psychologists employed in the state hospitals and schools for the retarded are: clinical psychologist, $5,000-$6,000, plus full maintenance; psychologist IV, $4,140-$4,860 plus full maintenance; and psychologist III, $3,360-$4,080 plus full maintenance.

The number of qualified psychologists available is far below demand both in Iowa and the United States as a whole. Vacancies exist in Iowa for school psychologists, psychologists in the mental health institutes and centers, and in the prison system. Jobs are available, but candidates are not.

The 4 hospitals have a total of 18 psychologists; there are two vacancies. Of the 18, only 4 are qualified as clinical psychologists; 9 have their M. A. degrees; two have only a B. A.; and the other three are trainees or interns. Iowa Psychopathic Hospital has 2 psychologists with Ph. D's.

The ratios of psychologists to patients in the four state hospitals range from 1:170 at Independence to 1:700 at Mt. Pleasant; the average is 1:300. The ratio of clinical psychologists ranges from 1:600 at Independence to 1:1,400 at Mt. Pleasant. APA standards call for one clinical psychologist to each 430-500 patients.

There should be at least 9 clinical psychologists in the clinics. At present there are 11 psychologists, of whom 3 have their doctorates and two are completing work for this degree.

TRAINING OF PSYCHOLOGISTS

As soon as possible, the Ph. D. degree in clinical psychology should be required for all psychology positions in the hospitals and clinics. The Division of Psychology in the University should provide courses, lectures,

seminars and clinical training for psychologists now on the staff. In some cases it will be necessary to grant training leaves. Other state educational institutions should institute training programs. The immediate problem is to increase training facilities, either by enlarging facilities of approved schools or improving training at other universities so that they can be approved.

The Department graduates 6-8 clinical psychologists per year.

The Psychopathic Hospital now trains two clinical psychology interns per year. By adding 2 psychologists to the teaching staff, it could train 5 more, do the necessary in-service training and contribute to the training of the other professions. The two should be added immediately and provision made for more in the near future.

Internships are also available at the VA hospital in Knoxville, the state hospitals at Mt. Pleasant, Clarinda and Cherokee, and Iowa City Hospital.

PSYCHIATRIC SOCIAL WORKERS

Psychiatric social workers work in clinics and in the admissions and discharge units of hospitals, as well as in public and private service agencies. As experts in social relations, they relate medical treatment to home and work situations.

The number of social workers of all types in Iowa has increased substantially in the past 20 years. The state total is still low in relation to other states, however, and the number specializing in psychiatric social work is even lower. The four hospitals have 14 social workers and 5 vacancies. Of the 14, 3 have MA degrees, 4 have BA's, and 7 no formal training. Iowa Psychopathic Hospital has 5 social workers, of whom 2 have MA's and 3 have BA's. The ratio of social workers to patients ranges from 1:280 at Cherokee to 1:600 at Independence; at Iowa Psychopathic it is 1:12. APA standards call for 1 social worker to each 125 patients in state hospitals. According to this standard, the hospitals would need about 42 social workers, three times the present number.

The social work staffs of the clinics are comparatively strong. In the 9 state-supported clinics, there are 19 social workers, of whom 15 have MA degrees from graduate schools of social work and 2 have finished a year of graduate training.

TRAINING OF SOCIAL WORKERS

The University School of Social Work offers an MA degree in social work. Psychiatric placement is available at 4 hospitals and 4 clinics. The school turns out 10-12 social workers with psychiatric placement a year; a total of

15 a year are graduated. Each year 2 or 3 of the social workers with psychiatric training accept field work placements at Iowa Psychopathic. The present rate of training is too slow to make a substantial improvement in the near future.

The social workers on hospital staffs need to be trained to a higher level as rapidly as possible and the social work staff increased substantially. The present staff members should be brought to the University for additional course work leading to a degree in social work. Eventually the hospitals should qualify as approved placement centers for field work. The staff of the Division of Social Service in the Department of Psychiatry needs to be increased.

PSYCHIATRIC NURSES

Psychiatric nurses assist the doctor in treatment and ward activities, assume a major responsibility for the patients' environment through their supervision of other personnel. Nurses and attendants have the skill to establish helpful relationships with patients. Nurses are in short supply all over the country, so short that most hospitals list only registered nurses and do not count psychiatric nurses separately. The nation's mental hospitals have only 10-15 percent of the number of trained nurses they need.

There are 38 registered nurses in the 4 hospitals, as against the 346 called for by APA standards; there are 8 vacancies. Of the 38, none have advanced degrees, 4 have bachelor's degrees, and the rest are R.N.'s. Only Independence offers affiliate training for student nurses. It has space for 25 students from the three nursing schools participating.

The nurse-patient ratios in the hospitals range from 1:70 at Independence to 1:350 at Mt. Pleasant; the average is 1:140. APA standards call for one nurse to each 15 patients.

Iowa Psychopathic Hospital has 14 nurses, of whom 11 are RN's, 2 have BS's, and one an MS.

TRAINING OF PSYCHIATRIC NURSES

The State University now has a program leading to a BS degree in nursing and a graduate nurse program which provides for specialization (2 years) in psychiatric nursing. It turns out 85-95 nurses a year, and 9 psychiatric nurses. This is the only program in the state which prepares graduate nurses in psychiatric nursing. Four other institutions provide experience in psychiatric nursing for the basic nursing student. These are St. Bernard's Hospital, Council Bluffs; Mental Health Institute, Independence; Veterans Administration Hospital, Knoxville; and St. Joseph's Sanitarium, Dubuque.

All student nurses get a 3-month psychiatric affiliation as part of their training; 9 schools of nursing send their students out of Iowa for this affiliation. The total trained yearly in the state is 900-1,000. The nursing shortage can not be relieved by routine means. Methods will have to be devised to raise the level of training of the present staff, to provide a larger number of candidates for employment, and to provide temporary or part-time work for nurses who wish to come out of retirement. Present regulations permit registered nurses from the state hospitals to come to the State University for psychiatric nursing courses. Some receive scholarships (paid for by the Board of Control), and others may take leave. This program should be expanded by the provision of more scholarships, and other steps to extend and improve the program should be investigated.

