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Mental Health Planning in Iowa

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Iowa. Mental Health Authority
Mental health planning in Iowa

A Comprehensive Mental Health Plan in Iowa

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February, 1966

THE HONORABLE HAROLD E. HUGHES, GOVERNOR,
AND THE CITIZENS OF IOWA

For over two years a large number of professional and lay people, and representatives of state and voluntary agencies have participated in planning for better mental health for the people of Iowa. These groups have met scores of times, and with the help of facts gathered by several departments of the University of Iowa, have developed recommendations for comprehensive mental health care. From the very start all those engaged in this work recognized that planning is an on-going process, that today's recommendations need to be re-evaluated in the light of tomorrow's events.

This summary and report of major recommendations is a document which focuses our attention mainly upon local community resources in caring for the mentally ill. Though Iowa has made great strides in this direction in recent years, implementation of these recommendations will hasten the day when the mentally ill can be treated in or near their own communities.

Respectfully transmitted,

Paul E. Huston

Paul E. Huston, M.D., Director
Iowa Mental Health Authority

Enclosure

MENTAL HEALTH PLANNING IN IOWA

SUMMARY REPORT

July 1963 to December 1965

Iowa Mental Health Authority
Psychopathic Hospital
Iowa City, Iowa
December, 1965

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ACKNOWLEDGMENT

We wish to extend our sincere gratitude to the many persons, state agencies, and organizations who helped in this project. It would be impossible to thank everyone by name: the physicians, county home stewards and matrons, research assistants, nursing home administrators, and the many others who gave and collected data and opinions. We want to thank the various groups in The University of Iowa who made special studies: the Bureau of Business and Economic Research, the College of Law, the Department of Accounting, the Department of Sociology and Anthropology, the Institute of Gerontology, and the Institute of Public Affairs. We greatly appreciated the counsel of The University of Iowa Computer Center, the Department of Preventive Medicine and Environmental Health, the Division of Extension and University Services, the Preventive Psychiatry Committee, and the School of Social Work. In addition, we proffer our thanks to the members of the Department of Psychiatry for their important contributions and to Dr. Arthur Canter, in particular, for his guidance in our research endeavors.

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Chapter I
PLANNING PROCEDURE

Planning Project

The Two-Year Project, A Comprehensive Mental Health Plan for Iowa, was inaugurated on July 1, 1963, by the Iowa Mental Health Authority in cooperation with the Iowa Association for Mental Health, the Division of Mental Health, of the Board of Control of State Institutions, the State Department of Health, the Department of Social Welfare, the Department of Public Instruction, the Iowa Association for Retarded Children, and many other agencies.

The project was preceded by six months of rather intensive work on the part of the Mental Health Hygiene Committee in order to develop a planning proposal which would qualify for the funds extended by the Federal Grant-In-Aid to States. The total amount granted for the two-year planning period was $101,400, and this was to be matched many times over by state and local funds through the valuable contributions in time and effort made by concerned lay and professional citizens of our state.

The first six months of work on the project was largely organizational. A central staff (Appendix A), with offices at Psychopathic Hospital in Iowa City, was employed and all known interested agencies, groups, and individuals were contacted to gain their support and representation. Communications were established with various departments at The University of Iowa, taking advantage of their generous offers to participate in both research and planning phases of the project. Members of the planning staff made numerous get-acquainted visits and cooperation from countless facilities and agencies was pledged throughout the state.

Working Divisions

Philosophical differences were discussed at length and in October, 1963, the original planning proposal was modified somewhat. The Executive Committee, formerly the Mental Health Hygiene Committee, was enlarged to nine members and three working divisions were formed as follows:

1. The Governmental Agencies Division, to be coordinated by the Director of the Division of Mental Health of the Board of Control, was assigned the task of coordinating the ongoing mental health programs and communicating technical and administrative developments to community agencies;

2. The Voluntary Agencies Division, under the direction of the President of the Iowa Association for Mental Health, was to be responsible for publicity and for obtaining public interest;

3. The Scientific Division, made up from representatives of various University departments, state and voluntary agencies, and numerous professional organizations, was to be coordinated by the director of the Comprehensive Plan, and was set up to approach specific problems.

In addition, the University departments were, upon request, to function as consultants and resource personnel for all the divisions and committees.

How Divisions Functioned

All three divisions became active in December, 1963, and had eighty-two formal planning and informational sessions. The Voluntary Agencies Division performed its function of developing public interest through state and chapter meetings of the Iowa Association for Mental Health and via regular reports in the IAMH Newsletter. Plans are also being made to have community meetings in various sections of the state so that recommendations of the other two divisions can be discussed at the grass-roots level.

The Scientific Division operated through six committees to cover the areas of mentally ill adults, mentally ill adult offenders, alcoholism and drug addiction, the aged, children, and the mental health aspects of mental retardation. These committees of eleven to fifteen members each met every four to six weeks and considered their particular area from the standpoint of need, facilities, manpower, the law, administration, financing, public and professional education, research, prevention, and coordination. Lists of committee members are noted in Appendix B, and the committee reports are listed in Appendix C.

The Governmental Agencies Division met every three months and had broad representation from professional and lay organizations, state departments, county officials, and agencies, the Board of Control, Mental Health Institutes, and others. The present and future roles of the various groups were discussed with particular emphasis on the problem of coordination of services at all levels. A list of participating groups is found in Appendix D.

Research Projects

A number of special research projects were conducted under the Scientific Division by departments of The University of Iowa. These studies provided information needed concerning facilities, patients served, manpower, the law, costs and financing, length of hospital stay, coordination, community agreements for financing service, patients served by general practitioners, and population trends. Appendix E lists these reports.

Coordination with other Planning Projects

Congress also passed legislation in the fall of 1963 authorizing funds for planning comprehensive action to combat mental retardation and funds for the construction of community mental health centers and facilities for the mentally retarded. On March 4, 1964, the Governor of Iowa designated the Board of Control of State Institutions to administer funds for mental retardation planning and on April 2, 1964, the 60th General Assembly passed a bill designating the State Department of Public Health as the agency to administer construction funds for both types of facilities. Thus, the cooperation and coordination of three separate planning agencies has been of utmost importance since each plan interlocks with the other two. The directors of all

three planning operations served on boards or committees of the other two projects. Also, there was joint cooperation in collection of data in specific areas of common interest. (See Appendix T regarding construction program.)

The general direction of planning, published in the form of committee reports and research findings (Appendices C and E) has been distributed to nearly 600 persons in Iowa. Furthermore, comments concerning all committee recommendations were solicited from about eighty selected persons. Those suggestions were very helpful in the preparation of the final committee reports.

Chapter II
HISTORICAL PERSPECTIVE

Mental Health in Iowa

Iowa's first mental health program began in 1854, a few months after President Franklin Pierce had vetoed a bill passed by Congress to set aside millions of acres of public land for the benefit of the mentally ill. The national concern which had moved Congress to consider such an ambitious venture was stimulated in great part by Dorothea Lynde Dix who, upon her death in 1887, was called "the most useful and distinguished woman America has yet produced." For forty years, she had been a world famous crusader in an unique cause, humane treatment for the mentally ill. She had been shocked to see mentally ill persons locked up in jail cells and neglected in alms houses. In January, 1843, she presented a memorial to the Massachusetts Legislation: "I come as the advocate of helpless, forgotten, insane, and idiotic men and women . . . for being wretched in our prisons and more wretched in our alms houses. I proceed Gentlemen, briefly, to call your attention to the state of the Insane Persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens. Chained, naked, beaten with rods, and lashed into obedience." The solution she proposed was state hospitals. "Hospitals are the only places where insane persons can be at once humanly and properly controlled. Poor houses, converted into madhouses, cease to effect the purpose for which they were established, and instead of being asylums for the aged, the homeless, etc., are transformed into perpetual bedlams. . . ." Although she had suffered a great defeat when the President vetoed the congressional bill in support of her plan, the impact of her crusade was deeply felt in Iowa.

Meeting a few months after President Pierce's veto, the Iowa General Assembly expressed its first concern for the mentally ill during the Fifth Session when Iowa City was still the State Capitol. The out-going governor, Stephen Hemstead, addressed the General Assembly on December 8, 1854: "The establishment and endowment of an Asylum for lunatics, is a measure which should commend itself to your favorable consideration. We cannot but be aware of the fact, that we have a considerable number of those unfortunate persons in our state, who have strong claims upon our sympathy and bounty, and who must be removed from their friends to other states in order to obtain the means of alleviating and improving their condition, or of being confined in our jails and poor houses."

On December 9, 1854, the newly elected governor, James W. Grimes, made the following address: "The General Assembly cannot be too urgently called on to take immediate steps to establish state charitable institutions. According to the most reliable information, there are now more than one hundred pauper insane persons in the state. One-half of these are confined in the common jails, and are thus placed beyond even a reasonable expectation of recovery; the other moiety are roaming at large, a terror to their friends and neighbors, and by exposure to exciting causes rendering their disease hopelessly incurable. Every dictate of humanity—every principle of sound public policy—demands that the state should make immediate provision for the care and treatment of the unfortunate class of our fellow citizens."

Iowa had primarily a rural population of less than 400,000 people in 1855. This fact, along with the public attitudes regarding the treatment of mental illness, is reflected in the early planning for the building of treatment centers. A legislative committee report to the House of Representatives in 1855 included the following: "Your committee are fully impressed with the importance of providing ways and means whereby the insane of this state may be treated in a more humane and proper manner than they now are. To confine those who have been deprived of reason with the criminal and degraded, as our laws at present do, is unworthy and unbecoming a civilized people. The savage would hardly be guilty of such an outrage." . . . "Your committee are of the opinion that in a few years the state will be required to establish two or three hospitals for the state: that one of these institutions is much needed at this time, and that the legislature should make ample provisions for the establishment of the same." "Your committee are of the opinion that this institution should be located at a point of easy access to the present inhabitants of the state, and with a view to the future locations of institutions of this character, and also that its location should be in a healthy section of country, where nature has been bountiful in her gifts and made beautiful her scenery."

Then, as now, reluctance developed over cost. The Fifth General Assembly first appropriated $50,000 and soon another $50,000, but the cost of construction climbed at a time when the economy was in recession. A strong appeal was directed to the General Assembly in 1858. "The building in progress of erection at Mount Pleasant was planned by the highest authority in the country and when completed will be superior to any edifice of the kind in the West. No building of like character and architecture can be completed at cost less than two hundred or two hundred and fifty thousand dollars—The insane are calling from every quarter of the state for a place of refuge. They are calling from the jails, and poor-houses, and outhouses, and other miserable places for the speedy completion of this work. It is for the General Assembly to say how that call to which no ear should be deaf shall be answered."

The call was heard by the General Assembly and Iowa's first "Asylum for the Insane" was dedicated on March 6, 1861, the week of President Lincoln's inauguration and a month before the beginning of the Civil War. This marked the beginning of an institutional mental health program which received continued support for expansion for over forty years. The beginning was not without problems, however, as Dr. Patterson, first medical superintendent of the Mt. Pleasant asylum, in 1861, struggled with the General Assembly to keep the quality of care high. Two major concerns dominated his biennial reports: overcrowding, and re-

turning patients back to the jails and poor farms. Dr. Patterson wrote in his first biennial report: "In a few weeks our present rooms will be all filled, in a few months longer they will be crowded, and then must commence the unwelcome duty of returning chronic, incurable cases to the counties, some of them to their old quarters in the jails, to make room for curable cases, as provided by law."

Problems of cost continued. The impact of the Civil War pushed patient cost from $2.50 a week to $3.00 a week. In his second biennial report the medical superintendent urged that quality of care remain high. He wrote in 1863: "We could lessen our expenditure by converting our new excellent hospital into a great alms house or a mere receptacle for custodial cases, but we do not think this would meet the spirit of the law, or that of the people, or the views of your Board. We have endeavored to make this institution, in its true sense, a hospital or curative establishment which shall rank high among the best of its kind in this or any other country, and one of which every citizen of Iowa may justly feel proud."

By 1904 the fourth and last large state hospital had been built and these were located to serve roughly four equal areas of the state. Although Iowa's first "Poor Law" was passed in 1842, making provisions for the poorhouse (later called county home), only a few were in existence when the Mt. Pleasant Asylum was opened. At the turn of the century there were more than fifty county homes, and by 1920 there were more than eighty. In 1911 a law was passed to permit the transfer of harmless and incurable insane from the state hospital to county homes. This parallel development of state and county facilities was in great part due to the laws which specified that each county was financially responsible for the care of its residents at the state institutions. With the increasing size and numbers of facilities, problems of policy and administration developed and in 1898 the Board of Control was established for all state charitable and correctional institutions, and it was given general supervision of all county poorhouses where insane persons were kept. Although there were several small county insane asylums and private charitable asylums built, the last major state mental health effort before the economic depression of 1929 was the dedication of the State Psychopathic Hospital in 1920 as a teaching and research center affiliated with the State University of Iowa College of Medicine.

With the passage of time, an attitude that mental disease was incurable developed within society and in the medical profession itself. As a result, the state institutions became larger and larger, and acquired massive administrative problems. There was overcrowding, financial limitations, and there was understaffing. Patients lost their identity and lived on in the institutions for years or often until they died. News reporters began to refer to the state hospital as "the shame of the states." Visitors to state institutions often returned with shocking stories. A custodial and pessimistic attitude toward treatment hung heavily over these institutions. By 1940 the state of the mentally ill confined within an institution was seen in many respects as similar to that expressed by Dorothea Dix 100 years earlier.

During World War II society and the medical profession began to look more closely at the nation's mental health problems. This national concern and interest was reflected by the passage of the National Mental Health Act in 1946 which authorized the creation of the National Institute of Mental Health in Bethesda, Maryland, in 1949. The three main functions of the program outlined by the National Mental Health Act were: 1) Research in the field of mental disease, 2) Training of personnel, 3) Assisting the states in developing their mental health programs.

At that same time, a new perspective was growing. The educated public had begun to appreciate the importance and the significant extent of mental and emotional problems in the population at large. Most of the rejections for military service in World War II were consequences of psychiatric disorders and most of the medical discharges from military service were also for psychiatric reasons. During the war it was discovered that many soldiers with acute emotional illnesses could be functionally restored or cured if treated promptly and close to the battlefront. Physicians also began to appreciate the importance of mental and emotional problems. They began to re-emphasize what general practitioners had known for a long time, that to treat a patient successfully, whatever his disease, it is frequently necessary to manage or treat the emotional component to the illness.

Within this new perspective a number of significant developments began to occur primarily in the field of private practice, which had moved psychiatry closer to medicine, and these developments have demonstrated to the profession and the public that patients with mental illness can be treated successfully in their own communities. The growth of psychiatric private practice began after World War II. In 1946 there were approximately twelve psychiatrists in private practice in Iowa. By 1950 there were twenty-four. The Iowa Neuropsychiatric Society was organized in 1948. These private psychiatrists began to treat many of the milder psychiatric conditions in their offices. The first psychiatric unit in a general hospital in Iowa was opened in 1946, and by 1950 there were five. The effectiveness of electrotherapy and drugs in the treatment of psychiatric conditions helped make these units possible. Furthermore, the increasing industrialization of Iowa in the 1940's, associated with the urban shift of population, provided group insurance coverage to many more people. This insurance, along with extension of other insurance coverage, materially assisted the development of the psychiatric units in general hospitals.

During the post World War II years, other movements began. The state hospital programs suffered tremendously during World War II from the manpower shortage. However, as mentioned previously, the war acted in many ways as a catalyzing agent in the growth of psychiatry. New developments had to take place, as the needs of the time demanded application of diagnostic and therapeutic procedures on a broad basis. Social workers and clinical psychologists were employed extensively in these new programs which were later carried on by the Veterans Administration. This type of program development in which social workers and clinical psychologists took active and determining part was particularly evident in the fields of group therapy, rehabilitation, and child psychiatry. The number of resident patients in Iowa's four state mental hospitals in 1946 was 6,575. As programs began to improve, the resident population in the hospitals began to decrease, and by 1955 there were 5,336.

Another movement which began during the post World

War II years, was the multiplication of community mental health centers. Originally patterned after the child guidance clinics, they became more like psychiatric outpatient clinics. The first one in Iowa was the Des Moines Child Guidance Clinic. Beginning in 1947 with the establishment of the Iowa Mental Health Authority at the Psychopathic Hospital, new centers were sponsored. By 1955 there were seven community mental health centers in Iowa, located in major urban areas. These centers differed somewhat from those found in other parts of the country, as for example, in New York and Minnesota, where a large portion of financial support came from the state. In Iowa, the centers were entirely locally managed and controlled and more than 90 per cent locally financed. Another unique difference had to do with the location of the Mental Health Authority. In over half of the states, this agency was located in the Department of Health, in about a quarter of the states it was located in the Department of Welfare, and in seven or eight it was located in the Department of Mental Health. In the remaining states, it was scattered in various departments. In Iowa, it was located in close contact with the University College of Medicine and under the Board of Regents, and its primary function was considered to be education—public education in mental health, professional education of mental health center staffs, and consultative assistance to communities organizing new mental health centers.

Nationally and in Iowa, interest in mental health continued to grow during the mid 1950's. The governor's conference on Mental Health, the Mental Health Study Act of the 84th Congress, the Hill Burton Program, and the establishment of the Joint Commission on Mental Illness and Health broadened and intensified capital improvements, interest in research, training of specialized personnel, and community services throughout the nation. The trend in national legislation in the early 1960's reveals a shift from almost total federal spending for research and training to the support of services. This appears to have started with the final report of the Joint Commission on Mental Illness and Health which saw first congressional approval in the Kennedy Legislation on community mental health centers (Public Law 88-164).* In 1963, federal money was made available for the improvement of the quality of patient care in state hospitals under demonstration project grants and for the development of inservice training programs for state hospital personnel. Also, in 1963 the two-year federally sponsored project for state comprehensive mental health planning was begun. New federal legislation in 1965 amended the community mental health centers act to provide operational money to community mental health centers for a limited time. However, in 1965 the most important legislation related to mental health was undoubtedly the medicare act. As yet, it is not known what this federal legislation will mean, but the increasing trend of federal involvement in the mental health field is certainly apparent. In Iowa the Governor's Committee on Mental Health employed the American Psychiatric Association to make a study of the mental health problems in the state in 1955. Since that time new governors have appointed advisory committees on mental health. They have continued to focus attention on persistent problems despite the handicap of no permanent staff and lack of continuity from one committee to the next. Through their many efforts and recommendations they have developed considerable public interest, brought about new legislation, and stimulated new programs. These efforts plus the work of the State Medical Society, the Iowa Association for Mental Health, and many other groups have contributed markedly to Iowa's progress in the field of mental health during the past ten years.

Since 1955 many important changes have taken place. A few examples are illustrative. Treatment has increasingly improved in the various state institutions through the employment of qualified personnel. In 1955 there were 293 professional personnel in the state mental hospitals and schools for the retarded. By 1962, this number had increased to 465. In 1955, there were 5,336 resident patients in the four state mental hospitals. By 1965, there were 2,018.** The number of admissions to the state mental hospitals has increased, however, and the length of stay per hospitalization of patients has gradually decreased. Training programs for psychiatry have expanded. In 1955, there were five psychiatric residents and in 1964 at the Psychopathic Hospital and two state mental hospitals there were forty-two. To strengthen both the undergraduate medical student and the residency training program, patient visits to the Psychopathic Hospital outpatient clinic have increased from about 3,000 in 1955 to over 7,000 in 1964. The state mental hospitals also developed out-patient clinics and provided services for over 1,600 patients in 1964. Research activities have multiplied. In 1955 five articles were published in professional journals by Psychopathic Hospital personnel. During the past two years more than 100 scientific papers by the staff of Psychopathic Hospital have been published or accepted for publication. Also, several scientific papers have been published by mental health center personnel. The number of admissions to community general hospitals for psychiatric treatment has greatly increased. The first psychiatric unit in a general hospital was established in Iowa in 1946. By 1964 there were twelve of these units in Iowa. There were more than 4,300 admissions to community general hospitals for psychiatric treatment in 1964. Mental health centers have grown in number and have expanded. In 1955 there were seven mental health centers which provided direct services to more than 1,800 patients. In 1965, there were fifteen mental health centers located in two-thirds of Iowa's major urban centers and direct services were provided to more than 8,000 patients. Services from mental health centers in Iowa are now available to more than 58 per cent of the state's population. A sixteenth center has recently been organized and will be operating in the near future, and several are in the process of organizing. There are approximately ten more psychiatrists in private practice, bringing the total to fifty-two, and physicians throughout the state are taking more interest in mental health and mental retardation. Also, an increasing number of citizens have been devoting extensive efforts to develop a modern mental health program in Iowa. In a sense, Iowa began its comprehensive mental health planning many years ago.

This brief historical review highlights some of the major advances and changes occurring in the field of mental health

*See Appendix T.

**See Graph showing percentage decrease in patient population, Appendix S.

in Iowa and the nation. It is apparent that there has been enormous expansion and development, particularly in the past twenty years, and there are many reasons to believe this trend will continue.

General Characteristics of Iowa

Iowa lies in the center of North America, bordered by the continent's two major rivers, the Mississippi and the Missouri. "Iowa" is an Indian name meaning "Beautiful Land." Our state is characterized by fertile and level prairies, meandering streams and rivers, and wooded valleys. One-fourth of the finest farm land of the United States is here. Great crops of corn, soy beans, and oats are produced, as well as beef and dairy cattle, swine, butter, milk, and eggs. "Horace Greeley meant Iowa," is one of our most astute mottoes.

Iowa reached a population peak in the early part of this century. Its people came mainly by migration from the Eastern and Northern sections of the country and the stock is chiefly English, Irish, Norwegian, German, Scotch, Bohemian, and Dutch.

With the marked improvement in agricultural methods, machines have been gradually replacing men on the farms. Along with this the volume of manufacturing products has increased so that now slightly over half the state's revenue comes from non-farm activities. Farms, meanwhile, have grown larger in size and some areas of the state continue to lose population. This is most noticeable in southwestern Iowa where the poorer land is found. The population of the eastern half of the state, however, is growing where the new industries tend to locate.

The Iowa highway system is one of the nation's most complete, having a higher average of surfaced roads per square mile of its area than any other state. Iowa has constructed 350 miles of its interstate system allotment of 710 miles, which will be virtually completed by 1970. Furthermore, the Iowa State Highway Commission plans to build an additional 760 miles of freeways during the fifteen years following completion of the interstate system. The combined interstate and freeway systems will directly serve 76 per cent of the people living in urban places larger than 2,500 in population.

Culturally, Iowa is considered middle class. There is neither a large, very wealthy class nor a vast underprivileged group. It has excellent universities, many private colleges, and the lowest illiteracy rate of any state in the nation. Generally speaking, Iowans have strongly supported their educational institutions.