The addition of one new faculty member also in the College of Nursing is recommended, specifically to collaborate with the hospitals in setting up nurse education programs and to organize courses in the instruction of aides and attendants. More should be added later.

ATTENDANTS AND PRACTICAL NURSES

Cherokee is the only state hospital which has set up special employee categories for practical nurses and trained attendants. It has 22 practical nurses and 91 attendants who have been through a special course of in-service training. There are 975 attendants in the 4 hospitals. Cherokee's 91 additional trained attendants brings the total to 1,066. APA quota for the hospitals is 1,040 attendants, an average of 260 per hospital.

The aides and attendants are the people whom the patients see most frequently, and whose influence for good or ill is most continuously in operation. At present their salaries are too low to permit satisfactory selection of employees, and the provisions for living on the grounds work in the direction of high labor turnover. Steps must be taken to improve the caliber of employees hired and to decrease turnover. It will then be possible to launch a successful in-service training program. Scholarships should also be made available at the State University, perhaps leading to a certificate as psychiatric aide, certainly qualifying the holder to increased compensation on his return.

OCCUPATIONAL AND RECREATIONAL THERAPISTS

The 4 hospitals have 18 occupational therapists on their staffs and 2 vacancies. None of these is formally trained or registered with the American Association of Occupational Therapists. Of 11 recreational therapists, 6 have a BA degree in some field. Five have had no formal training.

According to APA standards, there should be 22 or 23 registered occupational therapists in the four hospitals and between 40 and 50 trained therapists in recreation, music, etc.

TRAINING OF OCCUPATIONAL AND RECREATIONAL THERAPISTS

The School of Occupational Therapy at the State University now turns out 20 graduates a year. Only 5 can receive their clinical training in Iowa City; the others must go out of the state for such placement.

The Department of Psychiatry should provide the institutions with a consultant in occupational therapy to give lectures and workshops and provide consultation. Extension courses should be arranged which would count toward a degree from the University. Scholarships and other inducements should be offered attendants and others now working as therapists, to encourage them to take formal training at the University. At least one additional therapist on the Department of Psychiatry staff would be needed for this purpose immediately.

The addition of a recreational and special therapist to the Psychopathic Hospital staff would make consultation available to the hospitals to help them set up adequate programs. Hospital personnel could also be sent to the University for special work.

OTHER CATEGORIES OF PERSONNEL

ELECTROENCEPHALOGRAPHERS

No state hospital or school now has an electroencephalographer. In order to get EEG readings, patients must be sent to Iowa City; this is time-consuming and may result in damage to the patient. A qualified electroencephalographer at the University would permit bringing medical personnel in for 6 to 12 months of training. They could then take courses required by the Board of Electroencephalography. Trainees can not now be accepted because of the load of service work to meet Medical School needs.

EEG technicians could be trained in a one-year period; a half-time technician would have to be hired for the purpose. A consultant could be sent from Iowa City to EEG laboratories in the state, advising on the taking and interpretation of records, and lecturing to the staffs.

VOLUNTEERS

This group can be extremely useful as a supplement to professional staff workers in the hospitals. Their function is to increase the contact between the patient and the normal world. They must be carefully selected, work under a supervisor or coordinator, and must be given adequate orientation courses.

OTHER PERSONNEL

Hospitals also require a number of other people, ranging from dentists to laundry workers and the people who keep the machinery of the hospital running. While their work is not primarily psychotherapy, they can, if skillfully directed and not overworked, contribute to the recovery process and to the atmosphere of confidence and hope which pervades a good hospital.

RECRUITMENT

A state which wants even the nucleus of a trained staff must recruit it in the open market. To get staff, the state must offer enough money and other inducements to top other offers. In the long run, the only answer is training. But there can be no training effective unless there is a nucleus of well-trained personnel in the central office and in each institution.

Iowa's salaries for hospital superintendents are competitive with those in other states. The top level of $15,000 plus maintenance provides an income reasonably competitive with private practice. Salaries in lower levels drop more sharply than is true in other states, and the resulting tendency is to push younger men into private practice or outside the state. Assistant superintendents get a top of $7,800 plus maintenance, which is not enough to attract and keep good psychiatrists. Salaries for psychologists and psychiatric social workers are somewhat below competitive levels. Those for nurses are close to the level in general hospitals but not high enough to attract the needed number. Salaries for attendants are below those for semi-skilled workers in industry and on farms.

Maintenance is included in the compensation of workers in institutions. If the staff members prefer to live off the grounds, however, the payment in lieu of maintenance is calculated at $100 a month or less, which provides only a fraction of the living available at the hospital. This is not a realistic figure. More and more states are changing their practices on maintenance, and there is an increasing tendency to encourage the staff to live off the grounds. A necessary part of this encouragement is to remove the differential which now favors on-the-grounds living.

Another factor in recruitment is job satisfaction, which is used here to mean the satisfaction inherent in the work itself. In well-run services, the standards of professional accomplishment are high, and each individual feels a real pride in his share in the common task. Such services provide real attractions to competent personnel. An outgrowth of job satisfaction is professional advancement. State employment, if it is to compete successfully for competent personnel, must offer the employee a job that will fulfill his personal, financial, and professional requirements.

The day-to-day administration of a department, service or institution can affect recruitment. Specifically: Annual and sick leave policies should apply equally to all staff members; they should permit accrual of leave for those employees deferring vacations at the request of the hospital. Overtime should be compensated either in cash or compensatory time off. Pay increases should be based on merit. Determined efforts should be made to provide an adequate staff at all times, especially in the late afternoon or early evenings in the admissions units of the hospitals, as this is when many admissions occur. The present restrictions on hiring and on transfer from one personnel category to another of funds to fill vacancies have hampered operations. It is more satisfactory to get greater competence in the administrative staff and leave them free to exercise their proper responsibility.