Iowans tend to show a strong individualistic streak and at the same time a marked community spirit. The growth of the community mental health clinics in Iowa typifies this latter aspect. There have been no state funds for these clinics and yet they have gradually increased in number so that now there are fifteen covering more than half of Iowa's population. The history of the development of each of these clinics shows how communities have been able to plan intelligently for a new mental health facility. Significantly, none of these clinics has closed its doors after beginning operation. Their combined budgets have grown to nearly $1,000,000 a year, supported almost entirely out of local resources. Furthermore, county government is strong. Each county pays the cost of care for its residents who are patients in the state institutions for the mentally ill and the mentally retarded.

It would be expected, therefore, that sound community planning in Iowa would bear fruits. Iowa will likely not be subject to violent social, cultural, or economic upheavals in the next several decades. There resides within the population a capacity to carry through solidly on the development of new plans in mental health. Everywhere, as one turns, one sees sustained and substantial interest.

Chapter III
SCIENTIFIC DIVISION-SPECIAL PROJECTS

During the early phases of planning a number of special projects were initiated within the Scientific Division in order to provide information concerning facilities, patients served, manpower, the law, financing, length of hospital stay, coordination, community agreements, patients served by general practitioners, and population trends. The design, development, and administration of each project involved the cooperative efforts of the planning committee members, the central office staff, and various departments of The University of Iowa with its resources of highly qualified individuals and modern data-processing equipment. Upon the completion of these studies, reports were prepared and distributed widely to all persons active in planning.

This chapter contains reference to fourteen of the projects, most of them in summary form. Several reports made up of primarily reference material for the use of committee members are not included.

A number of special studies are still underway and more are being considered as planning continues. Reports on five-year follow-up studies of both psychiatric inpatient and outpatient admissions, on extensive surveys of aftercare facilities, and on the changing patterns of patient care will be published in the near future. (See Appendix E.)

Iowa Population Trends and Characteristics

Prepared By
The University of Iowa Bureau of Business and Economic Research and the Iowa Mental Health Authority

INTRODUCTION

This report provides basic information about the state of Iowa which is important for the planning and development of new and existing community mental health services. Since mental health services, as they now exist, serve whole populations of fairly well-defined geographical areas, population trends by county and state must be a prime consideration in the planning for such services.

General population shifts after 1900 are discussed with major emphasis on the decade between 1950 and 1960, since population estimates must rely on a continuation of the trend of this base period. Further, in analyzing the reasons for and consequences of Iowa's population movements other topics are touched upon, including shifts in county income, industrial development, and urbanization. Material is presented by individual county so that the reader can assess the position of a particular county or group of counties relative to the state as a whole. (See example Table 8.)

IOWA POPULATION TRENDS AND CHARACTERISTICS

From 1850 to today Iowa's population has grown from 192,000 to 2.8 million and is projected to 3 million by 1975. Figure 1 shows a rapid increase during the first half of the period with a moderate, yet steady, increase during the latter half. Since 1900, Iowa's population has increased by 500,000 persons (19 per cent), while that of the United States has doubled. It is also apparent in Figure 1 that the urban population has been increasing at a more rapid rate than that of the entire state, while the rural population has shown a steady decline.

Because of migration to other states, Iowa's growth in population during the last half century has been much less than its natural increase. During the decade from 1950 to 1960, net migration was approximately one quarter of a million persons. (See Table 1.)

The distribution of population, by county, for 1960 is shown in Figure 2. Note the heavy concentration of population in the central and east central portions of Iowa. A number of the southern tier of counties have less than 10,000 persons each, while many of the east central counties exceed 30,000. Figure 3 shows the areas of growth and decline in Iowa's population from 1950 to 1960. The areas of greatest increase tend to be situated in the east and north, with an average increase of about 5 per cent. This same growth pattern is expected to continue through 1975 as illustrated in Figure 4.

Another way to view population change is in terms of each county's share of the state population at various time periods. Figures 5 and 6 show each county's percentage of state population in 1900 and 1960. There is a striking similarity between the two maps, with the higher percentages attributable to river transportation or the presence of a town supplying service functions to the surrounding rural area. In general, the highs have tended to become higher and lows lower, (Figures 7 and 8) as a reflection of the consistent rural to urban movement. Thus, the population is becoming more concentrated in the central and eastern portions. In fact, with the exception of Pottawattamie, no county west of Polk is expected to increase its percentage of the state's population by 1975.

The percentage of persons age sixty-five and over in each county in 1960 is revealed in Figure 9. By projecting the trend to 1975, as seen in Figure 10, it may be predicted that counties with high growth will tend to reduce the proportion of their residents sixty-five and over, while counties declining in population will increase their share of persons in the older age brackets. Note that the counties with concentrations below 12 per cent (Figure 9) form a pattern similar to the high rates of increase in Figure 8, indicating that the population movements are composed primarily of people in younger age groups. The per cent of population over sixty-five for the entire state will decrease from 11.9 to 11.6 in 1975.

Note that the pattern of counties with below 12 per cent of population over sixty-five in the northwest (Figure 9) does not appear in the distribution in Figure 10. Only recently have these counties experienced population growth less than the state average, resulting in a relative increase in the number of older persons as more of the younger age brackets migrate to the rest of the state.

PERSONAL INCOME

The percentage of total state personal income by county

for 1960 is set forth in Figure 11. Only counties containing cities of over 10,000 claim a share of 1 per cent or more. A comparison of Figure 11 with Figure 6 reveals that generally the same counties have both a higher percentage of state income and a higher percentage of state population. However, close examination reveals that thirteen counties with cities of over 10,000 people have a greater percentage of state income than state population, and the greater in excess of 10,000 an urban center becomes, the greater is the difference in per cent of state income. Undoubtedly, the difference between income and population shares accounts for much of the population movement within the state. Changes in the percentage of state income from 1950 to 1960 by county are revealed in Figure 12, which is strikingly similar in pattern to that of relative population shifts for the same period (Figure 8). However, it is notable that two counties, Cerro Gordo and Webster, demonstrated a relative income growth without a similar relative population increase. This might be explained by a shift in employment (service and professional functions) from surrounding counties to the principal cities of Mason City and Fort Dodge.

It is also of interest that the income shifts tend to be higher than the population shifts, suggesting that population readjustments lag behind income changes. Ultimately, however, one might expect this gap to diminish over time due to immigration into high-income counties and emigration from low-income counties.

It is anticipated that shifts in population and income will continue in the same direction they have been moving since 1900. However, a note of caution must be added since a straight-line projection would result in an absence of population for some counties. This is impossible, so we must conceive of a "lower limit" for both population and income in declining counties. In many rural areas a decline in population will have no effect upon total income. Actually, per capita income may rise as the value of agricultural production increases. In addition, people in the counties with a higher percentage of older age groups receive income through transfer payments such as insurance, social security, and retirement benefits.

It seems logical that the "lower limit" for a given county would include only the necessary producers and the business and professional people necessary to serve the area. A point of stability would be reached. Perhaps, already, certain declining counties are nearing this "limit."

CHARACTERISTICS OF URBAN PLACES

Iowa, like other states of the Middle West, is experiencing the impact of increasing urbanism. Between 1950 and 1960 its urban population increased by 17 per cent,[1] while the over-all population increased only 5 per cent. However, this increase was largely confined to the major urban centers, the number of towns under 2,500 remaining relatively constant in population for the past forty years.

Though not considered urban by the U.S. Census, more than 1,000 settlements below 2,500 in population are important to Iowa because of their extensive service functions to the surrounding rural populace. Reciprocally, these small towns obtain most of their support from the adjacent rural areas. With mechanization, farms are increasing in size and decreasing in number. Between 1954 and 1959 there was an 8 per cent decline in the number of Iowa farms,[2] and during the same period the two southern tiers of counties experienced a 10 per cent reduction.[3]

As a consequence, the agricultural population is declining and this, in turn, results in diminished expenditures in these smaller urban settlements.

Town Size Classes

Table 2 presents a breakdown of the 1,544 towns in Iowa according to size, showing that most are small village-type settlements which have developed in response to the rural demand for goods and services. It is apparent from the table that 70 per cent of the towns are under 500 in population, 85 per cent are under 1,000, and 92 per cent are under 2,000. Small towns are scattered throughout the state, but their degree of concentration varies. This is particularly true for those under 100 people, the greatest concentration being in the middle of the southern two tiers of counties where there has been the greatest decline in the number of farms. Thus, reduction in rural population, increased farm size, and increasing travel opportunities appears to have made the small towns of these counties less important or necessary in supplying service functions to the surrounding area.[4]

Growth and Decline of Urban Places

Table 3 shows a breakdown of the 1950-1960 percentage changes in population for the 937 urban places in Iowa listed by the U.S. Census. Though not apparent from the table, the higher growth rates were largely confined to towns of over 2,500. However, for communities under 2,500 there were relatively the same number of positive and negative changes. In Table 4, which lists the mean population change according to town size, note that places under 250 in population declined by 3.2 per cent from 1950 to 1960.

Further information on the nature of growth and decline of Iowa urban places is given in Figure 13, showing negative and positive changes (1950-1960) in the population of the same 937 communities. The circles are proportionate to the per cent of change. The southern two tiers of counties stand out as an almost solid area of negative per cent change and there is a general negative per cent change in the western half of the state. The east, west, south division is shown diagramatically in Figure 14.

The difference between urban centers which are located close to larger urban areas and those located in rural areas is striking. Almost all the towns and villages near Des Moines have a marked increase in population, some as much as 100 per cent. Yet towns and villages located in the rural areas of the state reveal smaller increases in population or quite often declines in population.

The findings of Salisbury and Rushton[5], that growing towns have younger populations and newer housing suggests

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[1] U.S. Bureau of Census, Census of Population 1960, Vol. 1, General Population Characteristics, Part 17B.

[2] U.S. Bureau of Census, *Census of Agriculture*, 1959.

[3] C. W. Thompson and Conrad Stucky, *Iowa 1975*, Iowa Business Digest, August, 1961, p. 2.

[4] The decline of S.W. Iowa towns has been documented in: Brian J. L. Berry, H. Gardiner Barnum, and Robert J. Tenant, Retail Location and Consumer Behavior, *Papers of the Regional Science Association*, Vol. 9, 1962.

[5] Salisbury and Rushton, p. 86.

that some of the growing towns are serving as residential communities for larger urban centers.

Economic Characteristics of Urban Places

Population changes are also related to the economic characteristics of urban areas. Unfortunately, information is not available on the economic activities of all towns in Iowa. The U.S. Census does collect information on employment for all urban places, but this data is collected by place of residence and not by place of work. A study by Scheld[6] of 144 Iowa towns shows that the economics differ greatly (Table 5). Notice the break at the 2,500 town population level. Agriculture, mining, and retailing stand out with higher percentages in towns of 2,500 population or less, and manufacturing is higher in the larger towns. Services, however, are markedly higher in towns of 1,000 or less. Table 6 shows the per cent employment in major economic categories for the entire state. A comparison of Tables 5 and 6 shows which town sizes are above or below the employment percentage for the whole state.

In general, the products of manufacturing, especially durable products, are consumed some distance from the place of manufacture. Therefore, an increase in employment in the manufacturing category is not dependent on local population growth. Most of the other major employment categories, however, provide service mainly for the local population, and because of this it may be extremely difficult to increase employment in the service categories in an area lacking population growth.

Trade Areas

Communities often dominate specific territories about them which are commonly known as trade areas. Some of these areas are man-made, such as school districts. Others occur naturally and are determined in size and shape by competition of nearby communities, and by the number of customers or dollars required to support a given service, by customer preferences, by travel patterns, etc. A town may dominate one area in terms of food sales and quite another area for clothing purchases. Thus a town has many trade areas. It would be impossible to make a single map of all the trade areas in the state. Table 7 (taken from a 1960 survey) shows travel purchase preferences of rural Iowans for some services. In areas of low population density the trade areas for a particular service must necessarily be larger than in densely settled areas if they are to contain equal numbers of potential customers.

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[6] Karl Anton Scheld, A Comparative Analysis of the Level and Composition of Economic Activity in 144 Iowa Towns, Unpublished Dissertation, The University of Iowa, 1963.

SUMMARY AND CONCLUSIONS

As previously stated, population trends by county and state must be a prime consideration in planning for community mental health services. Figure 15 shows the locations of communities with over 10,000 population, toward which the migrating population appears to be attracted. These are the areas that are growing, not only in population but also in income which is so necessary for the financial support of needed services. A comparison of Figure 15 with a map of the present location of Mental Health Centers in Iowa, Figure 16, shows that, with few exceptions, centers have naturally developed in accordance with population trends. As might be expected, the pattern has been affected somewhat by trade areas (Spencer, Decorah, Waverly) and the availability of service from private psychiatry and general hospitals (Sioux City, Ottumwa, Dubuque).

On the basis of past experience, it can be predicted that additional mental health services will first be developed in centers of over 10,000 population, and perhaps in slightly smaller communities which have a large trade area. Aside from location, of course, there is the type of service to be provided, and this will be influenced a great deal by such additional factors as age, type of employment, economics, and other population characteristics of the area served.

This report has presented historical and projected data on population movement in the state of Iowa with some discussion of the factors involved. Mechanization has resulted in a consolidation of farms; fewer farmers are needed and the agricultural population has tended to migrate toward the larger communities. Since industry has developed in population centers, the younger age groups, in particular, have migrated to these areas of possible employment.

Maps and tables demonstrate that population growth and industrial development are largely confined to the eastern half of the state. Of equal importance in the southernmost two tiers of counties is the consolidation of farms, the declining population, the increased proportion of persons over age sixty-five, and the increasing number of small towns which are diminishing still further in size. Except for a certain "lower limit" it seems that the less populated counties will continue to decline in population and income while the larger ones will grow still larger.

Assuming that they are properly motivated and organized, these more rapidly growing areas of the state will essentially "take care of themselves" as far as mental health services are concerned. The greatest problem will be in the development of a comprehensive community mental health program which will meet the needs of the more remote, less populated, economically depressed areas of the state.

Figure 1

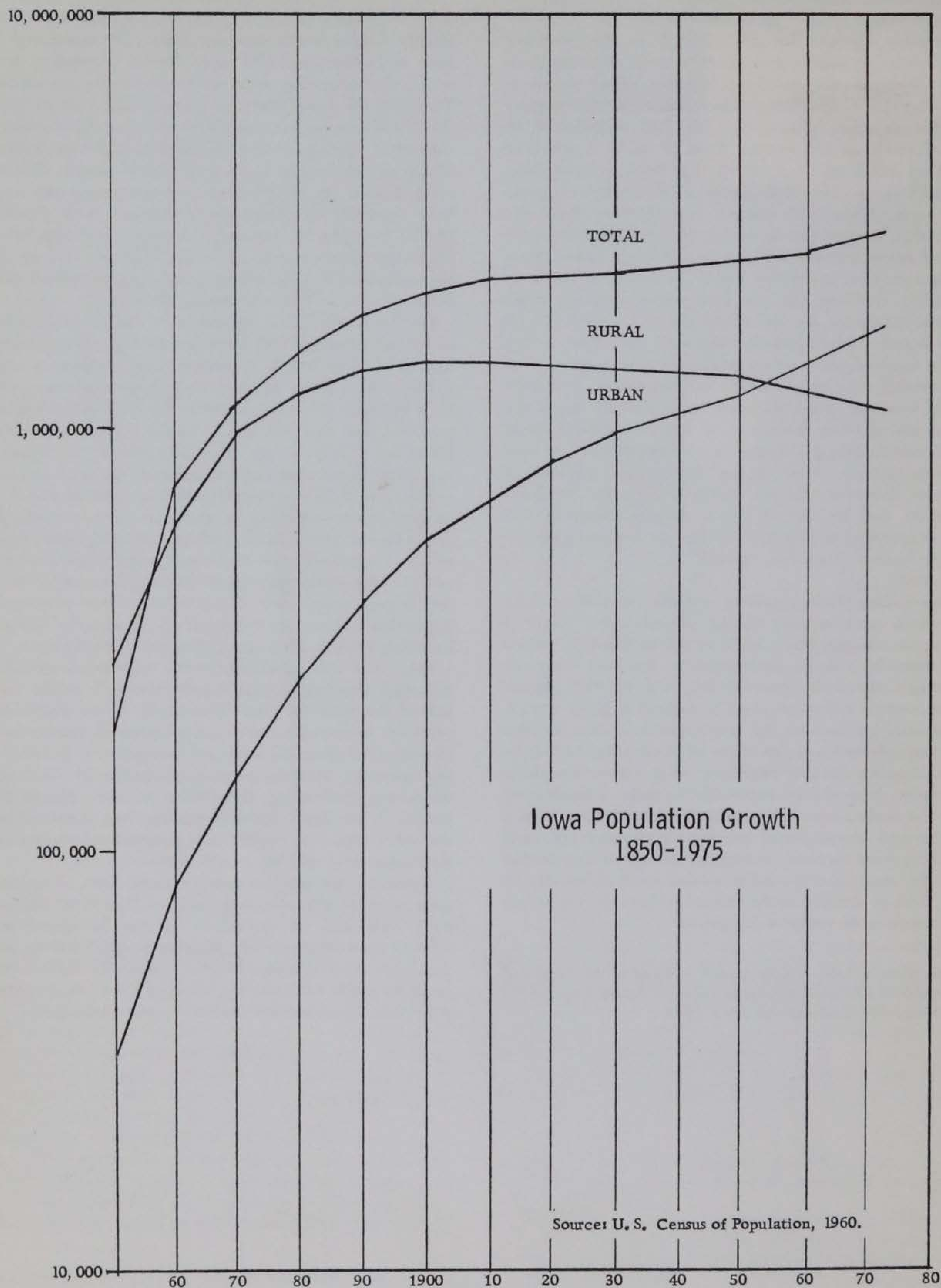
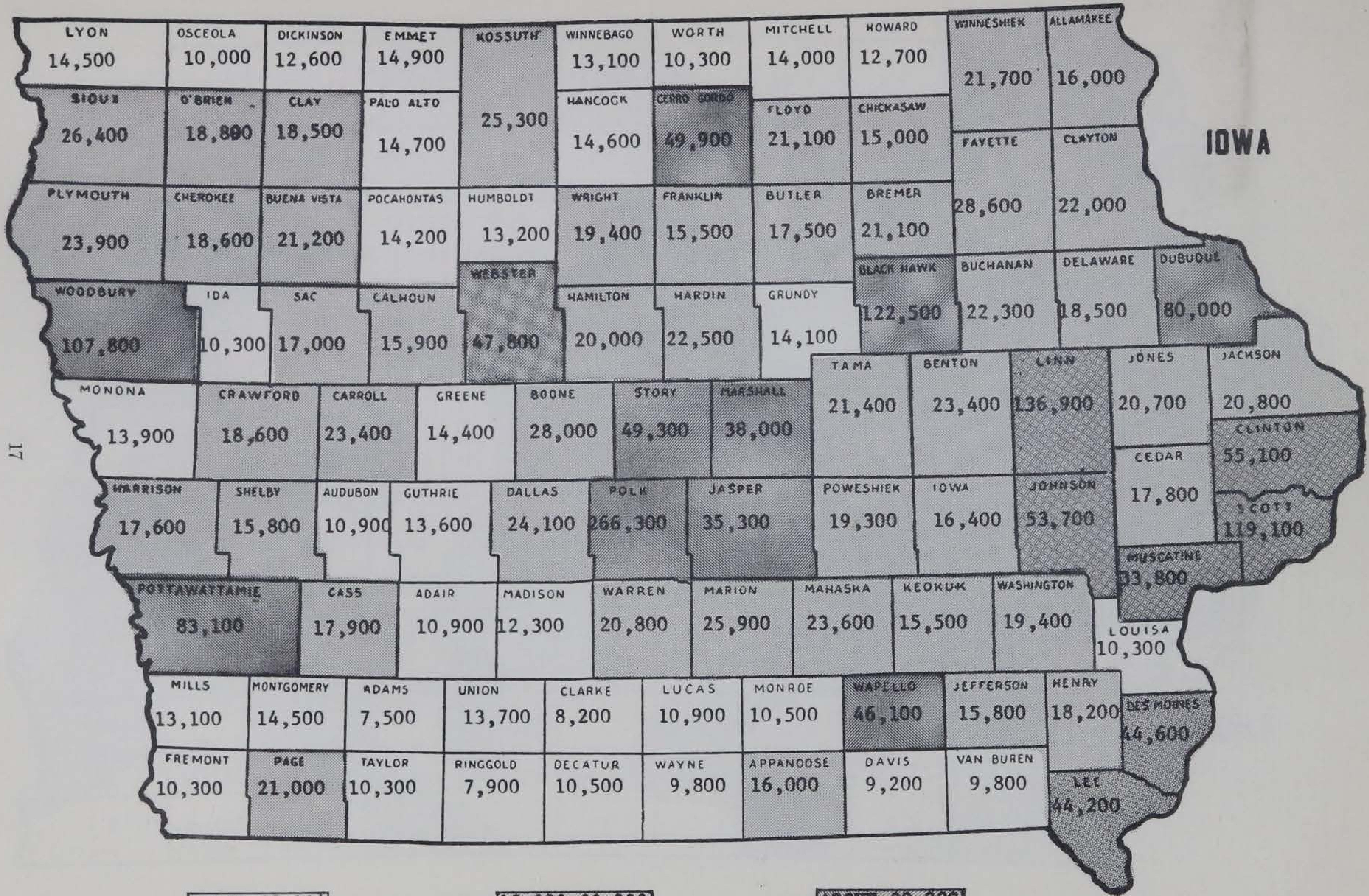
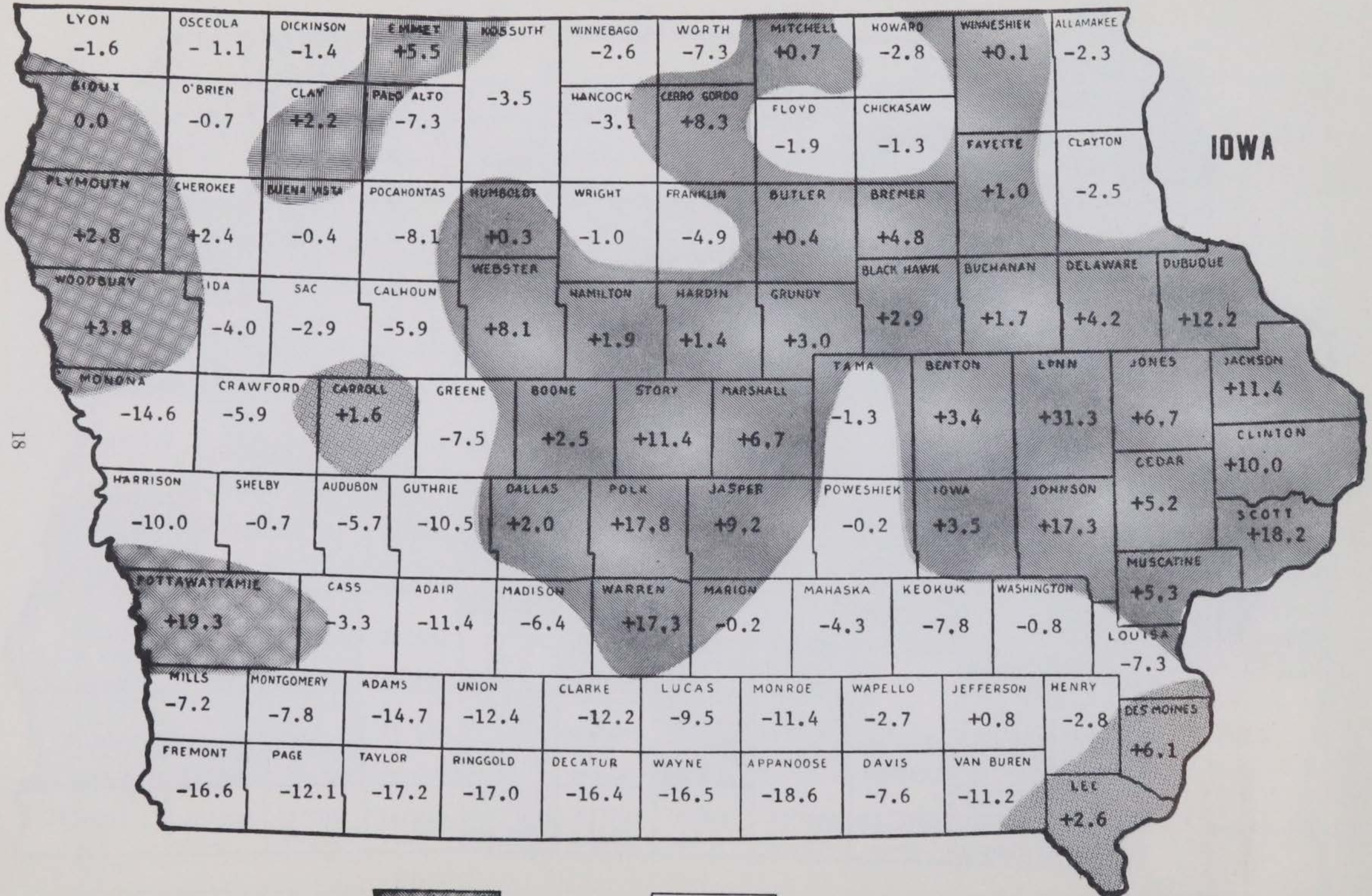