RESEARCH

Advance in the treatment of mental illness depends upon advance in knowledge. Such knowledge must include new facts about the causes of mental illness, the environment in which it develops and flourishes, facts about normal and abnormal behavior, and means of assessing therapeutic procedures. Unfortunately, research in this field has been neglected. Expenditures have been rising in recent years, but the total is still pitifully small in relation to the size of the problem. In 1955, just under $11 million was spent in the United States. In contrast to this, the cost of caring for the mentally ill in 1953 (the latest year for which data are available) was a billion dollars. A continuing research program on a broad front would help to attract competent psychiatrists and other behavioral science specialists to Iowa institutions. It can best be centered in the University, where the tradition of research is strong, facilities are available, and communication is easiest. It must also extend to the state institutions and clinics to engage the efforts of personnel and to take advantage of research material and data available.

In the University, an expanded research program will require added staff members trained in scientific investigation, including psychiatrists and other professionally qualified personnel interested in mental illness, biochemistry, electronics, sociology and anthropology, biometrics, experimental psychology, social work and psychiatric nursing.

If the plans to add 30 psychiatric beds to the University Hospital are carried out, some present ward space in the Psychopathic Hospital can be converted to research areas. Some beds now devoted to urgent short-term service needs can be shifted to research needs. Further revisions of space can also be made in the Psychopathic Hospital.

These changes are estimated to cost about $400,000. Matching Federal funds can now be obtained for medical research construction; the cost to the State of Iowa would thus be only $200,000.

Needs outside the University are equally important. The director of education and research recommended for each institution should have assistance in the fields of psychiatric nursing, clinical psychology, statistics, and other aspects of the state program. In the beginning institutional research programs can be set up which do not require new special facilities. Funds should be made available later for laboratories and other research tools.

A continuing research budget must be provided; the program cannot be stopped and started. A reasonable program at Iowa City would cost $100,000 a year to start. Programs in state institutions will have to be built gradually but eventually should exceed this figure. Support for these programs can be provided in various ways. The "Minnesota Plan" has a revolving fund of appropriated money. The "Illinois Plan" uses income from patient fees, one quarter of which goes to support research personnel and equipment. Iowa will have to work out its own plan, but support should be made available promptly.

TEACHING OF PHYSICIANS

The emotional and social aspects of illness are becoming more prominent in medical training. The general practitioner needs to be able to diagnose and treat minor emotional illnesses, or refer patients to a psychiatrist if they require more care than he is able to give. The Department of Psychiatry at Iowa has been slow to move into this kind of teaching. Many members of the College Medicine faculty want the Psychiatry Department to participate in a program of comprehensive medical teaching, primarily with patients now hospitalized on other services in University Hospital. Many departments would also like to collaborate with psychiatrists in joint research projects involving psychosomatic illnesses. Limited staff has kept the Department of Psychiatry from beginning this type of teaching and research. To establish such a program, 3 additional psychiatrists, 2 psychologists and a social worker will be necessary.

Facilities are needed in University Hospital for this purpose. Office space is needed as a base of operations. Ultimately there should be a unit of 30 to 40 beds for teaching comprehensive medicine and developing collaborate research with other clinical departments. Patients from other services whose illness is classified as psychosomatic would be admitted to this unit for more extensive study.

RECOMMENDATIONS

RECRUITMENT

1. Recruitment is vital to staff the key positions in the state's training and treatment institutions. A policy is needed which declares the state's

intention to remove present barriers to adequate staffing, recognizing that Iowa must compete in a very tight labor market for the skills needed.

2. Restrictions on out-of-state travel should be limited to general budgetary restrictions, and decisions should be made within the institutions.

3. Salaries in brackets below the superintendent level must be raised to compete with private employment in Iowa, and with public salaries in other states.

4. Maintenance provisions should be revised to permit employees to live outside the hospital without financial penalty.

5. Attention must be paid, in the central office and in the state's services, to the problem of job satisfaction. A major aspect of this problem is to improve the therapeutic quality of the institutions so that each employee will feel that his personal contribution is worthwhile.

6. Professional advancement must be provided for thorough in-service training, opportunities for research, facilitation of communication with others in the same field through attendance at meetings, access to publications, etc.

7. Annual and sick-leave policies, policies governing provisions of relief during emergencies, compensation offered for over-time work, the basis for pay increases and promotions, etc. need to be studied to determine their effect on recruitment, and where necessary revised.

8. The controls exercised from the Comptroller's Office should be relaxed to permit administrative officers to make adjustments in their staffing as vacancies occur, to keep staff levels at the highest level possible under existing appropriations.

9. A policy of liberality in meeting the desires of personnel should be adopted and publicized. This will quickly become known, and will aid recruiting.

10. A carefully planned recruitment program, with both immediate and long-range goals, should be organized in the central office and within each institution, school and clinic.

TRAINING AND EDUCATION

11. Training must be a major responsibility of the state mental health services. It must utilize the combined resources of the state university and the treatment services, as well as of other educational institutions in the State.

12. The state should declare a policy of financial assistance to training institutions to insure the availability of personnel for treatment and training purposes. This is where money will pay the biggest dividends. This amount should be appropriated first, and what is left used for operation in the central office and the state institutions.

13. A director (chief) of training and research should be appointed in the central office, to coordinate and expand the mental health resources of the state. A director of education and research should also be appointed in each institution with assistants in the major professional fields.

14. Provision should also be made in the State University to implement the plan of expansion outlined in this chapter. This will include the addition of a number of members to the training staff, provision of adequate office and laboratory space, and the establishment of psychiatric services in the University Hospitals.

15. Special assistance will be needed to increase staff in the Department of Psychiatry, and in the departments handling clinical psychology, social work and nursing so that they can increase the numbers of students trained, and send staff to each institution.