Figure 2
POPULATION BY COUNTY, 1960



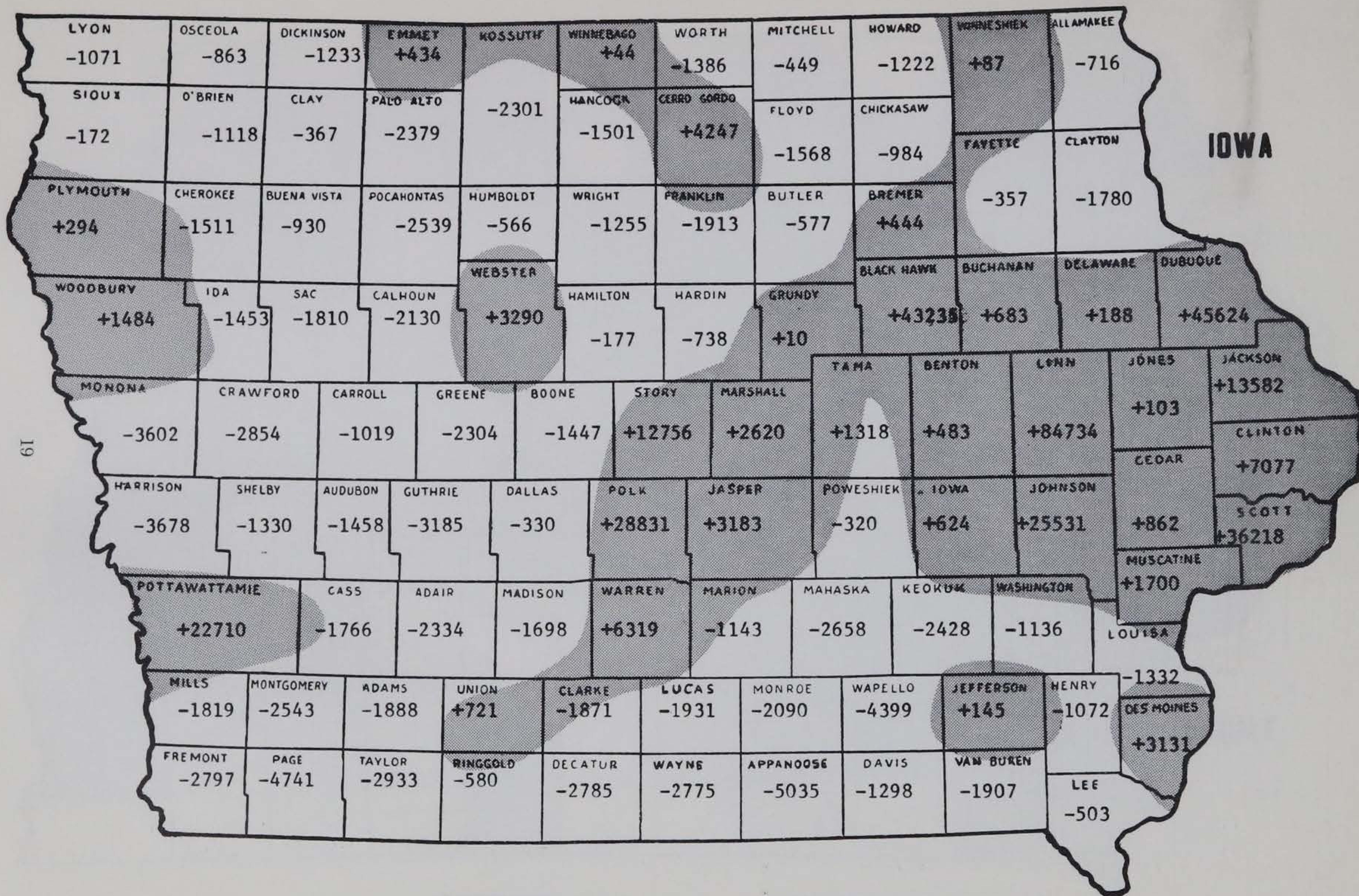
Source: U. S. Census of Population: 1960.

Figure 3
POPULATION, PER CENT CHANGE 1950-1960



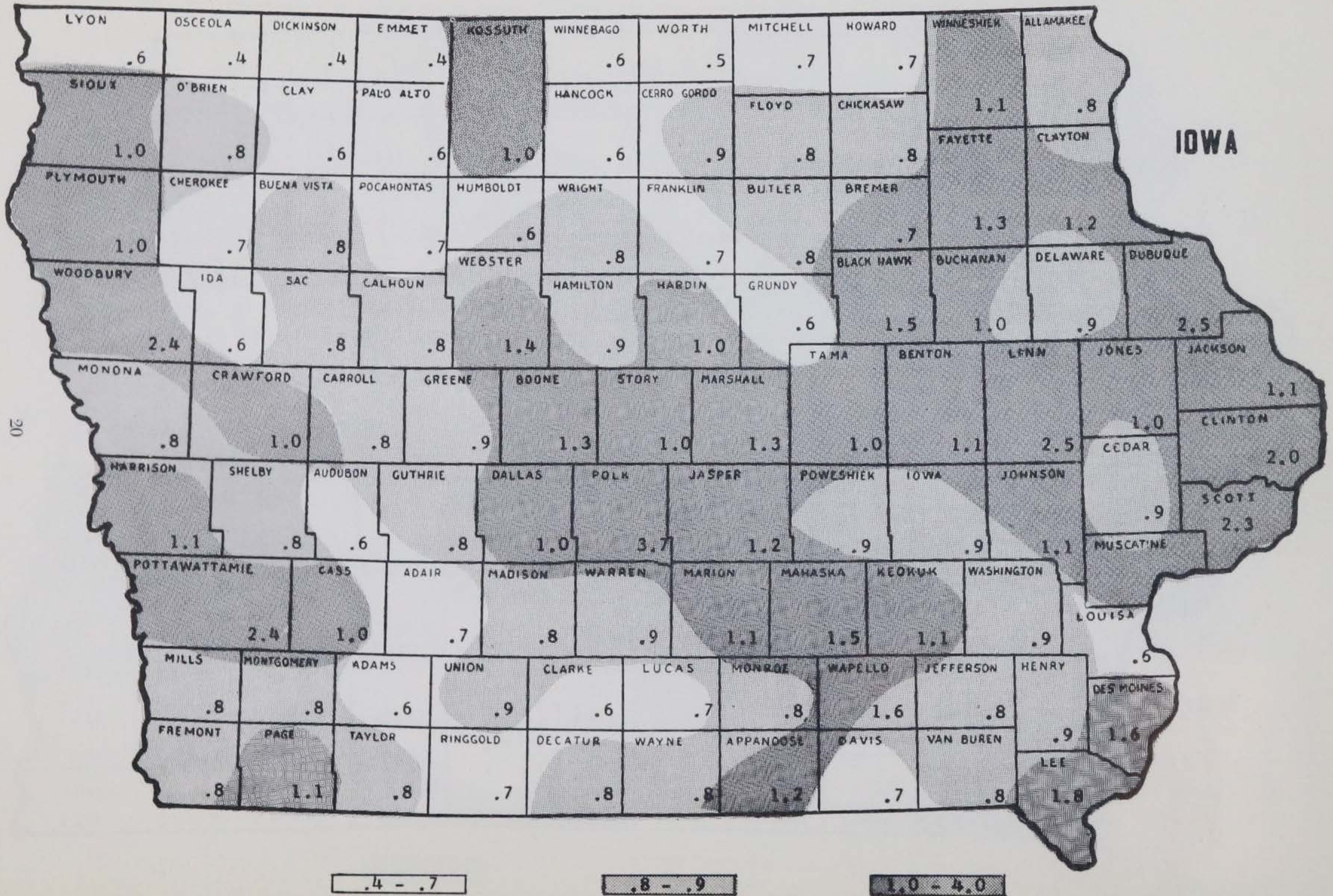
Source: U. S. Census of Population: 1960.

Figure 4
POPULATION CHANGE 1960-1975



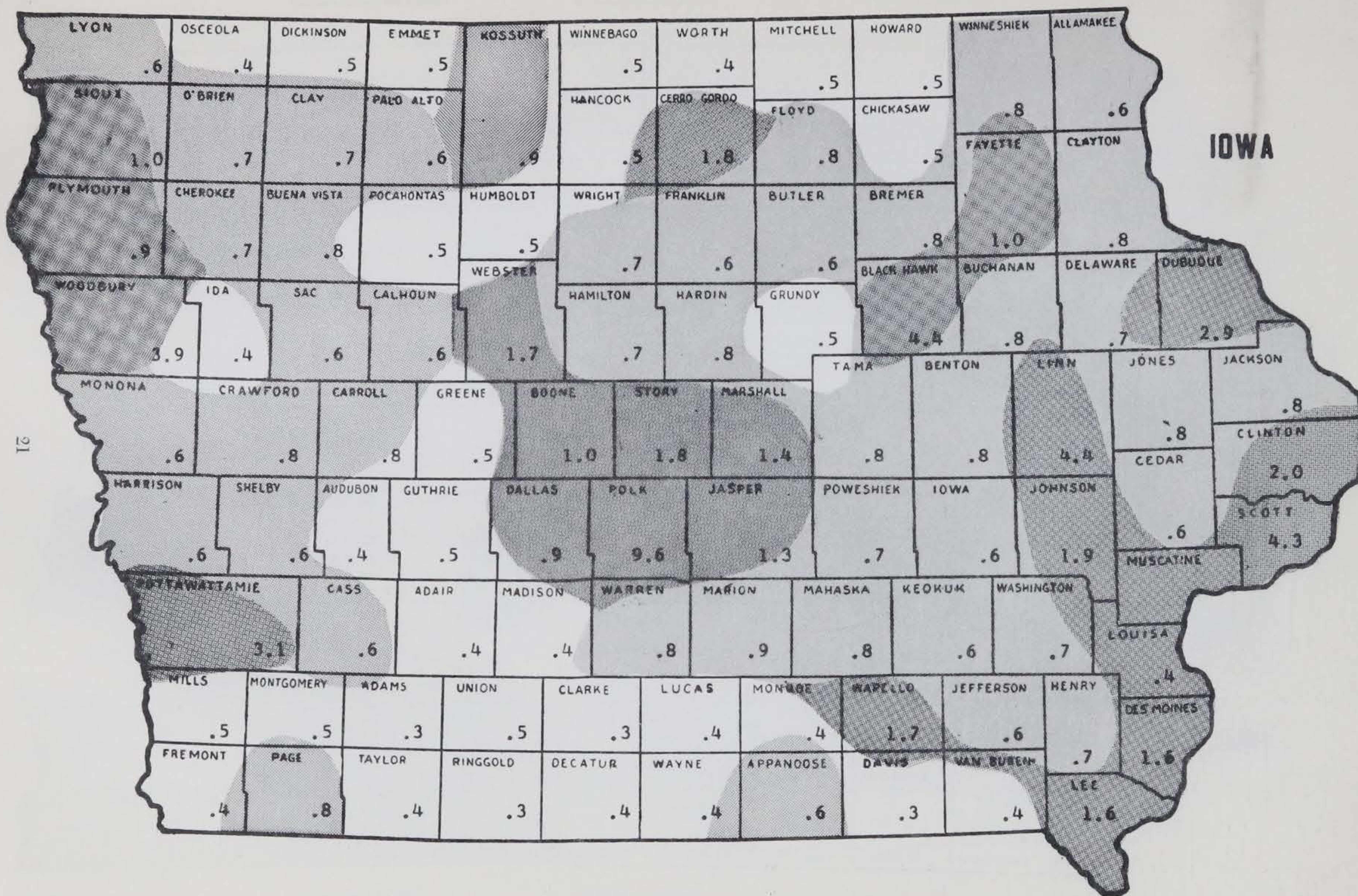
Sources: U. S. Census of Population: 1960.
Project 1497, Agricultural Experiment Station, Iowa State University, Ames, Iowa.

Figure 5
PER CENT OF TOTAL STATE POPULATION BY COUNTY, 1900



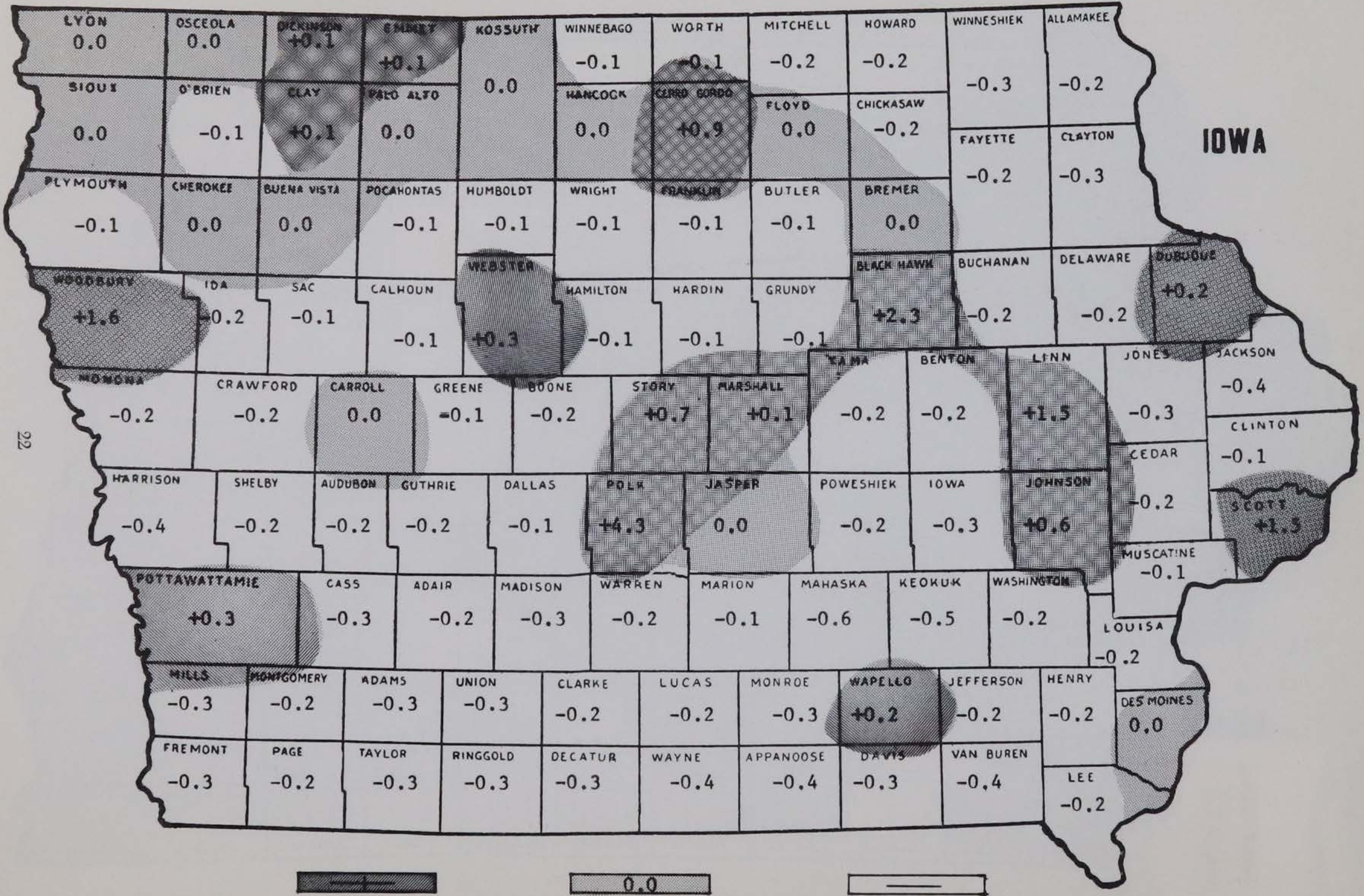
Source: U. S. Census of Population: 1960.

Figure 6
PER CENT TOTAL STATE POPULATION BY COUNTY 1960



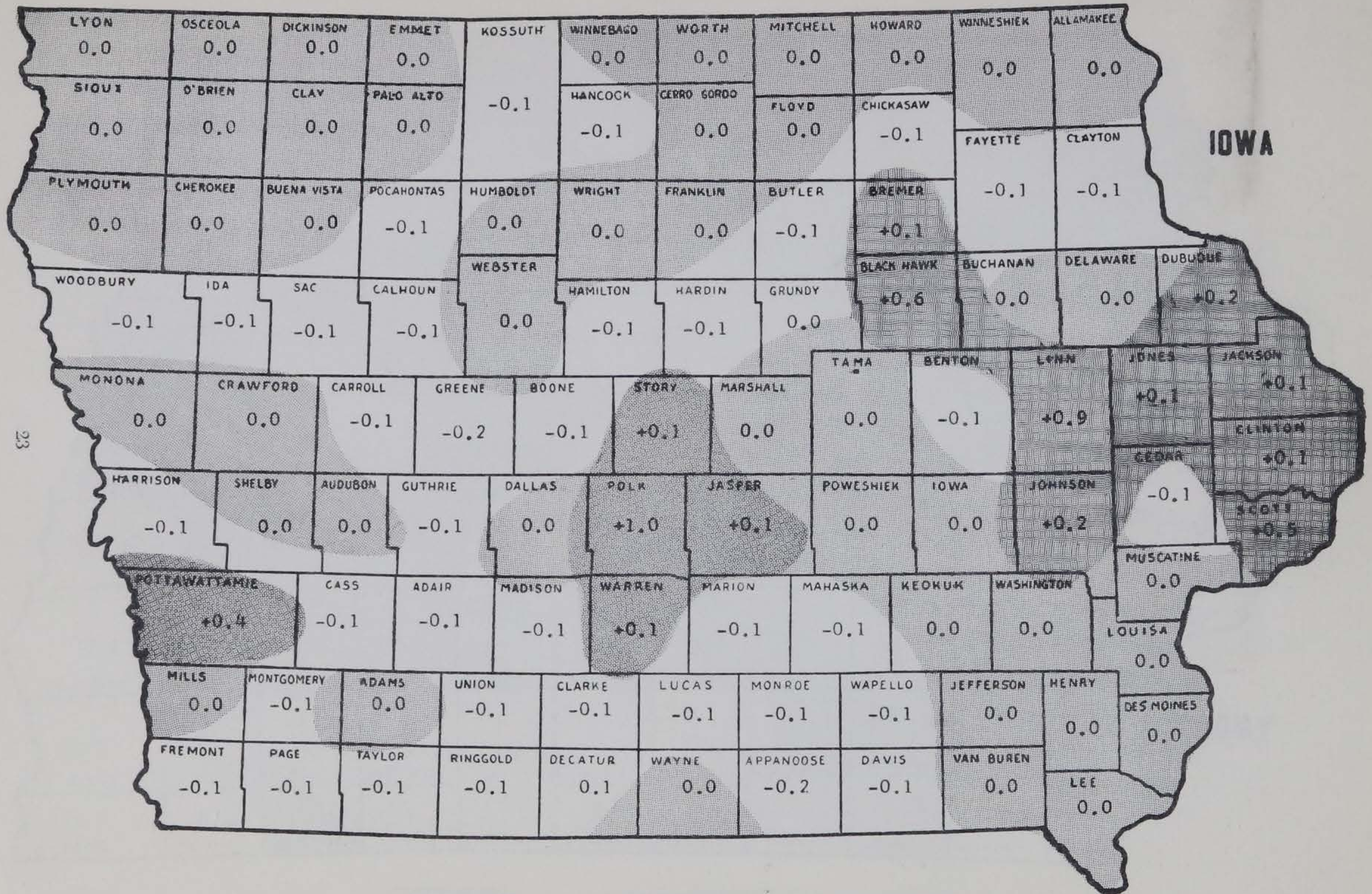
Source: U. S. Census of Population: 1960.

Figure 7
POPULATION, CHANGE IN COUNTY PERCENTAGES, 1900-1950



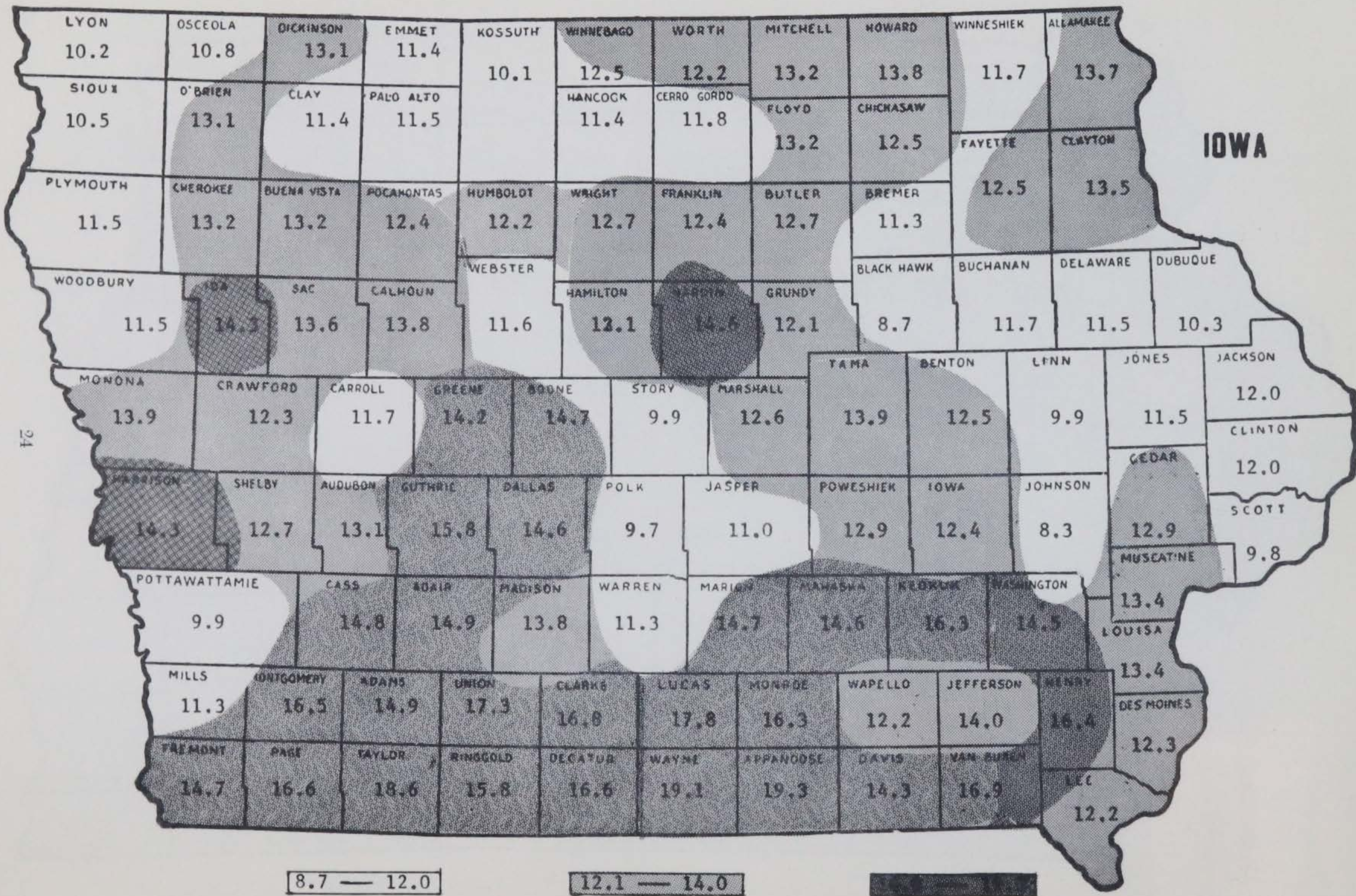
Source: U. S. Census of Population, 1960.

Figure 8
POPULATION, CHANGE IN COUNTY PERCENTAGES, 1950-1960



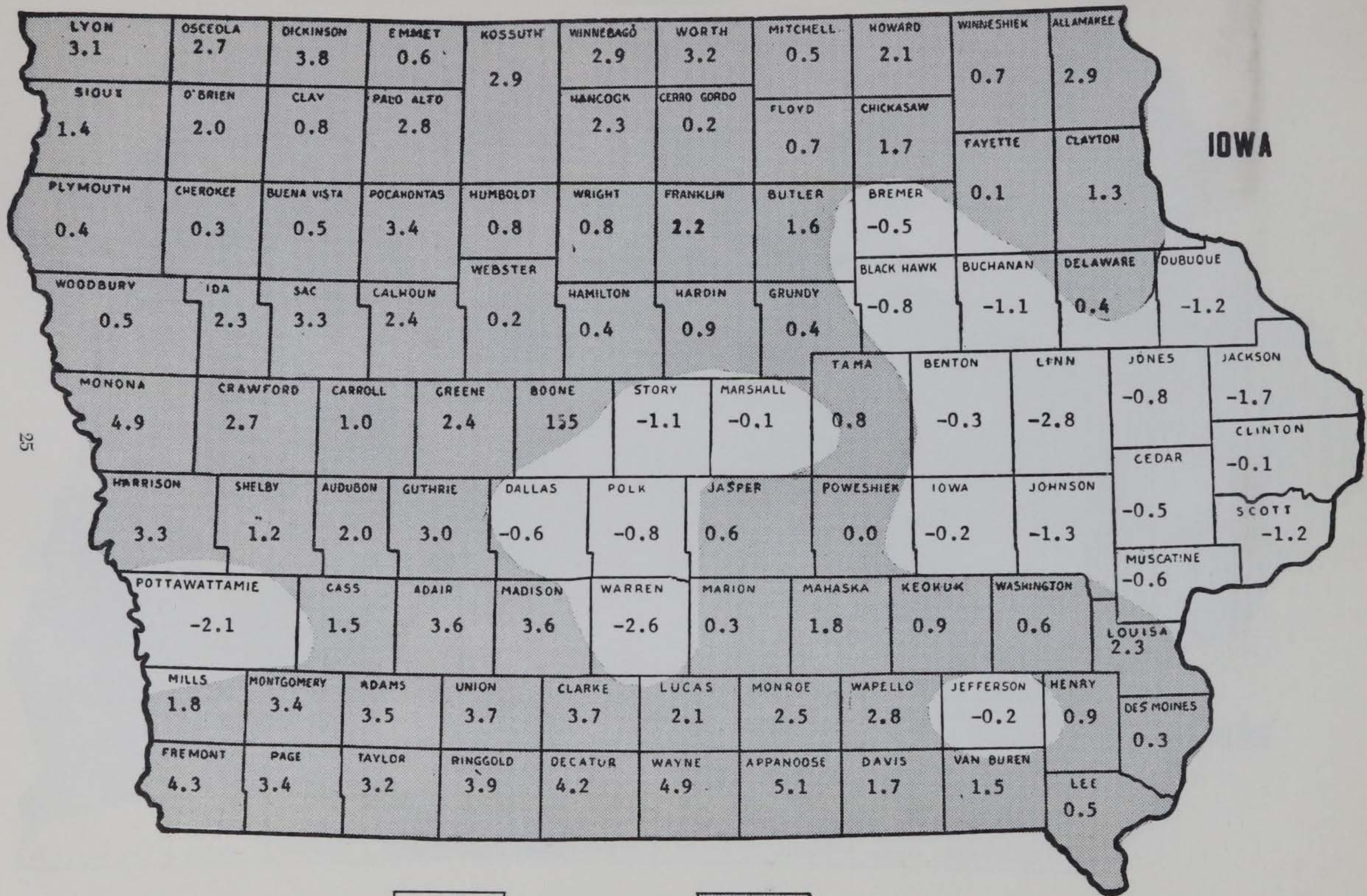
Source: U. S. Census of Population: 1960.

Figure 9
POPULATION 65 AND OVER, BY PER CENT, IN EACH COUNTY 1960



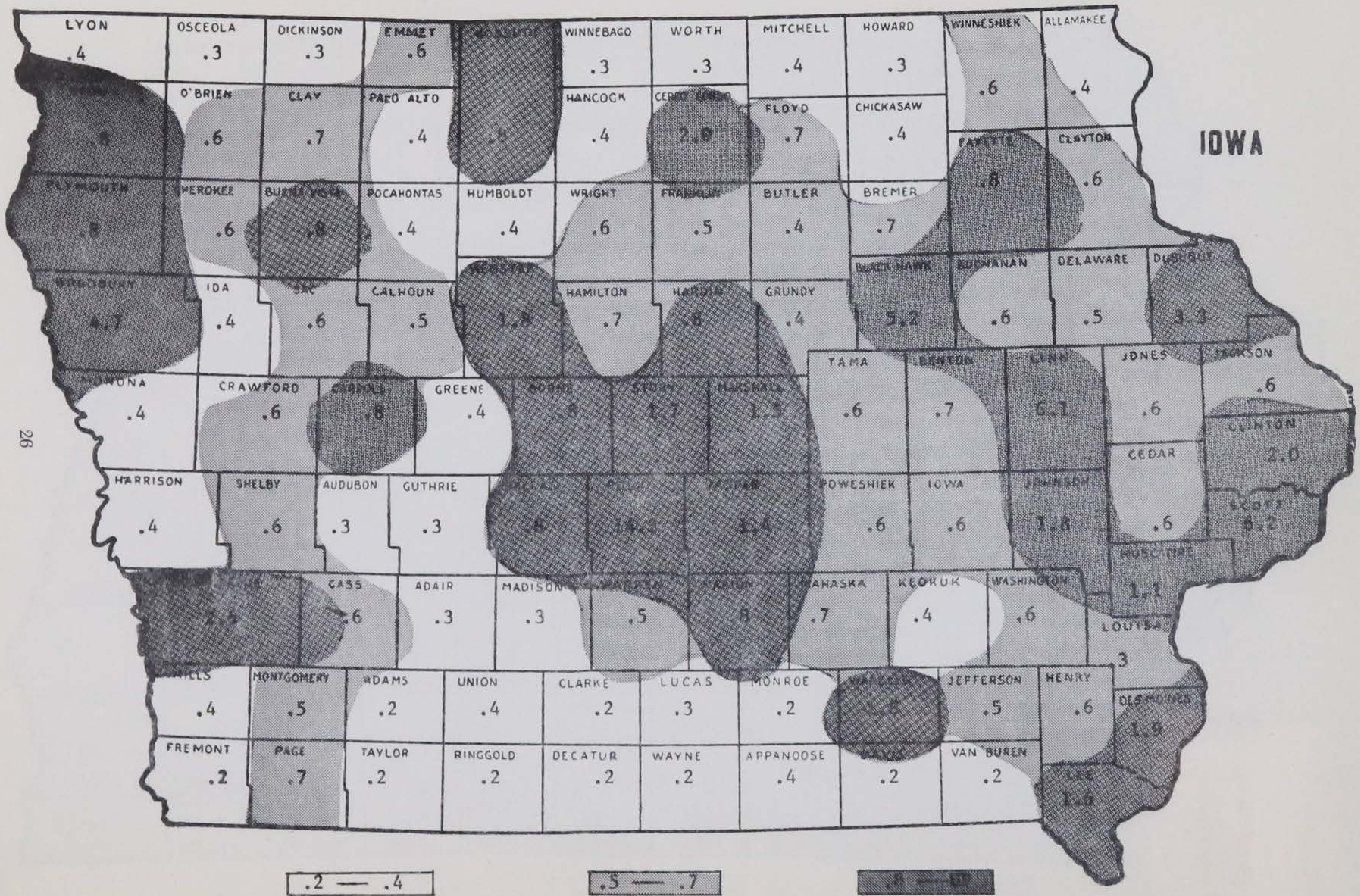
Source: U. S. Census of Population: 1960.

Figure 10
POPULATION 65 AND OVER, PER CENT CHANGES IN EACH COUNTY, 1960-1975



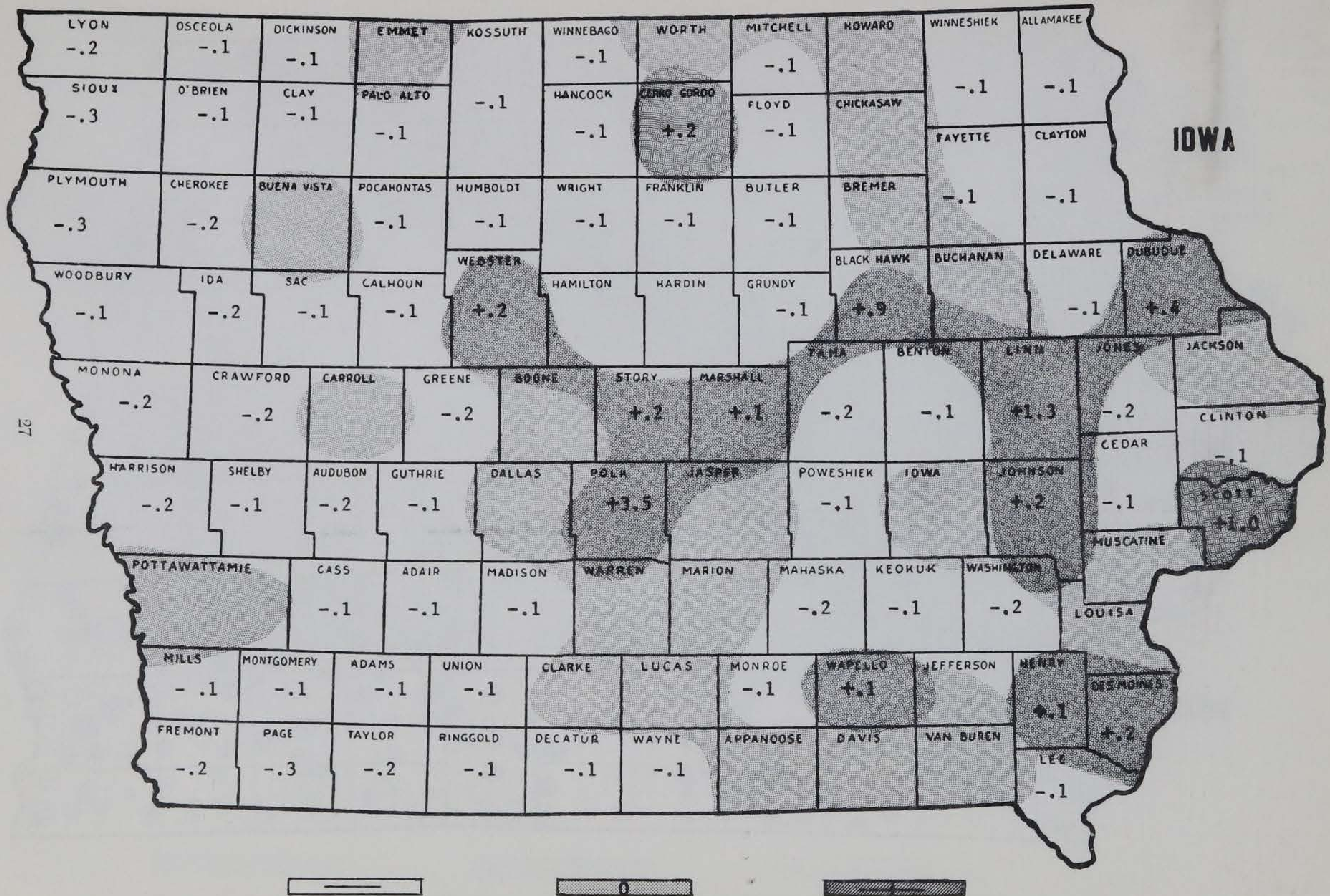
Sources: U. S. Census of Population: 1960.
Project 1497, Agricultural Experiment Station, Iowa State University, Ames, Iowa.

Figure 11
PERCENTAGE OF TOTAL STATE PERSONAL INCOME BY COUNTY, 1960



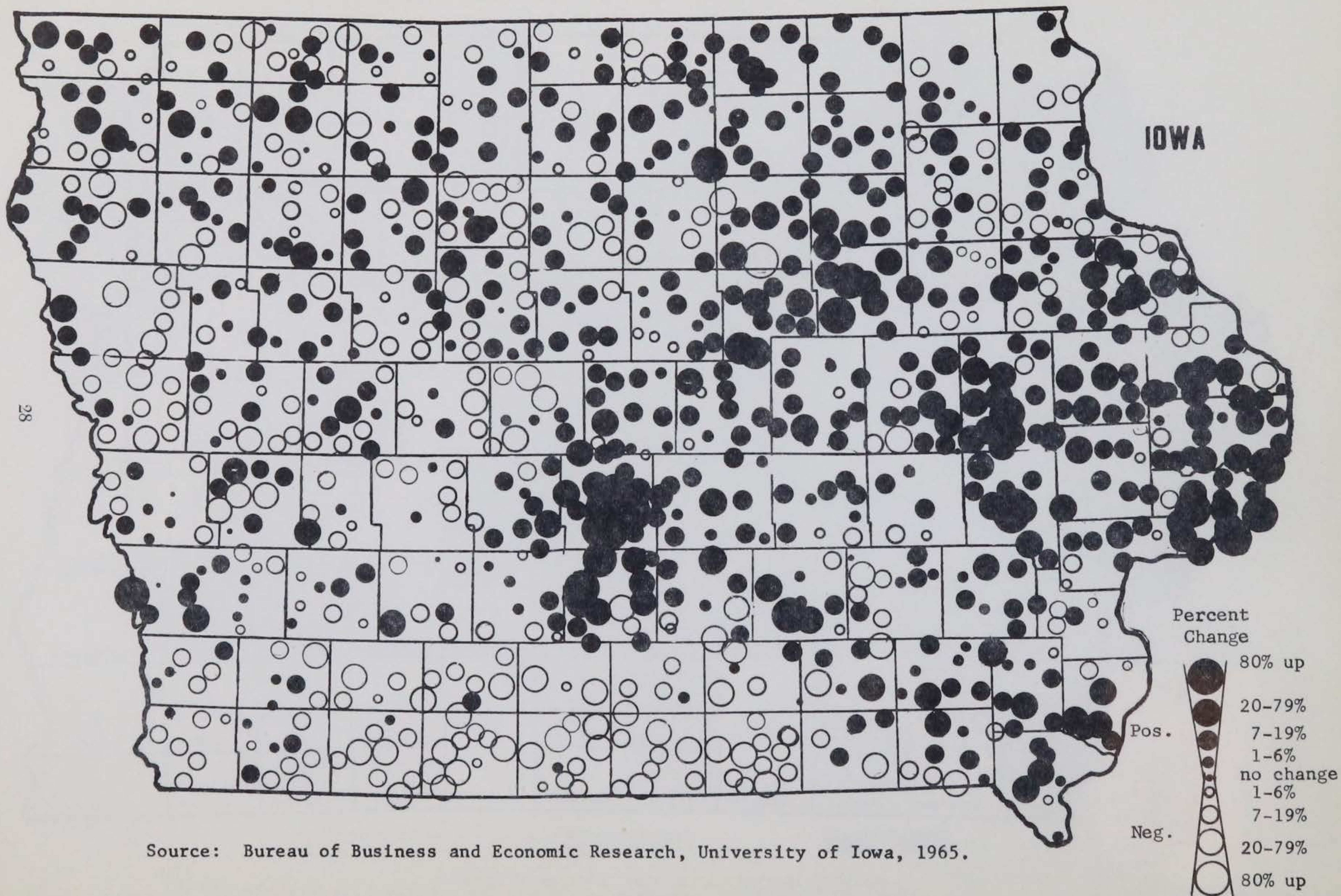
Source: Bureau of Business and Economic Research, University of Iowa.

Figure 12
PERSONAL INCOME, PER CENT CHANGE 1950-1960



Source: Bureau of Business and Economic Research, University of Iowa.

Figure 13
PER CENT CHANGE IN POPULATION OF INCORPORATED TOWNS, 1950-1960



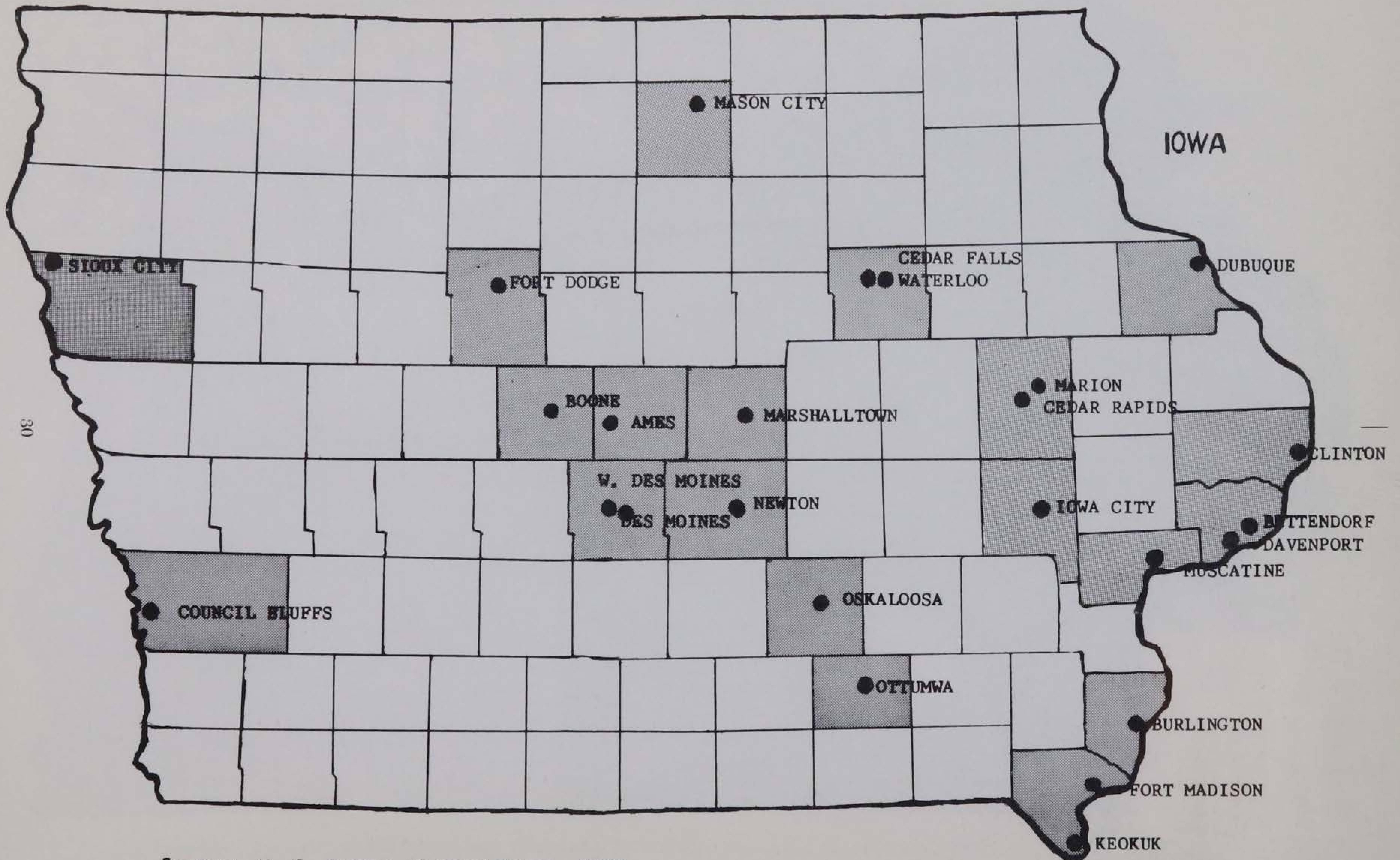
Source: Bureau of Business and Economic Research, University of Iowa, 1965.