16. Responsibility for training and research in each unit should be placed in the hands of University departments.

17. Provision should be made at the various state institutions to bring their staff up to the level which will give them training status.

18. Special appropriations are needed to provide short-term jobs for training purposes.

19. The University must expand its output of various types of children's specialists, especially child psychiatrists. Substantial expansion will be needed in the plans for the research center for emotionally disturbed and retarded children. One additional child psychiatrist, a psychologist, and two social workers will be needed immediately for a teaching and treatment staff.

20. Expansion of the children's center should include provision for in-patient services.

21. Psychologists now on the state staff should be aided in getting their doctorates. The Ph.D. should be considered a prerequisite for employment as a psychologist.

22. Every state institution should establish training programs in clinical psychology.

23. Provision should be made to send nurses from all hospitals to Iowa City for graduate training in psychiatric nursing. Stipends should be provided, as well as raises in salary upon completion of the course. Graduate courses at the state hospitals should be tried.

24. Affiliate training in psychiatry should be provided in all state institutions.

25. The hospitals should be staffed with graduate social workers, to permit use of these institutions for training.

26. Social workers in the hospitals should be brought to Iowa City for further training leading to degrees in social work.

27. The Department of Psychiatry should supply a consultant in occupational therapy to the institutions, to give lectures, workshops, and consultations to the staff.

28. Scholarships and other inducements should be offered to persons with educational qualifications to persuade them to take formal training in occupational therapy field. At least one occupational therapist will be needed at the Psychopathic Hospital for this purpose immediately, and another in the near future.

29. Addition of a recreational and special therapist to the University staff would permit offering consultation to the hospitals in establishing programs of recreation and special therapy.

30. Workers in recreation and special therapies should be sent from the hospitals to the University for special work.

31. Addition of a trained electroencephalographer to the University Department of Psychiatry would permit the Department to offer training to institution personnel.

32. In-service training should be given attendants and aides in each state institution. This should be done by means of intra-mural training programs, and by sending selected individuals to the University for more intensive work. Scholarships should be made available, perhaps leading to a certificate as psychiatric aide, and qualifying the recipient to increased compensation upon completion.

RESEARCH

33. Support for research needs to be greatly increased, both financially and as a matter of institution policy.

34. Research support is necessary at the University of Iowa. The proposed program will cost about $400,000, of which $200,000 can be had from

Federal government if it is sought promptly.

35. Research support at the institutions and in the central office is equally imperative. For this purpose, the most important step is to recruit research personnel trained in scientific investigation. Enough projects are readily at hand which do not require special equipment so that expenditures for this purpose can be somewhat delayed.

X. LEGAL PROBLEMS

Law and mental health are related in a number of ways. Among the most important are the provisions for commitment and discharge of mentally ill persons and the retention of civil rights, the legislative authority for the mental health functions of the state and its legal structure, the provisions governing treatment of mentally ill criminals, delinquent defectives, sexual psychopaths, etc., and provisions governing financial responsibility and payment for hospitalization.

A subcommittee of the Governor's Mental Health Committee has been working on a detailed legislative proposal on mental health laws. The detailed recommendations of this Committee will be presented to the Legislature by the subcommittee. The purpose of this chapter is to point out the areas in which revision is needed, and to suggest the nature of the changes.

COMMITMENT, TRANSFER, AND DISCHARGE

Most admissions to Iowa hospitals are through commitment, which is a function of the County Commissions on Insanity. Those commissions are composed of the clerk of the court, a physician, and an attorney. They act on information supplied by the family, welfare agencies, or other groups. A prior psychiatric diagnosis is not required for commitment.

The Commissions on Insanity are not a proper mechanism for admission to the hospitals. Most admissions should be voluntary. The testimony of physicians, particularly psychiatrists should ordinarily be sufficient. The present procedure probably acts to delay admissions, rather than to admit persons who are not mentally ill. In the absence of a psychiatric diagnosis, the Commissions probably lean in the direction of not committing rather than committing doubtful cases. Where commitment is necessary, as it often is, it should be a matter for court action, not delegated to any other body.

The Commissions on Insanity may commit patients directly to county homes. In the first case, the hospital is completely bypassed. In the second, patients are removed from psychiatric supervision, even though they are still mentally ill.

Hospitalization should be separated from incompetency proceedings. Being mentally ill does not necessarily imply incompetence. Where determination of incompetency is necessary and a guardian must be appointed, these proceedings should be separate.

The superintendent's right to admit and release patients should be clearly set forth in the law. The present law requires that the permission of the Board of Control and the Commission on Insanity be obtained before a patient can be discharged. This is an unnecessary administrative hurdle, and should be abolished.

The National Institute of Mental Health has prepared a Draft Act, or Model Commitment Law, which incorporates more satisfactory language on these points.

ORGANIZATIONAL STRUCTURE

Chapter V discusses a number of structural changes in the state's mental health functions. They are briefly listed here for the sake of completeness.

A department of mental health should be established, to administer the state hospitals, the psychiatric clinics, the schools for mental defectives and epileptics, special institutions for psychotic offenders, mentally ill children, tubercular mental patients, delinquent defectives, and other facilities and functions now in operation or later to be established. The independent department is recommended, assisted by an Advisory Council which could be the Board of Control expanded.

The department should be headed by a commissioner who is a psychiatrist with at least 5 years' experience in a mental hospital. Additional experience in a state mental health department or a psychiatric clinic would be desirable. Preference should be given diplomates of the American Board of Psychiatry and Neurology, and those certified by the committee on the certification of hospital administrators.

The commissioner should have power to appoint all central office employees and the superintendents of the institutions and heads of state-operated clinics. He himself should be appointed for a period of not less than 5 years, should be removable only for cause, and should have the right to appeal to the courts.

Superintendents should be qualified psychiatrists with at least 5 years' experience in large mental hospitals, two of which should have been in an administrative position. Preference should be given diplomates of the Board of Psychiatry and Neurology, and those certified by the committee on certification of mental hospital administrators.

The superintendent should have full authority to appoint and discharge all employees of the hospital, subject to the provision of laws pertaining to personnel.

The business manager should be trained and experienced in the business management of a large mental hospital. Preference should be given those with formal training in hospital management. The business manager should be appointed by and responsible to the superintendent.

All employees of the department should be discharged for cause only. They should have the right of appeal to the courts.

The laws pertaining to the admission and release of patients should be completely rewritten. The revised law should then be made available to the public. Obsolete and inappropriate words such as "insane," "parole," "warrant," etc., should be replaced by more applicable words.

MENTALLY ILL OFFENDERS

Necessary changes in the law on sexual psychopaths have been discussed in Chapter VIII. Essentially, the changes are needed to make the definition less specific, to make the laws apply to convicted individuals and not to a class of persons, and to provide treatment and rehabilitation.

A change is needed in the handling of psychotic criminals, which depends on the establishment of a maximum security unit for their confinement and treatment. Psychotic criminals should be given psychiatric treatment. Under present procedure they are confined at Anamosa on the basis of a court finding. They are not diagnosed at Anamosa, nor is treatment available. Those who are transferred to Anamosa because they become psychotic while in prison are neither diagnosed nor treated.

At one time the superintendents came in every six months for examination and recommendations as to disposition. This did not provide adequate diagnosis, nor of course did it provide any treatment; it appears to have been discontinued. Some of the superintendents stated that they had not been at Anamosa for this purpose in over 5 years.

The handling of delinquent defectives is unsatisfactory, as explained in Chapter VII. The law should be changed to permit their care and treatment in an institution separate from the state schools, and from the correctional institutions.

FINANCIAL RESPONSIBILITY

Under existing law, individuals pay for the care and treatment they receive, at a figure which does not exceed the actual cost to the state. Frequently it is far below, and often no payment is made. Collections average around 10 percent of the amounts expended. The counties are the collecting agencies. The state hospitals furnish an accounting, the county officials try to collect from families and relatives. Nearly all states have abandoned this practice,

because they find that there are sharp differences between counties in the proportion collected. Those who have changed have found that their collections went up after the change, without working a hardship on the family.

State vs. county responsibility for care and treatment of patients is another area where revision would be useful. Under present circumstances the state hospitals bill the counties for the patients in the hospital. Patients who are transferred to county care, however, are in a different category. For these the state pays the counties $3 a week apiece. The result is an incentive to transfer patients to county care, which is medically unsound. The law should be changed so as not to differentiate between mental patients, either as to the amount which is expected to cover their expenses or as to the source of funds to treat them.

RECOMMENDATIONS

Specific recommendations are not presented here. The statements above indicate the direction and type of changes to be made. Phrasing them in legal language is a task for specialists in medico-legal problems, and will be incorporated in the report of the subcommittee.

SUMMARIES OF INSPECTION REPORTS

The following pages are very brief summaries of the reports on the four state hospitals, made by the Central Inspection Board of the American Psychiatric Association. The detailed reports will be presented in a separate document.

MT. PLEASANT MENTAL HEALTH INSTITUTE

This hospital has 1,625 beds, and a rated capacity of 1,208, or overcrowding of 34.5 percent. In fiscal year 1956 there were 496 first and re-admissions and 367 discharges. There were 146 deaths. At the time of the survey, there were 1,311 patients in the hospital, and 232 on convalescent leave. There were 507 patients, 39 percent of the total, over age 60.

The hospital's physical needs include a modern reception and treatment center, a new building for disturbed and untidy patients and one for bedridden and semi-ambulatory geriatric patients. The medical and surgical building needs space for physical therapy, laboratories and offices. The present tuberculosis building is old and unsuitable; active cases should be transferred to a state center and space provided in this hospital for a small number of suspected and arrested cases. A recreation center is needed for a patients' library, gymnasium, game rooms, canteen and music center. Quarters should be provided for the superintendent and married physicians; employees now living in industrial buildings and Cottage #1 should be transferred to vacant space in the employee quarters. Industrial activities should be located in a fireproof building, and other fire protection measures should be taken throughout the hospital. The piggery needs enlargement and modernization.

Physicians number 9, half the APA quota. The superintendent is qualified, but there is no assistant superintendent, clinical director, pathologist or director of extramural psychiatry. All physicians except the superintendent are graduates of foreign medical schools, with no psychiatric training and a minimum of experience. There is 1 psychologist; the APA quota calls for 6. His function is limited principally to testing; he also conducts one group meeting a week and individual psychotherapy with a few patients. This is all the psychotherapy that is offered at the hospital.

There are 4 R.N.'s, 4.4 percent of the APA quota. Attendants number 273, which is 98.6 percent of the APA quota. There is little nursing service, but some supervision of attendants. An affiliate nurse training program is needed, together with an expansion of the present training program for attendants. The social service department has a qualified director and two untrained workers. There is no supervision of patients on convalescent leave and no teaching or

research. There is no out-patient or family care department.

The only educational activity is a 26-hour course for attendants; training for physicians, nurses, social workers and psychologists must be organized with university help, or recruitment efforts cannot succeed. A research program must also be undertaken: with a wealth of clinical material the present staff could be stimulated to make at least some minor studies if it is given outside help such as professional leadership from the central office or from the University.

The medical and surgical department has no director. Since there are no surgeons, a well-equipped modern surgical unit is unused except for minor surgery. No pathologist is employed and only one qualified laboratory technician. The X-ray department has no radiologist; the technician has had only a three-month training course. The medical library does not have a qualified librarian; less than $50.00 was spent for books last year. The library now contains 400 books and 5 periodicals. Physical therapy is carried on by one technician; there is no organized department. A director who is a specialist in physical medicine, equipment and staff are required.