Figure 14
GROWTH AND DECLINE OF URBAN PLACES

Source: Bureau of Business and Economic Research, University of Iowa, 1965.

IOWA STATE TRAVELING LIBRARY
DES MOINES, IOWA

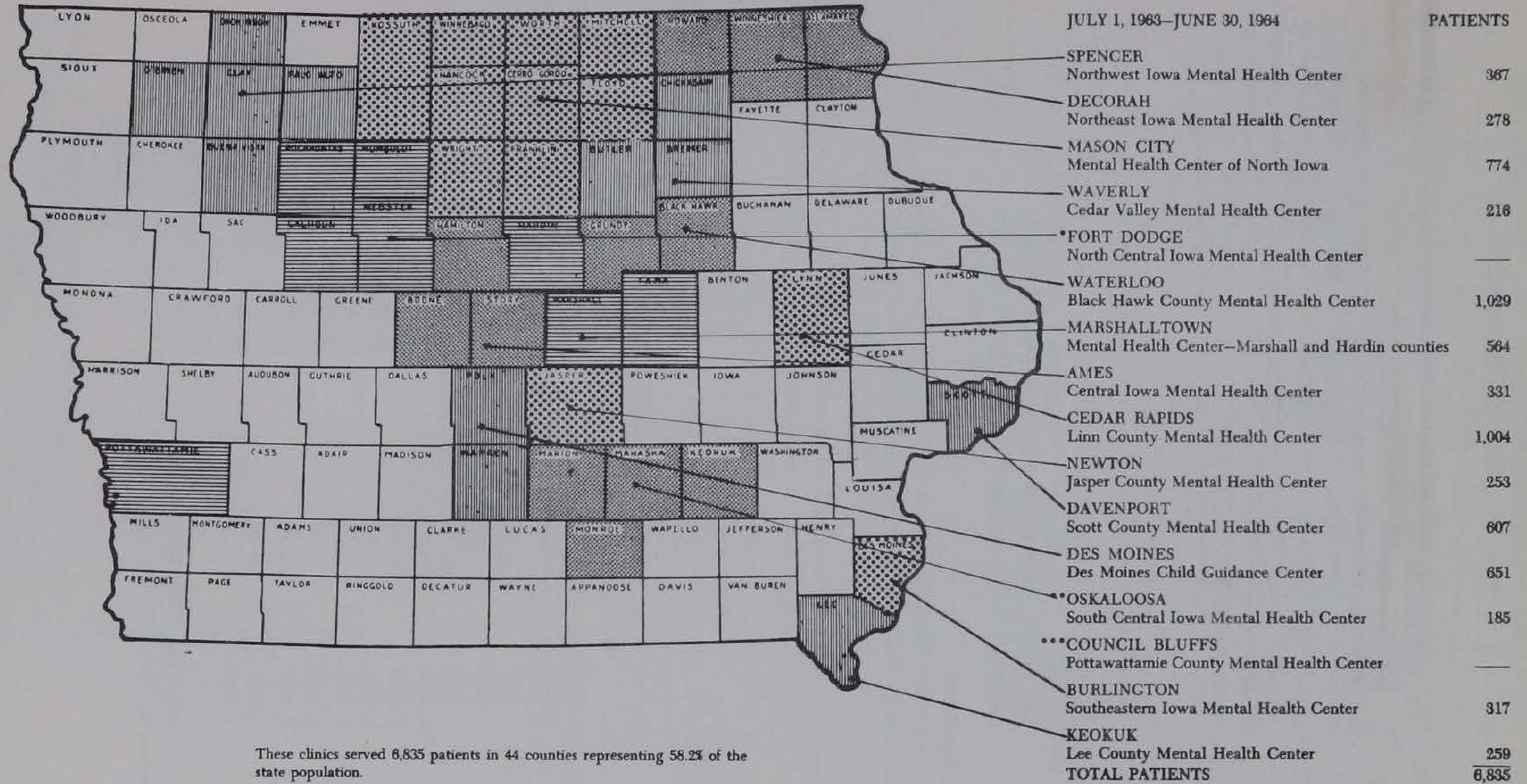
Figure 15
URBAN PLACES 10,000 OR LARGER, 1960



Source: U. S. Census of Population: 1960.

Figure 16
IOWA COMMUNITY MENTAL HEALTH CENTERS

Location, Area and Population Served



JULY 1, 1963–JUNE 30, 1964	PATIENTS
SPENCER Northwest Iowa Mental Health Center	367
DECORAH Northeast Iowa Mental Health Center	278
MASON CITY Mental Health Center of North Iowa	774
WAVERLY Cedar Valley Mental Health Center	216
*FORT DODGE North Central Iowa Mental Health Center	—
WATERLOO Black Hawk County Mental Health Center	1,029
MARSHALLTOWN Mental Health Center–Marshall and Hardin counties	564
AMES Central Iowa Mental Health Center	331
CEDAR RAPIDS Linn County Mental Health Center	1,004
NEWTON Jasper County Mental Health Center	253
DAVENPORT Scott County Mental Health Center	607
DES MOINES Des Moines Child Guidance Center	651
**OSKALOOSA South Central Iowa Mental Health Center	185
***COUNCIL BLUFFS Pottawattamie County Mental Health Center	—
BURLINGTON Southeastern Iowa Mental Health Center	317
KEOKUK Lee County Mental Health Center	259
TOTAL PATIENTS	6,835

These clinics served 6,835 patients in 44 counties representing 58.2% of the state population.

*North Central Iowa MHC opens fall, 1964
**South Central MHC opened September 1, 1963
***Pottawattamie County MHC opens fall, 1964

August 15, 1964

Table 1
TOTAL POPULATION, NATURAL INCREASE AND NET MIGRATION, IOWA BY DECADES 1920-1960

Decades	1 Actual Population at beginning of decade	2 Excess of births over deaths during decade (Natural Increase)	3 Potential population (1+2)	4 Actual population at end of decade	5 Net Number (4-3)	6 Migration for decade As a percentage of actual population at beginning of decade (5+1)	Net migration as a percentage of the natural increase (5÷2)
1920-1930	2, 404, 021	228, 336	2, 632, 357	2, 470, 939	-161, 418	-6. 7	70. 7
1930-1940	2, 470, 939	171, 494	2, 642, 433	2, 538, 268	-104, 165	-4. 2	60. 7
1940-1950	2, 538, 268	280, 750	2, 819, 018	2, 621, 073	-197, 945	-7. 8	70. 5
1950-1960	2, 621, 073	365, 071	2, 986, 144	2, 739, 299	-246, 845	-9. 4	67. 6

Sources: U. S. Census of Population
Division of Vital Statistics, Iowa Department of Health, Des Moines, Iowa
Federal Security Agency, National Office of Vital Statistics, Washington, D. C.

Table 2

Town size	Number of towns	Cumulative totals	Per cent of total number of towns
0-49	312	312	20. 14
50-99	170	482	11. 01
100-249	366	848	23. 70
250-499	245	1, 093	15. 86
500-999	221	1, 314	14. 31
1, 000-1, 999	111	1, 425	7. 18
2, 000-4, 999	61	1, 486	3. 95
5, 000-9, 999	33	1, 519	2. 13
10, 000-19, 999	8	1, 527	0. 51
20, 000-29, 999	5	1, 532	0. 30
30, 000	12	1, 544	0. 77

Source: Clark, William A. V., Iowa-The Urban Background. (Unpublished Dissertation, The University of Iowa, 1964.)

Table 3
PER CENT CHANGE IN POPULATION INCORPORATED TOWNS, 1950-1960

Percentage	Positive Per Cent Change	Negative Per Cent Change
	Number of Towns	Number of Towns
0-5	142	114
5-10	106	107
10-20	145	134
20-30	52	47
30-40	30	17
40-50	8	4
50-60	7	1
60-70	3	
70-80	1	
80-90	5	1
90-100	3	
100	10	
	512	425

Source: Clark, William A. V., Iowa-The Urban Background, (Unpublished Dissertation, The University of Iowa, 1964.)

Table 4
PER CENT CHANGE IN TOWN POPULATION
AS RELATED TO TOWN SIZE CLASS
1950-1960

Town size class	Number of towns in town size class	1950-1960 Mean population per cent changes
100-250	216	- 3.2
250-500	223	3.4
500-1,000	213	6.4
1,000-2,500	135	10.6
2,500-5,000	47	33.5
5,000-10,000	33	18.5
over 10,000	23	26.4
TOTAL	890	

Source: Clark, William A. V., Iowa-The Urban Background, (Unpublished Dissertation, The University of Iowa, 1964.)

Table 5
PER CENT EMPLOYMENT

Town Size Class	Agriculture	Mining	Construction	Manufacturing	Public Utilities	Wholesale	Retail	Finance	Services	Gov't.
10,000	.60	.17	5.03	43.90	6.00	5.74	15.66	3.13	15.59	4.18
5,000-10,000	.72	1.22	6.20	18.58	5.82	5.55	25.68	3.49	24.46	8.29
2,500- 5,000	1.17	.95	6.91	23.02	5.11	6.18	22.51	2.87	19.66	11.61
1,000- 2,500	1.70	1.17	3.71	13.88	6.37	6.70	30.39	5.91	23.10	7.07
500- 1,000	3.61	1.43	5.46	8.78	7.77	8.88	29.11	4.03	28.68	2.25
0- 500	1.79	1.51	4.76	4.85	7.71	13.05	29.19	3.86	30.78	2.51

Source: K. A. Scheld, A Comparative Analysis of the Level and Composition of Economic Activity in 144 Iowa Towns. (Unpublished Dissertation, The University of Iowa, 1963.)

Table 6
PER CENT EMPLOYMENT IN MAJOR
ECONOMIC CATEGORIES

Agriculture	1.07
Mining	.77
Construction	5.32
Manufacturing	28.04
Public Utilities, Transport, Communications	6.20
Wholesale Trade	6.36
Retail Trade	22.28
Finance, Insurance, Real Estate	3.39
Service Trade	21.01
Government	3.37

Source: K. A. Scheld, A Comparative Analysis of the Level and Composition of Economic Activity in 144 Iowa Towns, (Unpublished Dissertation, The University of Iowa, 1963.)

Table 7
SELECTED CHARACTERISTICS OF COMMODITIES
(Mean Values)

Study #	Brief Description	Town of Maximum Purchase: Miles to X	Miles to S.D.	Pop. of (000) X	Pop. of (000) S.D.	Dollars X	Dollars S.D.
1	Food & drink away	10.7	12.1	1.8	4.6	126	177
2	Personal care items	10.7	16.7	1.4	3.7	30	28
3	Clothing, men's	15.6	17.0	2.5	4.8	110	94
4	Clothing, women's	30.3	57.7	10.6	45.2	101	97
5	Clothing, boys	15.6	11.4	2.3	4.1	128	110
6	Clothing, girls	29.3	53.4	6.8	25.9	123	101
7	Clothing, gifts	17.7	19.1	3.3	5.5	48	52
8	Major appliances	14.5	24.5	4.6	32.9	290	262
9	Minor appliances	26.0	44.1	12.5	54.7	75	92
10	Furniture	18.7	17.6	3.2	5.6	142	159
11	Textiles	20.5	24.8	3.5	5.9	22	29
12	Glassware & Silver	14.6	31.0	1.7	4.4	11	13
13	Fuel, house	7.8	6.8	0.7	2.4	198	101
14	Repairs, house	12.2	18.3	1.7	4.5	279	649
15	Physician & Chiropractor	13.6	23.5	1.5	4.2	100	110
16	Dentist	11.1	7.6	1.2	3.0	60	69
17	Medicines, prescribed	11.5	19.3	1.7	4.6	53	76
18	Medicines, not prescribed	9.2	7.6	1.0	2.6	15	14
19	Movies	16.7	31.5	4.2	23.0	14	19
20	Sporting goods	14.1	19.5	1.5	2.4	17	22
21	Hobby Equipment	13.3	23.0	1.9	4.2	20	46
22	Toys	15.0	11.5	2.6	4.5	48	150
23	Pets & pet care	13.4	8.6	1.3	2.8	5	11
24	Car, running costs	7.2	7.4	0.7	2.3	245	183
25	Church	5.4	4.1	0.4	1.4	162	200
26	Gifts, organizational	9.3	15.3	1.1	3.0	17	43
27	Beauty & barber	7.4	9.5	0.7	2.0	44	31
28	Dry Cleaning	10.6	9.5	1.1	2.6	21	20
29	Shoe Repair	9.5	6.0	1.0	2.2	6	5
30	Food Locker	9.9	23.8	1.9	20.9	32	25
31	Repairs, TV & Appliance	7.9	5.9	0.7	2.0	27	23
32	Car Purchase	19.7	23.9	2.2	4.8	1,221	914
33	Food	7.8	5.3	0.9	2.0	848	364

Source: Inter-College Community Research Center, Business Impact Study, 1960.

Table 8
EXAMPLE OF INDIVIDUAL COUNTY TABULATION

Age	1960 Total	1960 Male	1960 Female	1965 Total	1965 Male	1965 Female
0-14	43, 134	22, 124	21, 010	51, 094	25, 593	25, 501
15-19	9, 429	4, 399	5, 030	13, 956	6, 717	7, 239
20-34	27, 837	13, 345	14, 492	31, 385	15, 144	16, 241
35-44	17, 452	8, 703	8, 749	18, 968	9, 562	9, 406
45-64	25, 552	12, 423	13, 129	27, 106	13, 220	13, 886
65+	13, 495	5, 818	7, 677	14, 254	6, 101	8, 153
Totals	136, 899	66, 812	70, 087	156, 763	76, 337	80, 426
%		48. 8	51. 2		48. 7	51. 3

Age	1970 Total	1970 Male	1970 Female	1980 Total	1980 Male	1980 Female
0-14	60, 633	30, 546	30, 087	93, 722	46, 737	46, 985
15-19	16, 761	7, 581	9, 180	21, 375	9, 553	11, 822
20-34	40, 725	19, 436	21, 289	67, 730	32, 263	35, 467
35-44	20, 000	10, 109	9, 891	26, 834	13, 343	13, 491
45-64	30, 331	14, 978	15, 353	35, 921	17, 959	17, 962
65+	14, 696	6, 168	8, 528	16, 233	6, 853	9, 380
Totals	183, 146	88, 818	94, 328	261, 815	126, 708	135, 107
%		48. 5	51. 5		48. 4	51. 6

Percentage change:

Period	Change
1965-70	+ 16. 8%
1960-70	+ 33. 8%
1970-80	+ 43. 0%

Towns 2, 500 and over	1960 Population
Mount Vernon	2, 593
Marion	10, 882
Cedar Rapids	92, 035

Sound housing with all plumbing

Year	%
1960	77. 5%

Personal income per capita

Year	Income
1950	$1, 770
51	1, 925
52	2, 060
53	2, 067
54	2, 086
55	2, 145
56	2, 322
57	2, 389
58	2, 399
59	2, 530
1960	2, 491
61	2, 482
62	2, 545

Retail sales per capita

Year	Sales
1954	$1, 303
1958	859
1963	1, 497

Real property per capita

Year	Property
1954	$ 913
1958	1, 191
1963	1, 384

Labor force unemployed

Year	%
1950	1. 6%
1960	2. 4%

Note: Tables such as this are available for each of the 99 counties of Iowa. Write the Iowa Mental Health Authority.

DATA SOURCES

POPULATION PROJECTIONS

The population estimates upon which these tables are based were prepared according to the Hamilton-Perry method under the auspices of Project 1497 on population projections by the Agriculture Experiment Station at Iowa State University, Ames, Iowa.

The calculations for the age categories used, column totals, sex ratios, and percentage change (1965-70, etc.) were done by the Bureau of Business and Economic Research, University of Iowa, Iowa City, Iowa.

TOWNS 2,500 AND OVER, 1960

United States Census of Population, 1960, Iowa, Number of Inhabitants.

PERSONAL INCOME PER CAPITA

Estimates of county personal income by the Bureau of Business and Economic Research.

County population:

Census years—*United States Census of Population.*

Other years—*Annual Reports, Division of Vital Statistics, Iowa State Department of Health (Iowa, Vital Statistics).*

RETAIL SALES PER CAPITA

Retail sales from *Census of Business, Retail Trade—Area Statistics.*

County population from *United States Census of Population and Iowa, Vital Statistics.*

SOUND HOUSING WITH ALL PLUMBING

County and City Data Book, 1952

Table 3—Selected Data for All Counties.

County and City Data Book, 1962

Table 2—Counties. This category of housing is defined by the Census as follows:

The census enumerator determined the condition of each housing unit by observation, on the basis of specified criteria related to the extent or degree of visible defects. The application of these criteria necessarily involved some judgment on the part of the individual enumerator.

Sound housing is defined as housing with no defects or only slight defects which are normally corrected during the course of regular maintenance. Examples of slight defects are lack of paint, minor damage to porch or steps, small cracks in walls, plaster, or chimneys, and broken gutters or downspouts.

A housing unit with all plumbing facilities is one which has hot and cold running water inside the structure, and flush toilet and bathtub (or shower) inside the structure for the exclusive use of the occupants.

The two other broad classifications of conditions used in the census are deteriorating housing and dilapidated housing. Deteriorating housing needs more repair than would be provided in the course of regular maintenance and has one or more defects of an intermediate nature that must be corrected if the unit is to continue to provide safe and adequate shelter. Dilapidated housing does not provide safe and adequate shelter and endangers the health, safety, or well-being of the occupants. Data for these classes are not presented here.

REAL PROPERTY PER CAPITA

Real property:

Iowa State Tax Commission Report, 1958

Final Adjusted Taxable Value of All Realty.

Iowa State Tax Commission Report, 1954

Net Taxable Value of All Realty.

Figures for these two years are comparable, even though the heading was changed.

County population from *Iowa, Vital Statistics.*

LABOR FORCE UNEMPLOYED

County and City Data Book, 1952

County and City Data Book, 1962

1960 figures were taken directly from the column headed Civilian Labor Force, 1960 Unemployed.

1950 figures were calculated using the columns Civilian Labor Force and Total Employed.

Mental Health Facilities and Personnel in Iowa

Iowa Mental Health Authority
December 28, 1964

This is a statewide inventory of Mental Health Facilities and Personnel which are considered essential in Comprehensive Mental Health Planning. Some Personnel and Facilities are not included, e.g., social welfare does make payments for nursing care rendered in other than the facilities covered in this report. For further information regarding any of these figures contact the Iowa Mental Health Authority.

Table I
STATEWIDE INVENTORY OF MANPOWER (1964)

MANPOWER TYPE	Total Number in State		Type of Setting									
	Mental Health	Non-Mental Health	Federal Mental Hospitals	State Mental Health Institutes	State Psychopathic Hospital	Private Mental Hospitals	General Hospitals with Psychiatric Units	Institutions for the Mentally Retarded	Residential Treatment Centers For Emotionally Disturbed Children	Mental Health Centers	Private Practice	Other**
Psychiatrists*	108	0	8	31	12	8	30	2	6	17	51	2
Psychiatric Residents	42	---	0	21	17	0	0	0	4	0	0	0
Psychologists	205	150 (est)	9	14	4	2	7	17	7	26	12	107
Social Workers	156	200 (est)	21	37	8	2	8	19	20	34	7	0
Nurses R.N.	354	N.A.	92	97	17	41	67	23	10	1	0	6
Psychiatric Aides and LPN's	2057	---	398	918	75	81	76	458	51	0	0	0
Occupational Therapists	12	32	4	5	2	0	1	0	0	0	0	0
Recreational Therapists	5	---	3	0	1	0	0	0	0	0	0	1
Vocational Rehabilitation Counselors	40	---	0	4	0	0	0	0	0	0	0	36
Special Education Teachers	550	---	0	7	0	2	0	42	11	0	0	488
Others***	----	---	76	31	11	83	24	102	12	5	0	0

*Some of the psychiatrists in private practice are also listed under mental health centers and general hospitals.

**Includes transitional service, student health setting, full-time administration, etc.

***Includes physicians, speech therapists, physical therapists, and activity therapists.

Table II
STATEWIDE INVENTORY OF PSYCHIATRIC FACILITIES (1963)

TYPE OF FACILITY	Total Number in State	INPATIENT: Number of Beds or Accommodations	INPATIENT: Total Admissions per Year	INPATIENT: Total Separations per Year	INPATIENT: Patients on Rolls End of Year	OUTPATIENT: Total Admissions per Year	OUTPATIENT: Total Separations per Year	OUTPATIENT: Patients on Rolls End of Year	PERSONNEL: Psychiatrists	PERSONNEL: Psychologists	PERSONNEL: Social Workers	PERSONNEL: Nurses	PERSONNEL: Psychiatric Aides	PERSONNEL: Other*
Mental Hospitals	10	6, 509	9, 234	9, 511	4, 749	3, 893	3, 821	1, 999	59	29	68	247	1, 472	236
General Hospitals with Psychiatric Units	12	241	3, 673	--	--	180	225	143	30	7	8	67	76	25
General Hospitals with Psychiatric Facilities	6	--	458	458	--	--	--	--	6	--	--	--	---	--
Mental Health Centers	16	--	--	- -	--	4, 197	3, 967	3, 029	17	26	34	1	0	5
Residential Treatment Centers for Emotionally Disturbed Children	5	185	249	185	149	303	300	(est) 26	6	7	20	10	51	23
Institutions for the Mentally Retarded	2	3, 783	1, 278	1, 725	2, 273	--	--	--	2	17	19	23	458	102
TOTALS	51	10, 718	14, 892	11, 879	7, 171	8, 573	8, 313	5, 197	120	86	149	348	2, 057	381

*Includes physicians, occupational therapists, speech therapists, recreational counselors, etc.

Table III
INVENTORY OF MENTAL HOSPITALS (1963)

FACILITY	LOCATION		OWNERSHIP	AREA SERVED	INPATIENT				OUTPATIENT			PERSONNEL					
	COUNTY	TOWN			Number of Beds	Total Admissions per year	Total Separations per Year	Patients on Rolls End of Year	Total Admissions per Year	Total Separations per Year	Patients on Rolls End of Year	Psychiatrists	Psychologists	Social Workers	Nurses	Psychiatric Aides	Other*
Veterans Administration Hospital	Johnson	Iowa City	FED.		75	150	150	50	--	--	--	2	1	2	9	17	3
Veterans Administration Hospital	Marion	Knoxville	FED.		1, 515	780	651	1, 431	--	--	--	5	4	6	83	381	77
Veterans Administration Outpatient Clinic	Polk	Des Moines	FED.		--	--	--	--	160	109	140	1	4	13	0	0	3
Mental Health Institute	Cherokee	Cherokee	STATE		1, 272	1, 639	1, 750	712	717	950	386	8	3	12	26	219	9
Mental Health Institute	Page	Clarinda	STATE		1, 246	1, 340	1, 427	633	562	402	560	5	4	8	12	238	18
Mental Health Institute	Buchanan	Independence	STATE		1, 040	2, 397	2, 406	794	267	223	355	11	2	8	27	219	7
Mental Health Institute	Henry	Mt. Pleasant	STATE		896	1, 116	1, 237	756	472	437	278	6	4	8	30	212	8
Security Hospital	Jones	Anamosa	STATE		120	50	55	93	--	--	--	1	1	1	2	30	5
Psychopathic Hospital	Johnson	Iowa City	STATE		60	408	418	43	1, 715	(est.) 1, 700	(est.) 280	12	4	8	17	75	14
St. Joseph's	Dubuque	Dubuque	CH		117	772	815	100	--	--	--	4	1	2	19	48	79
St. Bernard's	Potta-wattamie	Council Bluffs	CH		168	582	602	137	--	--	--	4	1	0	22	33	6
TOTAL					6, 309	9, 234	9, 511	4, 749	3, 893	3, 821	1, 999	59	29	68	247	1, 472	229

*Includes physicians, occupational therapists, speech therapists, recreational counselors, etc.