The occupational therapy department has been operating without a director and in a poor location; only 62 patients participated in the program last year. Industrial therapy is under the direction of the manager and housekeeper and operates without medical supervision. It needs a trained industrial technician, a program of vocational training, and close association with an improved occupational therapy department.

The patients' library contains 1,200 books, none purchased last year. Visiting Protestant and Catholic clergy hold religious services; there are no services for shut-ins.

Fifteen men and 50 women were observed in restraint and 1 man and 9 women in seclusion. There were 33 tuberculous patients, with no isolation of active cases and no proper handling of contaminated waste or soiled linens. Bathtubs average 1 for every 50 patients, and toilets 3 for 50 patients. There is no podiatrist or routine care of teeth for the disabled.

The business department is under a competent trained steward. More space, store rooms and refrigeration are needed. Food is served cold on unattractive trays and without napkins. Many patients have only a spoon. Housekeeping is supervised by an ex-attendant with 15 employees and 50 or 60 patients. Mending rooms are in undesirable quarters and linen rooms are in the basement. There is a farm of 1,410 acres (800 of them tillable), with 20 employees and 40 patients. These are under the farm and business manager and have no connection with medical needs.

INDEPENDENCE MENTAL HEALTH INSTITUTE

With 1,321 beds and an APA rated capacity of 1,080 beds, the hospital is 22.3 percent overcrowded. A new 500-bed unit for geriatric patients and remodeling of an admissions and treatment building have improved the hospital. In fiscal 1956 there were 839 first and readmissions, 555 discharges, and 101 deaths. Resident population in a recent month was 1,089; 42 were on convalescent leave (trial visit). The number over 60 was 371.

Physicians on the hospital staff include a highly qualified superintendent and assistant superintendent, a qualified clinical director, 2 physicians with long experience in the hospital, and 5 junior physicians without psychiatric experience. The latter 7 are graduates of foreign medical schools. The consulting and visiting staff includes 24 physicians in 11 specialties, 10 of whom make regular visits. The rest are on call. There is no gynecologist or neurologist, and no routine examination of patients on admission or at regular clinics by the visiting staff.

There are three psychologists: The acting director has a Ph. D. and the other two have Master's degrees; there are also two interns. Their time is largely devoted to testing, with some psychotherapy. The only connection with the university is in the training of interns. The psychologists are interested in research.

The nursing service has a superintendent of nursing, a director of education and 12 R.N.'s in supervisory positions. There are also 19 affiliate students in training. The 227 attendants employed are 103 percent of the APA minimum quota.

Social service has no qualified director. The 4 workers include one with a BA degree and 2 with a year's graduate work in social work. Histories are taken on 80 percent of new admissions and there is supervision of 60 percent of convalescent care patients. With expansion of social service so urgently needed, arrangements must be made for field work placements and university connections. There is no organized out-patient department, but 200 adults and 50 children were seen last year in the office of the assistant superintendent, psychologist, or social worker.

Approval of a one-year psychiatric residency training was canceled recently but may be reinstated; the new clinical director is board-certified and a competent teacher. The nursing department has an approved affiliate training program which includes students from three hospitals, and two psychology interns are receiving a one-year course. There is no organized program of research, but two projects are under way in the psychology department.

Routine clinical laboratory tests are carried out by assistants trained on the job. No position of pathologist exists, but some visiting work is done. X-ray

equipment needs replacement and a registered technician is required. The pharmacy is in a poor location in the basement; it is staffed part-time by a registered pharmacist. Medical records contain essential data but they are improperly bound and without fire protection. There is no medical records librarian. A total of $577 was spent on books and journals last year. They are scattered over the hospital; there is no adequate reading room or stacks, and the material is not properly indexed.

There is one dentist and one dental assistant; not all needed work is done.

Shock therapy is used at the hospital; in fiscal 1956, 328 patients received 4,804 electroconvulsive treatments and 170 patients received 3,682 sub-coma and 557 deep-coma insulin treatments. A total of 1,300 hydrotherapy treatments were given under the direction of an attendant supervised by an R. N. There is no organized physical therapy department, but 800 ultra-violet and infra-red lamp treatments were given. Occupational therapy is directed by a high school graduate who worked under a qualified occupational therapist for one year. An average of 30 patients (7,000 in a year) attend half-day sessions in occupational therapy. The director of activity therapy has an M. S. in hospital recreation and rehabilitation. The music department has a recently appointed director with a doctor's degree in music. Industrial therapy is under the direction of the business manager and consists of work in a furniture and shoe repair and an upholstery shop, the latter in an unsatisfactory location in the basement, and the sewing shop does not have enough room. Twenty-five patients work 40 hours a week; some are paid a nominal wage ($3 a month). Industrial work is not related to therapy.

There were 25 women and 5 men in restraint when the hospital was visited and 6 men and 2 women in seclusion. Blanket restraint orders, in effect as long as 30 days, were found; patients were not continuously supervised.

Eight women and 10 men were on the tuberculosis service when it was visited. There is a doctor in charge but no registered nurse. Arrested and active cases occupy the same area.

In the older buildings there is one tub and one shower for 50 patients; toilet facilities are also inadequate.

Quarters for 100 employees are vacant; most of these are unsatisfactory and should be put to other use. A total of 190 employees live in.

The head of the dietetics department has a B. A. in home economics. The cost for food was 54¢ a day during July 1956, including value of farm produce but not including surplus produce used (10¢ should be added for this). The farm could use a poultry unit and reactivation of the cannery and freezers.

CLARINDA MENTAL HEALTH INSTITUTE

With 1,482 beds and a rated capacity of 1,043 according to APA standards, this hospital is 42.1 percent overcrowded. In fiscal 1956 there were 687 first and readmissions, and 508 patients were discharged. There were 208 deaths. At the time of the survey there were 1,274 patients in residence and 440 on convalescent leave (trial visit). Patients over 60 numbered 526, or 41 percent.

A reception and treatment center is needed, as well as a geriatric center, since geriatric patients are now scattered. There is no medical and surgical center.

Tuberculous patients are now housed in overcrowded, poorly equipped space; active cases should be sent to a state center and a small unit established for isolation of suspected and arrested cases. Employees' quarters in Hope Hall should be converted to patient and administrative space. Personnel regulations should be changed to permit and encourage employees to live off the hospital grounds. This would help to avoid further construction. Quarters should be provided for the superintendent and married physicians outside the administrative building.

A recreation center should also be built, to include an auditorium (the present one is a firetrap), a canteen (now housed in a basement) and a gymnasium and music and game room. The athletic field also needs improvement. The occupational therapy shop, now housed in a basement, should be located in an enlarged center with other rehabilitation services. The sewing room, now over the generators, should be located in a cooler place.

The superintendent is a qualified psychiatrist. He has no assistant superintendent or clinical director. One physician has had previous psychiatric experience; the 6 others are foreign doctors with no experience. The hospital is 9 physicians short of the APA quota. There is no journal club, procedure book, refresher courses, or contact with local hospitals. The consulting and visiting staff does not have an orthopedist, ophthalmologist, otolaryngologist, neurosurgeon, obstetrician or gynecologist. There are no regular specialty clinics, formal organization of consultants, or regular meetings.

The nursing service consists of 7 R.N.'s, including the director. This is 8.3 percent of the APA quota. Equipment is inadequate; there is no affiliated nurse training program.

The psychology department, which has a qualified director and three other staff members, is interested in research and is a valuable addition to the staff. However, there is no training program or university connection.

The social service department has a qualified director and three untrained junior workers. No research or training is carried on.

Occupational therapy does not have an organized department; it is carried on by four staff members qualified only for the lowest untrained positions. It needs a qualified director, more space and personnel, and a program for new patients.

A qualified director of physical therapy is also needed. A program should be organized to take advantage of modern advances in this important activity. Also needed are equipment, space, and a survey of all patients to determine their needs for physical therapy.

The out-patient department needs a director of extramural psychiatry, who can direct foster-home care and also be in charge of a family care program serving patients on convalescent leave, for whom no family care program is now provided. Only a few such patients are seen in the out-patient department.

Education and research programs need strengthening; at present there is no training and little research except in the psychology department. A tie-in with the University is necessary to establish a training program.

Psychotherapy is done only by psychologists and the chaplain. Nineteen patients and 6 groups are served. There are no conferences, training, or auxiliary personnel.

The surgical department is short on certain specialists. The operating room needs emergency lighting, humidity control, and safer electric equipment. The medical service needs a director and a qualified diagnostician. There is no pathologist or registered laboratory technician; laboratory work is done by untrained personnel.

The dental office needs relocation; there is no proper check on old or new patients. The pharmacy department has no registered pharmacists, hospital formulary, or library; narcotics and alcohol are kept insecurely. A cost accounting system and inventory should be introduced.

There is no registered medical librarian and no standard practice or instruction for preparing histories, results of examinations, etc. Microfilming of old records is recommended. The medical library has 850 books and 30 periodicals. It needs supervision and a better location.

CHEROKEE MENTAL HEALTH INSTITUTE

This hospital has 1,492 beds, compared with an APA rated capacity of 1,000 beds. There is 49.2 percent overcrowding. In fiscal year 1956 there was a total of 606 admissions and 507 discharges. During the same period 138 patients died. At the time of the survey there were 1,254 patients in the hospital and 247 patients on convalescent leave (trial visit).

Among the hospital's needs in physical plant are: Enlargement of the medical and surgical service; a modern reception and treatment center; suitable quarters for ambulatory geriatric patients; and remodeling of the main building with improved employees' quarters should be converted to patient care space. The admission building needs remodeling to house offices and a teaching center. Many of the employee quarters in this building are undesirable; new personnel regulations permitting some employees to live off the grounds may eliminate the need for constructing new quarters. There is no suitable recreation building. The chapel is too small, and emergency egress is blocked.

The superintendent is a Fellow of the American Psychiatric Association. He is certified by the American Board of Psychiatry and Neurology, and as a mental hospital administrator. The assistant superintendent has 6 years' psychiatric experience and the clinical director 5; both are APA members. The pathologist has 7 years' experience, including a year's training in psychiatry. Five staff physicians include 4 recent arrivals from abroad, each with a year's training in psychiatry. The fifth has a state license and 12 years in student health work. There are 5 first-year residents from foreign countries, 3 of whom have had some experience in psychiatry. The quota (there is one vacancy now) should meet APA standards.

Consulting and visiting staffs include 8 specialists; an orthopedist, ophthalmologist and others should be added. There is no formal organization of the consulting or visiting staffs. The use of general practitioners for certain duties is needed to help the resident staff. Use of part-time psychiatrists from the nearby community to check continued treatment patients would help relations with neighborhood physicians.

Two clinical conferences are held each week and two clinical pathological conferences each month. There are good relations with the local hospital. The hospital is now approved for one year's psychiatric residence, but this will not continue unless arrangements with a medical school are completed.

The superintendent and assistant superintendent of the nursing service are experienced R.N.'s and 10 other R.N.'s are in supervisory positions. No ward head nurses are professional nurses. The number of R.N.'s is far below standard and the number of employees in this service is reported insufficient for good patient care. A total of 232 attendants, of whom 91 have had 6 months' training in psychiatric nursing and 22 are trained practical nurses, are employed; this is considered good.

The director of the social work department had journalism experience and one year of social work before becoming director. None of the other 5 workers has had formal social work training. Workers take histories of 75 percent of new patients, orient relatives, and prepare patients for discharge; two of them assist in psychotherapy and public relations. There is no standard routine to handle convalescent leave patients; special cases get attention. This department

also does administrative work and case histories for the out-patient department. Reasons for the absence of qualified social workers should be studied and the total number brought up to standard.