Table IV
INVENTORY OF GENERAL HOSPITALS WITH PSYCHIATRIC UNITS (1963)

FACILITY	LOCATION		OWNERSHIP	AREA SERVED	INPATIENT		OUTPATIENT			PERSONNEL					
	COUNTY	TOWN			Total Number of Beds	Total Admissions per Year	Total Admissions per Year	Total Separations per Year	Patients on Rolls End of Year	Psychiatrists	Psychologists	Social Workers	Nurses	Psychiatric Aides	Other*
Allen Memorial	Black Hawk	Waterloo	CH		31	464				3	2	0	6	2	0
Broadlawns	Polk	Des Moines	CO		23	761	180	225	143	2	2	5	4	6	4
Iowa Methodist	Polk	Des Moines	CH		22	221				8	0	1	6	12	3
Burlington	Des Moines	Burlington	NPA		14	64				2	0	0	4	6	0
Mercy	Marshall	Marshalltown	CH		10	121				1	2	1	4	3	4
Mercy	Scott	Davenport	CH		25	517				3	0	0	10	12	4
Methodist	Woodbury	Sioux City	CH		14	171				2	0	0	6	7	0
Ottumwa	Wapello	Ottumwa	NPA		13	95				1	0	0	3	4	3
St. Luke's	Linn	Cedar Rapids	CH		37	620				4	0	1	7	7	6
St. Joseph's Mercy	Cerro Gordo	Mason City	CH		14	215				2	1	0	4	9	1
St. Joseph's Mercy	Woodbury	Sioux City	CH		38	424				2	0	0	13	8	0
Lutheran	Polk	Des Moines	CH	(Under Construction)											
TOTAL					241	3673	180	225	143	30	7	8	67	76	25

* Includes physicians, occupational therapists, speech therapists, recreational counselors, etc.

Table V
INVENTORY OF GENERAL HOSPITALS WITH PSYCHIATRIC FACILITIES (1964)

FACILITY	LOCATION		OWNERSHIP	TOTAL ADMISSIONS PER YEAR	PSYCHI-ATRISTS
	COUNTY	TOWN			
Mary Greeley Memorial Hospital	Story	Ames	CH	55	1
St. Joseph Mercy Hospital	Clinton	Clinton	CH	18	1
Jennie Edmundson Memorial Hospital	Pottawattamie	Council Bluffs	CH	161	1
Mahaska County Hospital	Mahaska	Oskaloosa	CO	4	1
Mary Francis Skiff Hospital	Jasper	Newton	CH	173	1
Mercy Hospital	Johnson	Iowa City	CH	47	1
TOTAL				458	6

Table VI
INVENTORY OF MENTAL HEALTH CENTERS (1964)

FACILITY	LOCATION		OWNERSHIP	AREA SERVED	Total Admissions per Year	Total Separations per Year	Patients on Rolls End of Year	PERSONNEL					
	COUNTY	TOWN						Psychiatrists	Psychologists	Social Workers	Nurses	Psychiatric Aides	Other*
Black Hawk County	Black Hawk	Waterloo	NPA		758	729	354	1	2	5	0	0	0
Cedar Valley	Bremer	Waverly	NPA		202	82	133	1	3	2	0	0	0
Central Iowa	Story	Ames	NPA		218	213	123	1	0	2	0	0	0
Des Moines Child Guidance Center	Polk	Des Moines	NPA		271	287	365	2	7	6	1	0	4
Jasper County	Jasper	Newton	NPA		265	168	97	1	1	1	0	0	0
Lee County	Lee	Keokuk	NPA		137	131	133	1	2	0	0	0	0
Linn County	Linn	Cedar Rapids	NPA		430	659	374	1	1	4	0	0	0
Marshall & Hardin Counties	Marshall	Marshalltown	NPA		363	339	235	1	3	1	0	0	0
North Iowa	Cerro Gordo	Mason City	NPA		495	610	168	2	3	3	0	0	0
North Central Iowa	Webster	Fort Dodge	NPA	Recruiting									
Northeast Iowa	Winneshiek	Decorah	NPA		185	124	168	1	0	2	0	0	0
Northwest Iowa	Clay	Spencer	NPA		152	57	312	1	1	2	0	0	0
Pottawattamie County	Potta-wattamie	Council Bluffs	NPA	Opened 1964									
Scott County	Scott	Davenport	NPA		362	358	261	2	2	4	0	0	1
South Central Iowa	Mahaska	Oskaloosa	NPA		195	122	73	1	1	1	0	0	0
Southeastern Iowa	Des Moines	Burlington	NPA		164	88	233	1	0	1	0	0	0
TOTALS					4197	3967	3029	17	26	34	1	0	5

* Includes physicians, occupational therapists, speech therapists, recreational counselors, etc.

Table VII
INVENTORY OF RESIDENTIAL TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN (1964)

FACILITY	LOCATION		OWNERSHIP	AREA SERVED	INPATIENT				OUTPATIENT			PERSONNEL					
	COUNTY	TOWN			Number of Beds	Total Admissions per Year	Total Separations per Year	Patients on Rolls End of Year	Total Admissions per Year	Total Separations per Year	Patients on Rolls End of Year	Psychiatrists	Psychologists	Social Workers	Nurses	Psychiatric Aides	Other*
Lutheran Children's Home	Bremer	Waverly	CH		54	14	15	40	--	--	--	1	1	7	1	0	0
Beloit	Story	Ames	CH		18	17	15	17	--	--	--	2	1	3	0	0	8
State Psychopathic Hospital	Johnson	Iowa City	STATE		23	63	55	11	303	(est) 300	(est) 26	1	3	4	9	17	3
Mental Health Institute	Buchanan	Independence	STATE		40	67	65	37	--	--	--	1	1	2	0	22	10
St. Mary's	Dubuque	Dubuque	CH		48	88	35	44	--	--	--	1	1	4	0	12	2
TOTAL					185	249	185	149	303	300	26	6	7	20	10	51	23

*Includes physicians, occupational therapists, speech therapists, recreational counselors, etc.

Table VIII
INVENTORY OF INSTITUTIONS FOR THE MENTALLY RETARDED (1963)

FACILITY	LOCATION		OWNERSHIP	AREA SERVED	Number of Beds	Total Admissions per Year	Total Separations per Year	Patients on Rolls End of Year	PERSONNEL					
	COUNTY	TOWN							Psychiatrists	Psychologists	Social Workers	Nurses	Psychiatric Aides	Other*
Glenwood	Mills	Glenwood	State		1877	749	920	1124	0	9	9	11	239	58
Woodward	Boone	Woodward	State		1906	529	805	1149	2	8	10	12	219	44
TOTAL					3783	1278	1725	2273	2	17	19	23	458	102

*Includes physicians, occupational therapists, speech therapists, recreational counselors, etc.

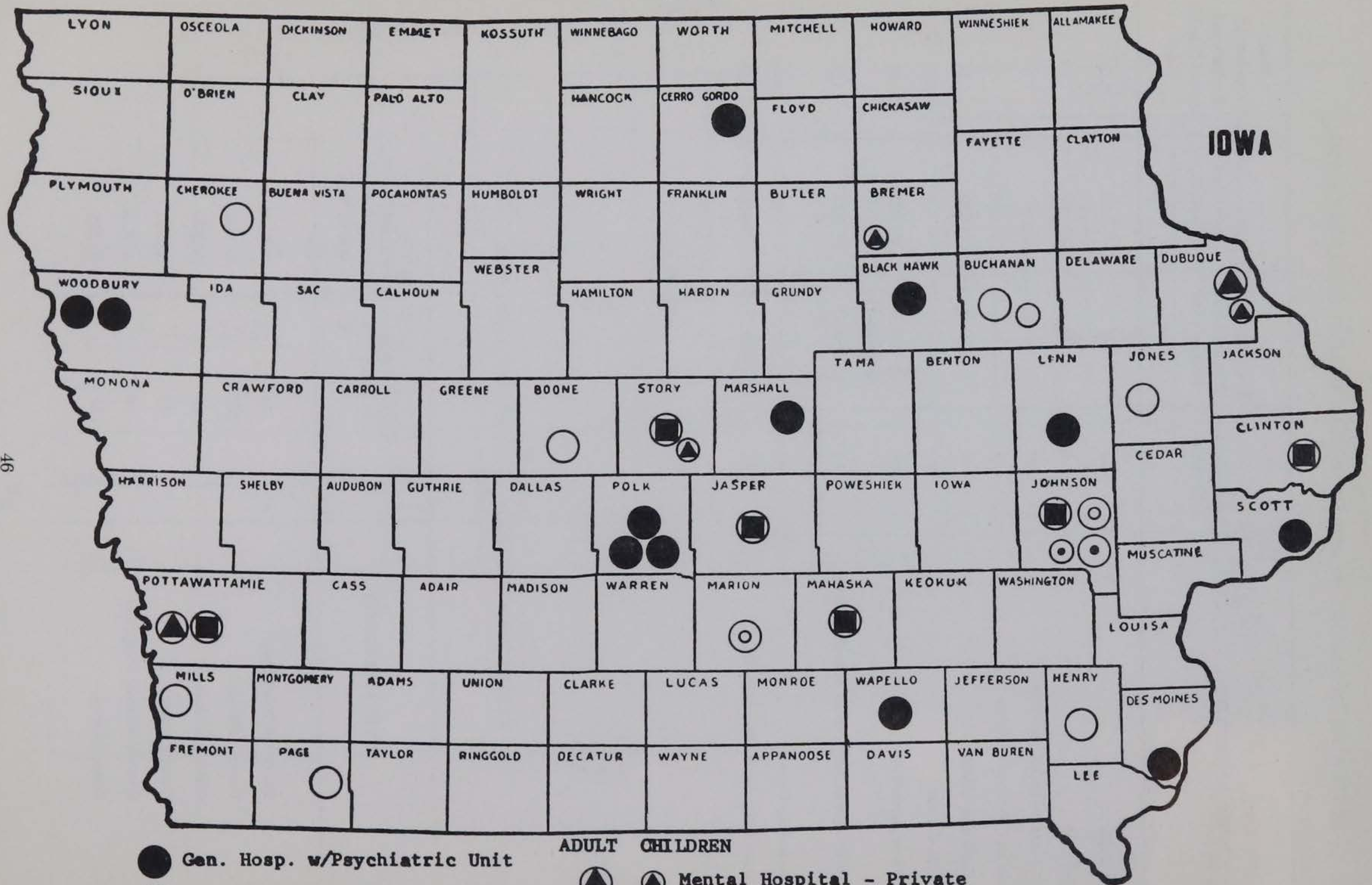
Table IX
STATEWIDE INVENTORY OF OTHER MENTAL HEALTH FACILITIES (1964)

TYPE OF FACILITY	Total Number In State	Total Estimated Persons Served During Year	Estimated Capacity	Total Number of Professional Mental Health Staff
Day-Night Units	--	---	---	---
Half-Way Houses	1	80	30	6
Outpatient Mental Health Services	--	---	---	---
Alcoholism and Narcotic Clinics	1	64	64	3
Mentally Retarded Clinics	2	530	530	11
Psychological Clinics	--	---	---	---
Family Service Agencies	8	3, 300 (Families)	3, 300	27
Special Psychological Services in School Systems	83 (Counties)	17, 000	17, 000	121
Marital Counseling Centers	--	---	---	---
Rehabilitation Services for Mentally Ill	16	846	846	40

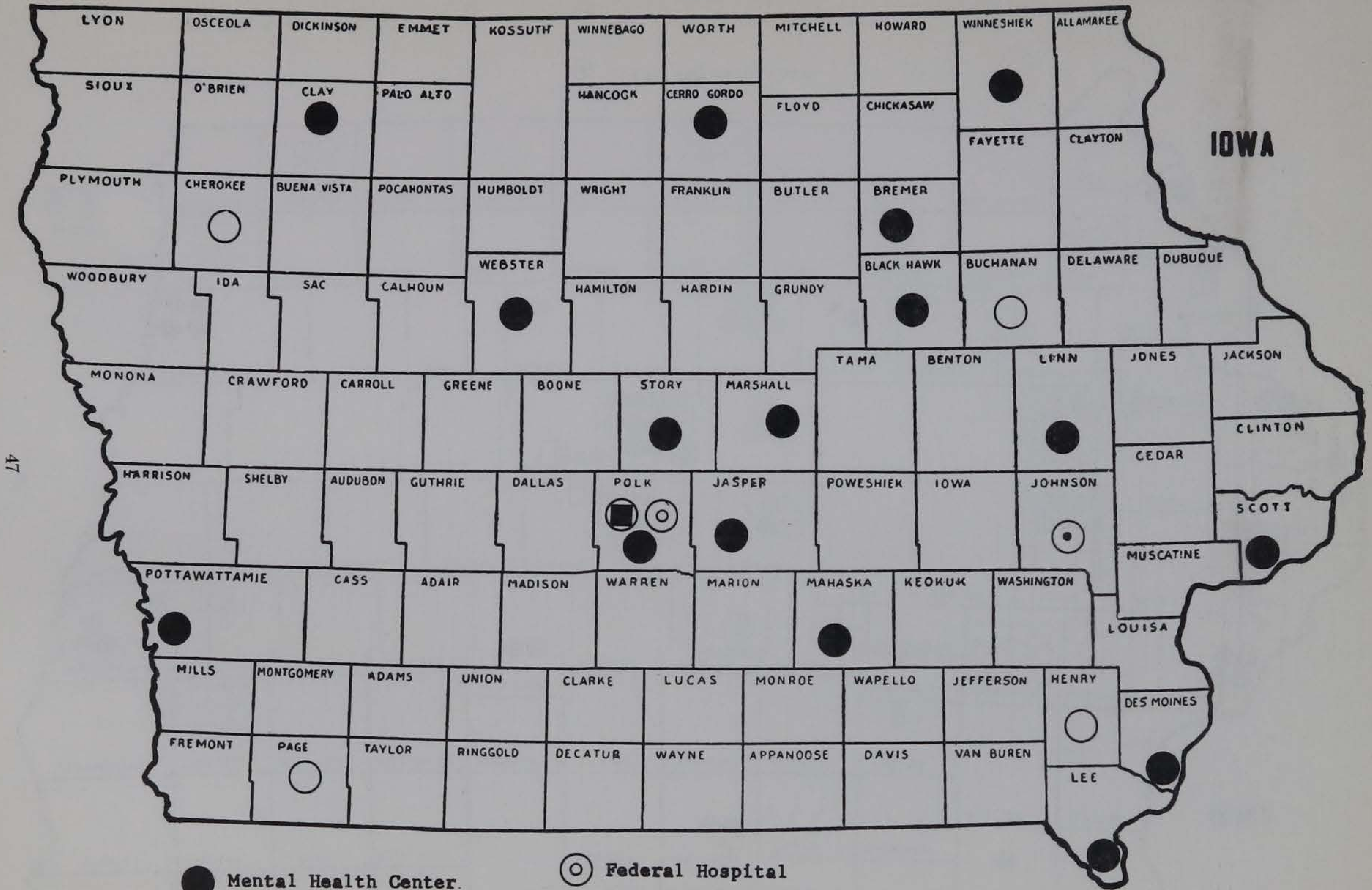
Table X
STATEWIDE INVENTORY OF AUXILIARY FACILITIES
(1964)

TYPE OF FACILITY	Total Number In State	Total Estimated Persons Served During Year
Sheltered Workshops	11	N. A.
Nursing Homes	427	16, 600
Custodial Homes	327	5, 300
County Homes	83	6, 200
Chronic Disease Hospitals	4	N. A.
Foster Homes	758	1, 895

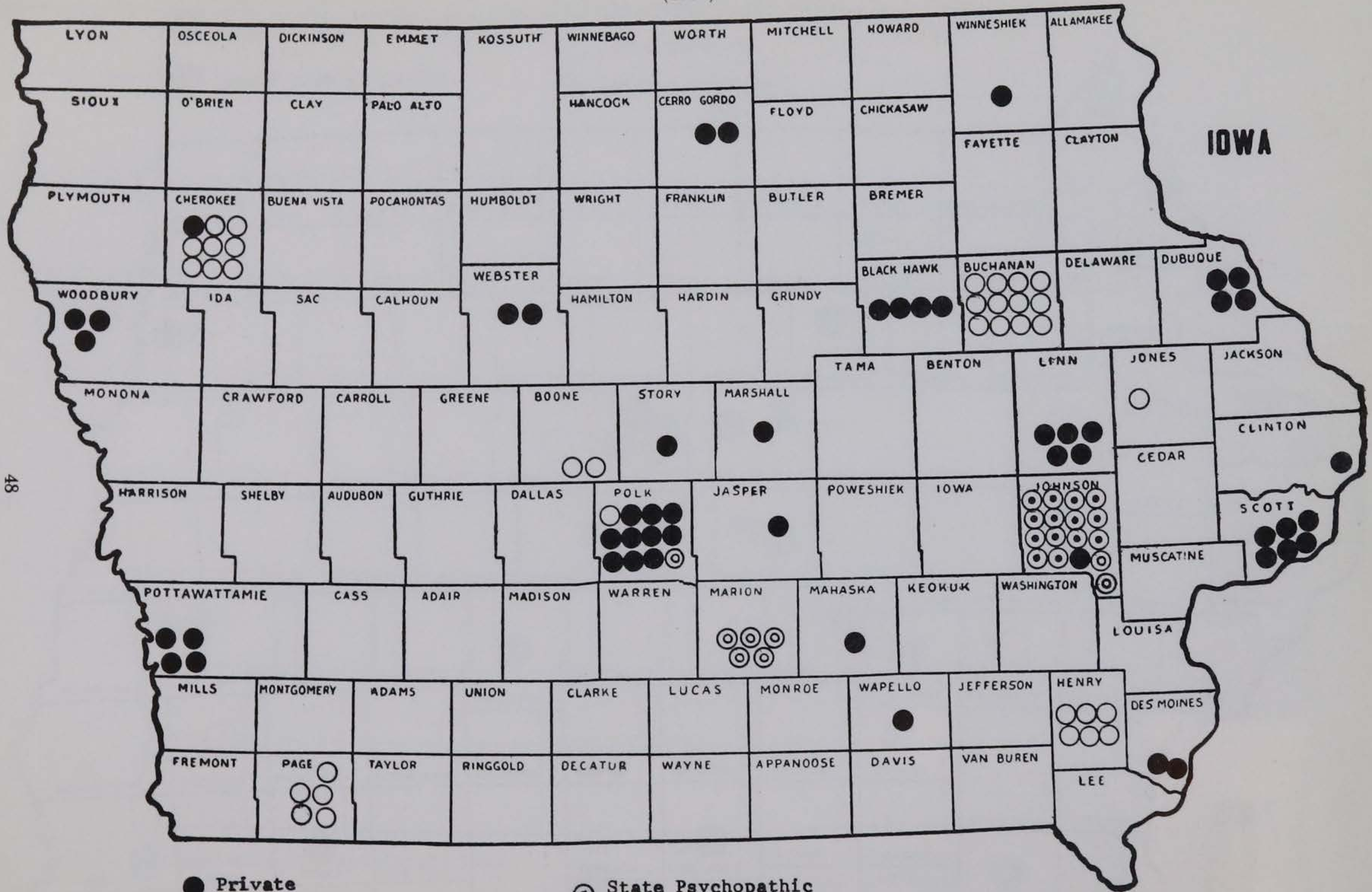
PSYCHIATRIC INPATIENT FACILITIES
(1964)



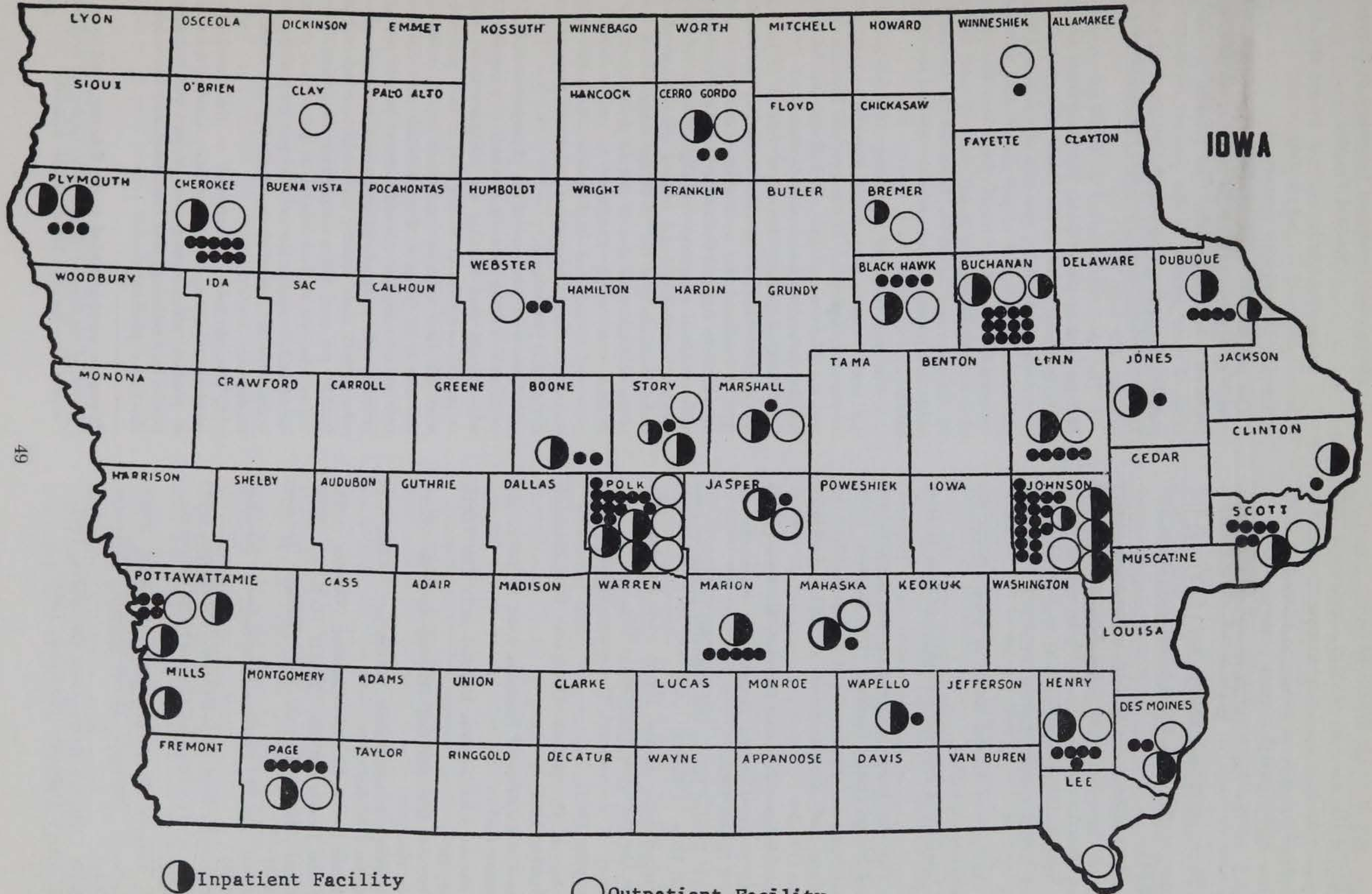
PSYCHIATRIC OUTPATIENT CLINICS
(1964)



PSYCHIATRISTS IN IOWA
(1964)



FACILITIES AND MANPOWER
(1964)



SOURCES OF INFORMATION

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2. Directory of Medical Specialists, Volume II (1963)
3. Biographical Directory of Fellows and Members of the American Psychiatric Association (1963)
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6. Directory of the Iowa Psychological Association, Inc. (1963-64)
7. A Handbook of Resources Available to Physicians (1963)
8. Board of Control of State Institutions 34th Biennial Report, (1963)
9. Iowa Mental Health Authority Manual (Community Mental Health Centers List of Personnel, October 1, 1964)
10. The Challenge of Mental Health in Iowa (IMHA 5th Biennial Report, 1961)
11. Fifth Directory of Psychiatric Facilities in Iowa (IMHA, 1959)
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14. Special Education Personnel Directory for Iowa (1963)
15. Annual Report—Licensed Hospitals in Iowa (Ia. St. Dept. of Health, 1962)
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17. A Comprehensive Mental Health Plan for Iowa—Facilities Questionnaires (Summer, 1964)
18. Directory of Recreational Therapists: William Smith (November, 1964)
19. Directory of Occupational Therapists: Mrs. Ehrenhaft (November, 1964)
20. Direct Confirmations of Personnel Data by Letter and Telephone for:
    a. Veterans Administration Hospital—Iowa City (October, 1964)
    b. Veterans Administration Hospital—Knoxville (October, 1964)
    c. Veterans Administration Outpatient Clinic—Des Moines (October, 1964)
    d. Mental Health Institute—Cherokee (October, 1964)
    e. Mental Health Institute—Clarinda (October, 1964)
    f. Mental Health Institute—Mt. Pleasant (October, 1964)
    g. Mental Health Institute—Independence (October, 1964)
    h. St. Joseph's Sanitarium—Dubuque (November, 1964)
    i. St. Bernard's Sanitarium—Council Bluffs (November, 1964)
    j. St. Joseph's Mercy—Sioux City (November, 1964)
    k. Lutheran Children's Home—Waverly (November, 1964)
    l. Beloit Children's Home—Ames (November, 1964)
    m. St. Mary's—Dubuque (November, 1964)

Mental and Emotional Symptoms in Private Medical Practice

*Richard Finn, M.D., and P. E. Huston, M.D.**

April 19, 1965

SUMMARY AND CONCLUSIONS

This report presents the results of a survey of full-time private medical practitioners in Iowa on the prevalence of emotional symptoms found in their patients, and the disposition of these patients. It also presents comments by the practitioners on the adequacy of their psychiatric training. Two hundred ninety-one physicians reported on over 29,000 patients. The main results are:

1. The physicians reported an emotional component in 18.5 per cent of the patients. This component was judged as a significant factor in the illness of 15.2 per cent and as a major factor in 3.3 per cent of patients. Twenty-two per cent of female and 14 per cent of male patients were reported to have an emotional component. The percentages of emotional disturbance peaked for both men and women in the age range of 45-64. Estimates of psychiatric morbidity in a population must take the age and sex factors into account.

2. The most frequently appearing symptoms or syndrome was anxiety-tension, 40 per cent; followed by psychosomatic, 14 per cent; depression, 14 per cent; and hypochondriasis, 10 per cent. Males were higher on alcoholism and brain disease, females on anxiety-tension and depression.

3. These physicians, themselves, treated 85 per cent of the patients with an emotional or mental component. The type of treatment was medication, counseling or combinations of these. Referral was advised in 11 per cent of patients with emotional symptoms and slightly more refused referral than accepted. Females refused referral more often than males, particularly in the 35-44 age range. About one-third of the referrals were sent to private psychiatrists, the other referrals were widely distributed to non-psychiatric physicians, and to state and local agencies. Specialists referred a greater percentage of patients to private psychiatrists than did general practitioners.

4. Forty-seven per cent of the physicians considered their psychiatric training in medical school as adequate. Doctors who thought their training was adequate found emotional or mental symptoms in 16 per cent of their patients; those who felt their training inadequate found emotional disturbance in 21 per cent. The physicians who regarded their training as adequate advised referral in 9.8 per cent of patients with an emotional component, while the physicians who judged their training as inadequate advised referral for 11.6 per cent. When doctors who considered their training as adequate advised referral, 54 per cent of the patients so advised accepted, but only 44 per cent of the patients accepted in the case of doctors believing their training to be inadequate.

5. The physicians commented on their medical school psychiatric training. In general they wanted more training in practical office management of patients, including supportive psychotherapy and counseling, and less emphasis on the major psychoses.

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*Complete report published in the February, 1966 issue of the Journal of the Iowa Medical Society. Copies are available upon request from the Iowa Mental Health Authority.

In view of the high frequency of patients with emotional and mental disorders found in the practice of medicine and the fact that a large majority of these patients are treated by the physicians themselves, general physicians constitute one of the largest single manpower resources for the treatment of mental and emotional conditions. More attention should be given by medical educators to improve the training of general physicians and specialists in the treatment of these patients.

Report on a Survey of Attitudes of Physicians With Patients in After-Care Homes*

Herbert L. Nelson, M.D.

During the summer months of 1964, data were being collected on after-care homes in Iowa (nursing, custodial, and county homes) as a necessary prelude to comprehensive mental-health planning. Surveys by mail and also direct visits were being utilized. However, it soon became apparent that we were obtaining little or no information from the physicians responsible for the medical care of patients in these homes. Consequently, we decided to expand the study to include general practitioners throughout the state, asking them to estimate the number of patients they had in each type of home and to estimate how many they felt were mentally ill. We decided to ask them to comment on the nature of the facilities and care available in their geographical areas, and to suggest whatever changes they thought would be desirable. In addition, we decided to ask them to indicate what part, if any, of medical-school education and postgraduate programs should be directed specifically toward the care of patients living in nursing homes, custodial homes, and county homes.

In August and September, 1,204 questionnaires were mailed out, and by January 1, 1965, a total of 339 had been returned, representing 28 per cent of the sample. Of those, thirty-six had to be discarded for various reasons such as the physicians' having retired or died, or having moved out of the state and left no forwarding address. Three hundred three usable responses remained, or 25 per cent of the original 1,204 questionnaires. Included were thirteen replies from physicians who had no patients in after-care homes but chose to comment on the topics covered in the questionnaire.

The entire group reported a total of 8,098 patients of whom 4,137 were in nursing homes, 1,574 in custodial homes, and 2,387 in county homes, and 3,453 of them were said to be mentally ill. One third of the physicians said they had one or more patients in a county home (52 counties represented), and thirty-nine claimed to have ten or more (33 county homes with 2,136 patients). A number of these last were county physicians with responsibility for 50 to 250 patients each, most of whom are mentally ill or retarded.

GENERAL ATTITUDES OF RESPONDING DOCTORS

Before proceeding to data and remarks concerning facilities and training, it is important for us to review some of the unsolicited philosophic comments that reflect divergences in the attitudes of physicians who participated in the study. A small number indicated a degree of pessimism by statements such as: "We are keeping many people alive, but if there is little for them to do, if they are in pain, if they're unhappy, or if they are mentally unaware, what progress does this represent?" or "As far as I can see, the county-home patients are put away by society to live without pain until they die. They will not return to society," or "Frankly, I am not 'sold' on the 'cure' of mental patients, and feel that a lot of good money can be thrown after bad in attempting it."

Several questioned the practice of transferring patients from state institutions to after-care homes in the patients' communities. "It is *not fair* to discharge all of these patients from state hospitals. State hospitals should be and are better equipped to care for these patients than are the 'nursing homes' or 'county homes.'" Another said, "It seems that the sick ones with real problems always are sent home or discharged to nursing homes, and the ones who don't have severe problems are forever being put in by their relatives or by themselves."

A few respondents reproved society for rejecting the aged and chronic mentally ill: "I feel that the so-called 'problems' arise chiefly because nowadays the aged are placed in homes and feel left out, discarded, forgotten, lonesome and unwanted, and they feel all the other reactions incident to suddenly finding themselves in a new environment." One physician expressed his belief "that the lack of concern for this group of people . . . is one of the glaring, unpleasant realities in our society which is top-heavy with service clubs, auxiliaries, church circles, gray ladies and fraternal orders, whose activities—presumably charitable or for community service—actually revolve about the social functions of their respective organizations." Another asserted, "If the public spent as much time with mental patients as it does in selecting 'queens,' it just might give some poor devil the incentive to understand his epilepsy and to become self-supporting."

Still others were openly hostile. One physician answered no questions, but exclaimed bluntly, "Information is badly needed on how to fill out county forms for payment!" Some complained of excessive paper work "which is time-consuming and without benefit other than making jobs for more state employees."

Far more respondents, however, showed a serious interest in the problems of after-care homes, and gave evidence of their concern for the many chronic patients in their care. Several offered to give of their time in planning or providing training, and most made suggestions such as the following: "I feel that if any real changes come about, they will have to come from public pressure, a willingness of the county supervisors to spend more money and to provide some overall program for the patient, and also a closer supervision from the Board of Control in the care of these patients."

THE PHYSICAL ADEQUACY OF AFTER-CARE HOMES

With regard to the physical adequacy of after-care homes, there were numerous references to new nursing homes and county homes in particular areas, though there were also indications that additional homes are needed, "especially in the smaller communities." Forty-two physicians commented specifically about overcrowded conditions: "Most nursing homes are very crowded, some pathetically so, with four or five elderly to a single room." Eighteen remarked on the

*Reprinted from the JOURNAL OF IOWA MEDICAL SOCIETY, April, 1965, pages 215-220; copyright, 1965, by Iowa Medical Society.

inadequacy of the physical facilities, pointing out that they are old private homes, offering no privacy. A few mentioned the odor: "Most of the nursing homes are hot, smelly wooden boxes where divorced women attempt to make a living by being in charge of operations," and "Visiting one of these homes on a hot, humid day makes the men's rest rooms at half-time during a football game in Iowa City smell like a rose garden."

Nine practitioners said there is difficulty in finding beds for their patients who are reluctant to go to a nursing home in a larger, distant community. Eleven proposed that after-care homes should be better located: "The main change I should like to see would be to have the nursing home adjacent to the hospital, so laboratory tests could be readily available and transfer to the hospital would be simplified. Many times a patient should be admitted to the hospital, but transfer promises to be so involved that added risks are often taken." Though several physicians seemed to favor "the smaller private homes," one commented, "A nursing home should be large enough to justify hiring a registered nurse for each of the three eight-hour shifts. Size also is necessary to justify physiotherapy and food-preparation equipment." Another contended, "Our new county home should have been eight or ten times larger, and called a nursing home instead of 'The Poor House.' "

In view of recent adverse publicity, it is of particular interest that fire hazards were mentioned only three times in all the comments on facilities.

PATIENT-CARE PROGRAMS

The questions concerning care and programs in these homes were intended to elicit constructive criticism, and it is quite apparent that many of the respondents gave a lot of thought to the matter. Yet, in spite of our invitation to criticize, fifty-one doctors declared that care was entirely adequate in the homes that they serve. There were many complimentary remarks, such as the following: "In spite of the fact that the building is an old one, it is kept clean, and the patients are kept clean and happy with the Sisters' tender loving care and good food. This nursing home is set up to be as much like a hospital as possible, with regular charting and nursing services, and with medicines dispensed from a central drug room, thereby avoiding many of the problems that a small nursing home run by untrained people might have." A county physician concluded, "Though I have been in many 'private' nursing homes, I have found none equal to the care patients receive in our county home. The patients are kept clean and receive at least one physical exam yearly, and the cooperation in work assignments is remarkable."

As was to be expected, most of the adverse reports on program were in the area of activities (85) and rehabilitation (64). The following comments are typical: "This is one of the glaring faults (no activities or rehabilitation) in most facilities, be they new or run-down," and "In general, I feel that the principal lack in old folks' homes is productive activity. Those who are able should be encouraged to undertake any constructive activity their abilities will permit." One physician asserted, "Activity programs too often consist of rolling the patient over so that soiled sheets can be changed (if, indeed, there is that much effort)." Another questioned whether the efforts of volunteers may not impede rather than aid in rehabilitation: "The pathetic feeling of uselessness that is common to old people in custodial and nursing homes is not helped by well-meaning gray ladies, candy-stripers, etc. The human need to be needed can be satisfied *only by being needed*—e.g., in the work around the home."

Suggestions for improving the activities and rehabilitation included the following: "I believe that much of such programs should be carried out by a voluntary community effort," "The aged need more spiritual help, and need someone to exhibit an interest in them," "This being a small town, I feel that relatives provide recreation and stimulation for patients by visiting them frequently, taking them to their homes for short visits, etc.," "At our county home, anyone who can work *does something*," and "Perhaps a 'floating' physiotherapist program (much like the county nurse program) would be a great boon to these patients, for many wouldn't become chronic if they had adequate physiotherapy."

MEDICAL CARE

Only twelve replies specifically mentioned inadequate medical and physical care. Far more indicated that the nursing homes do pretty well when one considers the amounts that are paid them. One physician related that "nursing homes in this community receive $6.00 per day. Considering the pay, they do a very good job. They provide board, room, nursing care, community rooms for TV, radio, and visiting, and a certain amount of physiotherapy. This is good, in view of the fact that a rooming and boarding house or a hotel charges just as much." Seven doctors voiced the opinion that care would be much improved if more medical facilities were available within the building. Eight remarked that more attention should be given to food —both as to quality and as to the manner in which it is served. "When the food is served to patients with the idea of saving all possible on the grocery bill, the situation should be looked into."

Relatively few respondents made reference to psychiatric consultants. Two indicated that they were aware that a psychiatrist visits the county home regularly, and one complained bitterly that "far too often, the consultation facilities are hardly those that lend themselves to the providing of prompt attention for patients who need some psychiatric care, but are trying to remain in their own homes, to continue their occupations, etc." There was also the remark: "It appears at times that psychiatrists are reluctant to provide consultation unless the patient can be hospitalized, and seem reluctant to see a patient in their offices for short-term supportive psychiatric care." From another large community came the remark: "Our local psychiatrists are in no way interested in this type of case, and are of no help whatever." Still another physician alleged, "Aged patients with depressive symptoms get 'the brush off' when they are referred to a psychiatric unit."

There were a number of suggestions pertaining specifically to county homes. At least one county reported that medical responsibility is rotated every three months among seven M.D.'s. One doctor stated that a psychiatric orientation of the county farm should be insisted upon. "Some of these people could be sent to the state mental facility for screening every few years, and some of them, perhaps, could be helped." Another proposed, "Circuit-riding psychiatric residents at the state mental hospitals could perform a service

to the patients (and themselves) by regularly checking on some of these people—in person!"

ADMINISTRATION

In the area of administration, the greatest number of responses concerned finances. At least fifty G.P.'s expressed feelings like these: "Our two better nursing homes are wonderful, but who can pay the price?" "Often the patient accepts the less qualified home because of the cost," "The standard of care in custodial homes in our area is necessarily low because welfare rates do not permit operators to hire sufficient trained personnel, even when they are available," "It seems that when the profit motive is introduced, as it is in our fanciest nursing homes, the care of patients is deplorable," and "Homes that accept patients on social welfare have to charge exorbitant prices to private patients to absorb Social Welfare's inadequacies."

Twenty-two acknowledged that record-keeping in their homes is deplorable, but few proposed any solutions. One said, "Records are inadequately kept, but it should be the responsibility of the doctor in attendance." Another physician recommended that a simple record system be standardized and required in all nursing homes.

There were about a dozen comments on the difficulties of coordination with local agencies: "Physicians must take the leadership role in coordination," "Locally, we have three different agencies that care for ill patients, and they should be centralized under one single office," and "Generally we do well in coordinating with other community agencies, but it takes two years to learn whom to call for what service." One lost soul probably reflected the confusion that must reign in many minds when he said, "One of the most difficult problems today is to comprehend the various overlapping social programs—their regulations, care of patients and billing requirements." He then gave at least fifteen or twenty examples of the difficulties he faces every day.

Three doctors felt that there should be better screening procedures before patients are admitted to after-care homes, but an equal number claimed that the homes are too selective. Five replies asked for more frequent and rigid inspections of homes, and one of them suggested that homes be graded for the degrees of senility or mental disease that they might accept. One physician contended, "Rigid inspection of these homes, and weeding out the obviously unsuitable ones by whatever legal means could be provided, would be the best way to upgrade the care given to these patients." Another voiced "a definite need for more nursing home inspectors who can give constructive suggestions," and one expressed concern that "no community agency is interested in the private residents of nursing homes in our area," as opposed to welfare recipients, whose needs are watched over by the county welfare office staff.

Perhaps all problems of administration would disappear into thin air if this "nutshell" solution were adopted: "We need more funds and freedom for the State Department of Health to operate. More inspections of existing homes are needed. Legislation requiring nursing homes to meet and maintain standards, and also increased rates for care of Welfare Department patients."

THE PERSONNEL OF AFTER-CARE HOMES

Of course the subject of personnel received a lot of comments, both favorable and unfavorable. Thirty-eight respondents referred to a shortage of staff, e.g., "Most places are lucky to have enough help to get the patients fed, let alone participate in activity programs." Forty-four others asserted that nursing-home personnel, including managers, were inadequately trained. Five remarks pertained to their poor attitudes: "Too many of the operators are 'do it yourself' practitioners, and too few of them are either trained or familiar with nursing procedures," or "Much care is provided by nurses' aides, many of whom think an agitated elderly patient is just being stubborn, or is a 'mean old man,' " or "most of the nursing homes . . . are run by elderly and/or retired, disgruntled nurses who refuse to keep records or who hire poor help to bathe the patients and change the bed sheets," and "Most seem to resent a physician's calling, and their only interest in the doctor is to get him there to sign a death certificate when a patient seems terminal, so as to relieve them of any charges of neglect."

A dozen replies contained pleas for more registered nurses in after-care homes because "the frequent use of hypos, catheters, etc. demands nurse care—*not* the services of practical nurses." But they weren't unanimous in that attitude. One remarked, "An experienced nurse in the home is a help if she doesn't get to expect everyone to go to sleep, arise and defecate on schedule every day," and another expressed his preference for L.P.N.'s, who "are as good as, if not better than, the new, new breed of R.N.'s (executives!)." There was one call for more social workers, and even one for a part-time psychiatrist for a county home.

Perhaps the many references to proper attitude are best exemplified by this statement: "I think improved facilities are fine, but the main thing, of course, is to have sufficient numbers of *dedicated* personnel who are willing to work with such patients."

TRAINING PROGRAMS

The final area to be covered is that of training for the care of the elderly and chronic mentally-ill in after-care homes. Special emphasis on such problems in the curricula of medical schools was called for by 155 physicians, but 56 of them cautioned that it could be overdone. Fifty offered no comments on this topic, or indicated that they felt no additional time should be devoted to it at the undergraduate level. An additional twenty-eight made the special point that they encountered no unusual problems in dealing with such patients, thus implying that their own training had equipped them satisfactorily for work of this type. Of those who favored additional emphasis in medical school, thirty-two stressed practical experience through clerkships or preceptorships, and cautioned that didactic lectures should be kept to a minimum.

Postgraduate courses in the care of chronic mentally-ill and elderly patients were called for by 132 physicians, but again there were those (21) who feared they might be carried to an extreme. Forty-nine of the 132 asked for special emphasis on drug therapy because of problems they had encountered with dosages and side effects.

The pessimists expressed doubts in such comments as the following: "I'm not sure this can be taught. Most of my classmates and I skipped the courses in mental illness, general practice and office management that were offered when we were in school. Are students different now?" "It should be taught, but *what is it??* How does one teach patience or sympathetic understanding? The country doctor of forty

years ago handled the elderly quite competently in their homes, aided by the patient's children and other relatives. As a result of cultural and economic factors, family help is leaving the picture, and the care function is assumed by indifferent organizations such as county, nursing and custodial homes which, like corporations, have no bodies to kick or souls to damn." Another had this to say: "In medical school most students think light of these problems. They are all of the opinion that their only problem in medicine will be the treatment of acute illnesses. It is only after some time in general practice that they come to realize the importance of this phase of medicine."

There also were those who questioned whether the medical schools are really prepared to do such teaching. Remarks such as these were common: "Those who do the teaching, it would be my guess, don't have patients in nursing homes, and wouldn't know what they were talking about." "I might suggest that mental health authorities visit these nursing homes with a G.P. before they attempt to direct postgraduate programs of this type." "Treatment at University Hospitals, with no consideration of costs or of who is to pay the bills is quite different from the realities which the physician in private practice must consider at all times." "Maybe the professors could help, too, if they would realize that for every case of even so common a disease as acute appendicitis, the physician who attends nursing-home patients will see thirty or fifty old people with anxiety reactions because they don't have a bowel movement every day." "I think much of this could best be taught by a G.P. or internist who is frequently involved in these problems, rather than by someone on the medical school staff." "With special reference to the psychiatric department, it should be emphasized that the mind of an elderly person degenerates more from loss of personal identity and integrity than from the results of sclerosis or drugs. We must find a way to preserve personal dignity in the declining years of life. Medical students should be made aware of this problem, and must be prepared to infuse whole communities with a better understanding of the full meaning of 'growing old' for the aging individual, for his family and for the community."

Others criticized the present trend toward specialization in medicine. "Isn't the likelihood of anyone's following a G.P. career quite remote? I no longer deceive myself about the prospects of G.P. replacements for the older ones of us. You are fooling yourself if you think the prospects are good. A general-practice career is discouraged at every level, beginning with the freshman year of medicine. The medical schools have encouraged anything but general practice; hospital accreditation boards insist on departmentalization, even in the smaller hospitals; and as you know, more and more hospital seminars are closed to G.P.'s." Medical schools were further taken to task for their emphasis on research: "Also, I think that medical schools are no longer schools. They are simply research centers with a few schoolrooms in connection. What in the world would they do without dear old N.I.H.! Did you see the editorial 'Rigged Research' in the NEW ENGLAND JOURNAL?"