The director of the psychology department has almost completed work for his Ph. D.; two assistants have their MA's, and two have almost completed requirements for it. They test all new patients and report on therapeutic possibilities.

Offices are adequate and there is a group therapy room. Weekly conferences on psychotherapy and weekly seminars are held. There is a course in psychology for psychiatric residents and for attendants active in research. A new test is being standardized. There is no training of psychology interns and no connection with a university or college.

The out-patient department holds 8 hours of clinic a week for adults and children, with 5 psychiatrists, a psychologist and a social worker on part-time. A total of 192 adults and 20 children were referred last year from the courts, schools, clergymen, social agencies and at their own request, a few for diagnosis but most for treatment. New quarters and more personnel would make this clinic even more useful to the community. There is no family care program. The after-care program includes 247 patients on trial visit, where they remain for 1 year before discharge. Little help is given to these patients because of staff shortages; about 10 percent report to the out-patient department or to social agencies.

There is no organized research department, although both medical and psychology staffs are interested in research and several programs are under way. Research should be linked to training and both related to other departments of the university. A research committee should be organized without waiting for a formal department, and funds and laboratories should be made available through a separate item in the budget.

Public relations are good, although more radio and TV time could be used. About 50 high school and college groups visit the hospital annually. A good program for volunteers is carried out, with 87 workers now on duty after having been screened and given orientation lectures.

The surgical department includes 4 general surgeons, 1 neuro-surgeon and 1 anesthesiologist, none Board-certified. Several specialties are missing. The surgical suite was recently improved and is fairly modern. There were 23 operations involving 14 surgical conditions last year and 32 lobotomies in 1955. There is no director of the medical and surgical service. The clinical and pathology laboratories are in a small one-story building. The pathology laboratory is under a Board-eligible pathologist but the clinical laboratory is under only a "practical" technician. Electroencephalograms and metabolism

rates are done at the hospitals, as are 30 different routine tests. The clinical and pathological laboratories should be united and space allocated in the proposed remodeled Neuropsychiatric Institute.

An x-ray specialist visits the hospital once a week; space and equipment are satisfactory but a fully trained technician is needed. Two part-time dentists and an untrained assistant are employed. Space and equipment and screening of new patients are satisfactory, but old patients are not seen often enough. The pharmacy is under an experienced pharmacist. Reference books are not up to date; work on a formulary is going on but not complete. Space in the medical and surgical building is recommended; a pharmacy committee is needed. The work is being done well at present with an inadequate staff. The staff in the medical records department is reported to be adequate, but no medical records committee has been appointed. Some improvements in procedures are recommended. The location and space of the medical library are adequate, but no reading space is provided. One thousand books and 31 medical journals are in the library; about $550 a year is spent.

Almost 100 patients received individual psychotherapy from psychiatrists and psychologists last year. The latter, and the social workers, also have a total of 7 therapy groups with 320 patients enrolled from the in-patient and out-patient services. This therapy should be available to all new patients. Sub-coma and electroconvulsive therapy are used; 302 patients received 3,042 electroconvulsive treatments and 14 patients insulin treatments in the past year. Diathermy, ultra-violet, and infra-red machines are available for physical therapy but are not used because no technician is employed.

Occupational therapy is under a trained worker; there are 6 well-equipped shops but only 3 (for women) are used. A news sheet is printed and parties are sponsored. Craft work is sold; there should be less emphasis on sales. It is difficult to make a process both commerical and therapeutic. The department needs a qualified director, a medical advisor from the staff, increased personnel, and a new and better located O. T. center. Physicians should also be instructed in occupational therapy.

There is no organized department of recreational therapy, although there are many recreation activities. The industry department is under the business manager, with work done in shoe, upholstering and print shop, in the sewing, mending and linen rooms, and on the farm, in the dietitian's office, in the laundry and power plant. A head industrial therapist should be employed to work closely with medical staff workers.

The patients' library is under a librarian. It contains 3,400 books and 88 magazines and newspapers. Book carts and newspapers are distributed to the bedridden. $800 is spent each year. New quarters in the recreation center are needed.

Religious services for the three major faiths are provided by visiting clergy and there is a monthly program of activities. New patients and the critically ill get special attention; shut-ins now have nothing.

Restraint is freely used, especially for geriatric patients to prevent falling, self-mutilation and violence. Seclusion is less used. The superintendent says restraint could be eliminated if a larger number of better trained attendants were available. More complete records should be kept and patients kept under closer supervision. Tuberculous patients are kept in special wards. Active cases should be sent to a center for the state and only suspected and inactive cases kept in the hospital. Care of linen and disposition of table waste should be improved and more adequate reports made.

Bathing facilities for patients are mostly inadequate, as are toilet facilities; a ratio of 2 toilets and 3 lavatories to 57 patients is common. A beauty parlor and barber shop are provided.

The business manager is qualified by education and experience. The business department needs an adequate garage and repair shop, an electricians' shop near the powerhouse, a salvage yard, storehouse with cold storage, an increase in the number of painters, and better location of the canteen. The dietetics department is directed by a food manager, with experience as a kitchen attendant. In a recent month 50.7¢ was spent per day for each patient and employee, 25 percent of which came from the farm. A standard diet ration is recommended, along with greater patient use of the central cafeteria, insulated containers for transportation of food, more equipment and improvement of serving and eating facilities.

A fire company consists of 18 employees who are paid for each fire drill; the Cherokee Fire Department is also cooperative. There is an automatic fire alarm system. Most buildings for patients are fire resistant, although fire doors are needed in many places. Fire drills for patients are not held, and rescue squads have not been organized.

The farm consists of 1,000 acres, 740 of them tillable, under a farmer with 30 years' experience who reports to the business manager. The dairy herd totals 297, there is a small poultry plant and a piggery. Products are sold to the hospital and on the open market.