Of course there were many and varied statements and recommendations from those who favored additional training in the care of the chronic mentally-ill aged: "Ninety per cent of my practice consists of conditions that were skimmed over in medical school while we studied commissurotomy, of which I've had three cases in fifteen years." "The student should be exposed to the magnitude of the problem, and should actually see and experience caring for these people on a personal basis in a nursing-home situation." "I have no idea how many quarters the medical student spends with the psychiatrists, but I do know that psychiatry is infinitely more important than biochemistry. Why not give psychiatry 20 per cent of the total hours of instruction?" "The time students spend studying rare diseases could be better spent making rounds with a competent nurse who knows how to care for the many 'little ailments' that are so common in old age." "Every student could benefit from a three- to six-week tour of duty in caring for the aged. It is a completely different phase of medicine. Training in the care of the feet, circulatory disorders of the extremities, control of the agitated and restless patients, and particularly the nutrition of these people—all these should be mandatory." One physician suggested the possibility of making geriatrics an elective or postgraduate course, but making it a prerequisite to licensure for anyone going into general practice. Another said, "I believe every M.D. should have at least two years of general practice before taking specialty training. He would learn something!"

Six physicians stressed that rehabilitation should be included in such training. "Nothing will be gained from lectures on care or problems until rehabilitation is pushed, and this is another insurmountable economic wall until we get out of our space ships and back to people on earth." "Rehabilitation is what I feel I need training in. There are too few physical therapists to go around, and we should be taught how to instruct hospital personnel and patients' relatives in physical therapy." "Medical schools should emphasize practical rehabilitation technics that can be administered by the family or semi-trained personnel."

CONCLUSION

Several pages of comments could be added to reflect further the philosophy of general practitioners who minister to the needs of these patients. They would like medical students to know that one must exercise love, consideration, kindness, gentleness, attentiveness, interest, understanding, concern, empathy, "TLC" and plain common sense. They emphasized that "time and patience enable one to practice the Art of Medicine in a true sense." "If you have 'it' (the Art of Medicine), you can care for these patients, and if you don't, you never can." One physician said, "Many of these elderly persons have to be treated almost like 'veterinary type' patients. Some can't communicate with their doctor because of hearing problems, aphasia, or mental illness. A doctor finds himself treating symptoms and using educated guesses far too often for comfort, but there is little else he can do under the circumstances." Another cautioned, "The tremendous differences encountered, at times, in the physiology and pharmacology of these patients render their care and treatment distinctly different from that of the younger population. Far too often it appears that these differences haven't been adequately recognized."

Three respondents emphasized that medical students should learn to treat their patients' relatives for their symptoms of anxiety, hostility and guilt feelings, and to teach the families to participate in the care of these patients. A more introspective medic postulated, "We doctors—or too many

of us—are afraid of the senile, the extremely feeble and the 'hopeless cancer' patients because they bring us too close to death. And many of us put off until 'tomorrow' our consideration of that ultimate condition. We prefer patients for whom we can do something, or whom we can 'cure.' These hopeless cases arouse too much anxiety in us, until we face up squarely to it. In truth, we can do much for these lonely ones. We don't have to 'cure' them. We can give them medical and psychological help, but the best medicine we can give them is *ourselves*. We can pause and listen to them, so that these very dependent people have a friend and a 'father.' Nurses and doctors in training need to discover this. Our training has been too mechanistic."

At least one practitioner showed his interest in preventive psychiatry when he said, "It also appears that our most pressing need, in the years ahead, will be to prepare doctors for more of a role in counseling these people who are preparing for retirement or who have entered retirement age. We must enable doctors to recognize the marked psychological disturbances that often occur during the unsatisfactory adjustments of this transition period."

Still another forward-looking member of the medical profession made this observation: "Many of the counties—even the smaller counties—have mental health centers, with psychiatrists, social workers and psychologists available. The programs of these centers will aid greatly in caring for mental problems. I feel that having such people available will help the local general practitioners. Perhaps it would be good for them to conduct symposia at the local level."

Certainly the man just quoted emphasizes the present trend toward providing mental health services at the community level. It is no longer acceptable to treat the mentally ill by sending them for extended visits to remote institutions. In every instance, treatment should be as short as possible, as close to home as possible, and as slightly disrupting to the patient's family and to his employment as possible.

Such a wealth of thoughtful, stimulating comments, ideas and suggestions (even the sarcastic ones) from Iowa's general practitioners will provide food for thought to anyone even remotely concerned with mental health—whether physician, social worker, politician, layman, nursing-home operator, nurse, aide or educator. Every one of their statements contains a kernel of wisdom and experience just waiting to be woven into the pattern of all-encompassing "Comprehensive Community Mental Health."

Consequences of Patient Entry Patterns in Three Psychiatric Settings

Stephan P. Spitzer, Ph.D., and Norman K. Denzin
March 15, 1965

SUMMARY AND CONCLUSIONS

This paper reports the results of an experiment conducted to determine the extent to which two variables, the legal status accorded patients prior to hospital entry and the source of the decision to enter hospital treament, influenced nursing staff attitudes in psychiatric wards, of Psychopathic Hospital, a Veterans Administration Hospital, and a large State Hospital. After reading a description of a patient who was said to have entered the hospital under one of four possible entry conditions, the staff member made predictions of the patient's manner of self presentation.

In all hospitals the voluntary entry patient was regarded as more attractive than the involuntary entry patient, and the effect was significant in the Psychopathic Hospital. The primary group referred patient was regarded as more attractive than the secondary group referred patient in two hospitals, and the effect was significant in the State Hospital. In the Veterans Administration Hospital the primary group referred patient was regarded most attractive only when entry was described as voluntary. These findings suggest that some components of mode of entry differ in relevance among hospitals.

The results of this investigation suggest that the culmination of the prepatient phase as represented by the patient's mode of entry into the hospital may well influence subsequent experiences in the career of the patient. If, as we suspect, staff members respond to patients in terms of stereotyped categories and if patients take on attitudes attributed to them by staff members, then the course of treatment, the relationships patients establish with hospital personnel, other patients, and family members, may all be influenced by the patient's initial mode of hospital entry.

Furthermore, if social organization is conceptualized as consisting of stable patterns of interaction, and it is assumed that attitudes are functionally related to interaction, it then becomes clear how attitudes held by staff members toward incoming patients influence the basic nature of organizations. For it is through socialization that patients tending to act and think in certain ways are created. By their behavior, they instigate variations in organizational characteristics to deal with them.

Copies of this report are available upon request from the Iowa Mental Health Authority.

Judicial Survey

Larry Gutz, J.D., and Samuel Fahr, LL.D.
November 14, 1964

This survey was designed to invoke a general response from the judiciary regarding basic problems in the area of mental health and the law. In choosing the sample, inquiries were mailed to all of the seventy-five district court judges in Iowa, fifty of which conveyed their willingness to cooperate. Of the latter group, twenty-six were actually interviewed, which number comprises the sample (34.67 per cent of the judges in the state). The number of questions had to be limited and the questions themselves were rather concise because of the limited amount of time available for each interview. The average lasted approximately one hour, which is the most free time the majority of the judges had at their disposal.

Questions were either proposed by or extracted from the minutes of the committees of the Comprehensive Plan. Due to the stages of advancement of the various committees at the initiation of the survey, some areas received more emphasis than others, notably the adult offenders area. Another factor which contributed to the preponderance of adult offender material in the survey questionnaire was that this is the area with which judges are most familiar, will voice their opinions readily, and can give the interviewer first-hand impressions. Since the court in Iowa is not a commiting agency (with isolated exceptions), some general questions regarding commitment and discharge of the mentally ill would have provided data which was not as authoritative as that obtained by questioning in other areas.

The mean age of the judges seen was 61.54 years, and the average experience on the bench was 10.15 years. The survey encompassed twenty-two counties, some of the larger counties receiving the attention of more than one interview. The average population of these counties was 52,032, and the total population of the counties visited was 1,144,702 (41.5 per cent of the state's total population). No response to the interview inquiry was received from the judges in 14 per cent of the counties. An additional 20 per cent of the counties in which judges consented to be interviewed were not visited. Forty-three per cent of the counties in this state have no judge in residence.

Although space does not permit the presentation of a complete report of the survey, findings lead to the following list of conclusions:

1. There is a marked need for education of law enforcement personnel and court-appointed counsel in regard to techniques for handling the mentally ill offender. Moreover, a fuller understanding of the role of mental health facilities in the legal process and their increased use is desirable.

2. The juvenile probation system throughout the state is apparently functioning well, however the amount of formal education of probation personnel might be increased. A supplementation of the state parole program through the vehicle of the bill on adult probation is favored, although a mandatory pre-sentence examination as proposed by the bill is not. There should be an over-all increase in manpower and appropriations in the probation area, allowing the program to become more treatment-oriented. Expungment of the record of casual offenders upon successful completion of probation is recognized as a useful judicial tool.

3. While a slightly larger percentage of the courts are using the mental health institutes for obtaining pre-sentence data, the consensus of opinion is that a local mental health center provides a faster, more convenient method of obtaining this information.

4. The need for a security hospital for use as a diagnostic facility as well as a treatment center for the dangerously and criminally ill is great. An institution of this type would negate the need for concern about transfers of dangerous patients and commitments of defendants found not guilty by reason of insanity.

5. The county jail system is archaic and inadequate. The implementation of "Huber-like" legislation to establish a treatment program for these offenders is indicated, as the work programs in existence are so occasional as to have little or no effect.

6. A more concise explanation of the function and definition of the terminology of the sexual psychopath statute should be given the courts to insure its constructive use.

7. The state should also adopt a form of emergency detention statute, in order to take detention of mental patients out of the police process.

8. The disposition of cases of mental illness involving the elderly is almost uniform throughout the state. The mental health institute is used as a screening center, and these patients are then transferred to county and private homes.

9. Patients on convalescent leave should be able to regain more of their rights with proper medical evidence.

10. There should be a closer scrutiny and increased safeguards of adoptions involving mentally ill parents. There should also be some coordinated effort among child-placing agencies in order to aid more effective and permanent placement.

11. Neither the use of psycho-toxic drugs nor alcohol has arisen as a distinct problem in the courts; however, the use of nonnarcotic drugs and alcohol is believed to play a part in a great number of traffic offenses. A method for screening recidivists in this area is needed in order to recognize and treat the habitual user.

A copy of this report is available upon request from the Iowa Mental Health Authority.

Synopsis of Iowa Statutes Regarding Commitment, Discharge, Guardianship and Competency of the Mentally Ill

Larry Gutz, J.D.
September 15, 1964

COMMITMENT

Iowa has two methods of involuntary hospitalization: judicial and administrative. Judicial proceedings are utilized only in cases of commitment to the State Psychopathic Hospital under the provisions of Chapter 225. The application can be made by any persons to the district court, alleging a need for treatment. No supporting evidence need be filed with the information. The court then appoints a physician for a pre-hearing medical examination, and notice of the hearing is served on the patient or his guardian. The patient is entitled to a trial by jury if he so requests. On a finding of an abnormal mental condition which can probably be remedied with observation, treatment, and care, the patient is committed to the State Psychopathic Hospital. The patient or his guardian can also waive the hearing and obtain a direct commitment by court order.

The commission is the administrative committing agency. It consists of the clerk of the district court, one reputable attorney, and one reputable physician in actual practice. The commission has jurisdiction of all applications for commitment of mentally ill persons within the county, unless such application is filed at a time when such person is held under indictment or information.

Chapter 229 provides for two independent administrative commitment proceedings. If the patient consents, an application for his temporary commitment may be made by his attending physician, and one other physician experienced in the treatment of mental disorders, for a period of thirty days. At the expiration of this period, the superintendent files a certified report as to the mental condition of the patient, and an extended period of observation may be authorized. At the end of the extended period, the commission must act on the superintendent's recommendation within five days, or the superintendent has power to discharge the patient.

Where there is no consent, the procedure for involuntary hospitalization is begun with an application by any person. If the commission feels the application sets forth reasonable cause, it may issue an order of custody to the county sheriff, and the patient can be confined until the hearing. The patient has a right to counsel and if he is not represented, the court must assign him counsel. If the commission finds a mental disorder, it then directs that the patient be confined for screening and observation. The patient has the

same right to appeal from this order as he does from the final commitment order. Upon recommendation from the superintendent of the hospital, the final order is issued, and the commitment is for an indeterminate period. Iowa has no procedure for emergency detention.

A special form of commitment to private institutions or hospitals, or county or other general hospitals, is found in 227.15. The commitment is made on the certificate of the commission of the county in which such person resides, or of two reputable physicians, each of which is a bona fide resident of the state. The certificate shall state that the person is a fit subject for treatment and restraint, and shall be the authority of the owners and officers of such hospital to receive and confine the patient.

Voluntary Admission. Voluntary patients may be admitted to the State Psychopathic Hospital (Chapter 225), but are not state-supported, and the regulations controlling such admissions are established by the Board of Regents. Voluntary admissions to the other state hospitals are controlled by the availability of facilities. The patient, once admitted, may apply for a discharge on three-day notice to the superintendent.

GUARDIANSHIP AND INCOMPETENCY

Iowa law is silent as to the effect of involuntary hospitalization on the issue of legal competency. The mechanics for an independent determination of incompetency are found in Chapter 670. An application for guardianship is made to the district court by any interested person. A guardian may be appointed for mental retardates, lunatics, persons of unsound mind, alcoholics, and spendthrifts. A verified affidavit must accompany the petition but no notice is necessary if it is filed by the person for whom guardianship is sought. All guardians are required to render an annual account to the district court (668.24).

Restoration of legal competency is begun with application by the ward to the district court in the form of a petition to terminate the guardianship. Notice is served on the guardian, and he is required to answer. If the guardian denies the allegations of the petition, there is a hearing. There may be a jury trial at the option of the petitioner. If the petition is granted, there is a full restoration of competency. Petitions to terminate may not be filed until the guardianship has existed for six months, and thereafter at a maximum frequency of four months.

TRANSFER

Incurables may be transferred from the State Psychopathic Hospital to other state hospitals for the mentally ill on application by the medical director to a special commission created within Psychopathic Hospital. Dangerous patients in the mental health institutes may be transferred to the security unit at Anamosa on application to the district court of the county in which such hospital is located.* Patients suffering from acute mental illness who are also violent and confined at public expense may be transferred by the Board to an appropriate state hospital. Patients suffering from chronic mental illness or senility may be transferred from state institutions to county or private institutions.

DISCHARGE

Judicial Discharge. Applications for discharge may be made by anyone to the district court of the county in which the hospital is located, at a maximum frequency of six months. At the hearing, one court-appointed medical examiner is a member of the commission of inquiry. If the patient is found to be recovered, he is released. (Habeas corpus is also retained.)

Administrative Discharge. The Board of Control may discharge a patient if it is found that he is not disordered, or if he can be cared for without danger to others. Even if dangerous, a patient may be discharged if relatives or friends will provide supervision, care, and restraint. A convalescent leave for one year may be granted by the Board.

*Presently under Appeal to the Iowa Supreme Court.

Summary and Index of Iowa Statutes Concerning Support of the Mentally Ill and Retarded

*September 8, 1964**

The Code of Iowa provides that public funds for support may be derived and dispersed in the following manner:

1. a. The county of legal settlement is liable for the patient's support. (222.61 as recodified by the 61st General Assembly; 230.1; 230.24)
   b. The county is responsible for the establishment of community mental health centers. (230.24) (See also: State Institution Fund 444.12)
2. a. The state must support those patients who have no county of legal settlement. (222.61 as recodified by the 61st General Assembly; 230.1 (2)
   b. Voluntary and committed public patients confined in Psychopathic Hospital are maintained by the state. (225.8)
   c. For each patient transferred from a state institution to a county or private home or committed directly to a county home, the state is required to pay said county $3.00 a week per patient. (227.16)
   d. The state is liable for the excess cost of educating children who need special education, which in practice includes health services. (281.9)

Private responsibility for support is created by the following:

1. a. The costs incident to guardianship, hearing, commitment, treatment and other services for the retarded may be collected from the patient or those legally chargeable with his support. (222.52; 222.79; 222.81 as recodified by the 61st General Assembly)
   b. Mentally ill persons and those chargeable for their support are liable. (230.15)
   c. Voluntary and committed private patients confined at Psychopathic Hospital are liable (225.8), and committed private patients must reimburse the state for expenses made in their behalf. (225.22)
   d. Wages paid to inmates of board of control institutions may be used to pay the costs of commitment. (218.40-43)
   e. If a patient's estate is not administered within one year the proceeds are credited to the institution where he was confined. (218.67-68)
   f. Assistance furnished under Chapter 230** is a lien on real estate. (230.25)

*Corrected and updated January 20, 1965 and February 3, 1966.
**To committed patients: Attorney General Opinion 2-16-60.

Specific Statutes Relating to the Support of the Mentally Ill and Retarded

Chapter 218: Government of Institutions

218.40-43 Inmates may be required to work and their wages may be used to pay the costs of *commitment.*

218.67-68 If administration is not granted in the estate of an inmate within one year of his death and such person has no surviving spouse, or heirs, the property in the estate may be converted into money and credited to the support fund of the institution where the intestate was confined.

Chapter 222: Mentally Retarded Persons*

222.11-12 Expenses paid from state treasury for taking into custody a runaway from an institution for retarded in another state and found in Iowa.

222.23 The district court shall assign counsel for the alleged mentally retarded person. Attorney fees paid by county.

222.32 (3) A diagnostic evaluation, required prior to commitment, is paid by county.

222.50-52 Costs of proceedings paid by county (or state if no legal settlement) and may be collected from persons legally chargeable.

222.61; 77 All legal and service costs paid by county (or state if no legal settlement) from state institution fund.

222.78 Cost of services for patients transferred to county care paid from state institution fund or county fund for mental health.

222.79; 81 Those legally chargeable are liable for costs. Limits of liability described.

222.82 Liability a claim against estate.

Chapter 227: County and Private Hospitals for Mentally Ill.

227.16 Patients transferred to county or private homes from state institutions, or committed to the county home, shall receive $3.00 weekly from the state mental aid fund.

227.17 State Mental Aid Fund—appropriation of $500,000 per year.

227.18 Claim filed quarterly.

Chapter 230: Support of the Mentally Ill

230.1 Costs are assessable to:

(1) The county of legal settlement.

(2) The state when such person has no legal settlement.

230.15 Mentally Ill persons and persons chargeable for their support shall be liable (persons chargeable for support include: spouse, mother, father, adult, child, and any person, firm, or corporation bound by contract to support such person).

230.24 County fund for mental health—psychiatric treatment. One mill may be levied for county home; one-half mill for community mental health center; may expend $250 per 1000 population from state institution fund to establish a community mental health center.

230.25. Assistance furnished under this chapter** shall be a lien on any real estate of which the patient or his spouse is the record owner.

*Recodified by the Sixty-First Iowa General Assembly.

**To committed patients: Attorney General Opinion 2-16-60.

Chapter 281: Education of Children Requiring Special Education

281.9 Any school district or county board of education may be reimbursed by the state for the excess cost of instruction of such children. Note: in a few counties an arrangement is agreed upon between the mental health center and the board of education for payment for examination, diagnosis, and treatment.

Chapter 444: Tax Levies

444.12 State Institution Fund

The Board of supervisors of each county shall yearly estimate an amount necessary to meet the expense of maintaining county patients, including the costs of commitment and transportation to state institutions; and shall levy a tax therefore. 60th G.A. (amending 444.12) The cost of establishing a community mental health center as provided in 230.24 is also to be included.

A Study of the Total Cost of Treatment for Mental Illness and Sources for its Financing in Iowa

Prepared by
The University of Iowa Bureau of Business and Economic Research
April 19, 1965

This study was conducted in an attempt to determine (1) the total treatment cost for mental illness by each of the major treatment resources in the state of Iowa and (2) the extent that this treatment cost was paid for by federal, state, county, or private funds. This study includes only the amount billed for treatment and does not include in state and federal facilities such costs as new physical facilities or cost of improving existing facilities. In nonprofit private facilities, depreciation, amortization, and other maintenance costs were considered only to the extent that they are included in the over-all service charges. The figures do not represent cost for an illness, but rather deal with office, clinic, and hospital cost for services.

In addition to the data on treatment costs, statistics on patient loads are provided where possible (see Summary Sheet II). In most instances, the same fiscal or calendar year was used in obtaining the cost data and the case load data from each resource. The data on the hospitals and the mental health centers is more accurate because such is required to keep annual statistics. The data on private psychiatry, physicians, and aftercare homes was obtained by several surveys and is less accurate. The case load figures do not exclude readmissions or recurrent cases within or between facilities. It was not possible within the scope of this study to obtain data on patient days nor on the quality or quantity of treatment provided.

Perhaps a similar study with a vastly expanded scope and financial budget would produce more detailed figures. However, considering the limitations which have been explained, the research personnel who worked on this study are of the opinion that the figures shown on the summary sheet of the present study are reasonably accurate and may be used for discussion and planning.

A copy of this report is available upon request from the Iowa Mental Health Authority.

Summary Sheet I

A STUDY OF THE TOTAL COST OF TREATMENT FOR MENTAL ILLNESS AND SOURCES FOR ITS FINANCING IN IOWA

(April 1, 1965)

	Index Schedule	SOURCE OF FUNDS FOR TREATMENT					
		Federal	State	County	Private	Charitable	Total
Federal Hospitals	A	$ 7, 325, 011					$ 7, 325, 011
State Psychopathic Hospital	B		$ 493, 191		$ 165, 294		658, 485
Mental Health Institutes	B		811, 793	$ 6, 644, 989	1, 572, 073		9, 028, 855
Institutes for the Retarded	B		164, 421	4, 018, 034	947, 913		5, 130, 368
Correctional & Training Institutions, Soldier's Home	B		103, 350				103, 350
Additional Appropriations for Board of Control Institutions	B		589, 944				589, 944
Private Psychiatric Hospitals	C				1, 439, 061		1, 439, 061
Private Children's Facilities	C			240, 746	98, 961	$211, 466	551, 173
General Hospital Psychiatric Units	D			181, 522	1, 241, 565		1, 423, 087
Community Mental Health Centers	E	74, 001		513, 231	91, 900	250, 740	929, 872
Private Psychiatrists, Psychologists, and Social Workers	F				2, 114, 560		2, 114, 560
Non-Psychiatric Physicians	G				11, 028, 213		11, 028, 213
Nursing, Custodial and County Homes	H	74, 409	2, 601, 105	3, 435, 188	3, 857, 719		10, 058, 421
TOTAL		$ 7, 473, 421	$ 4, 853, 804	$15, 033, 710	$22, 557, 259	$462, 206	$50, 380, 400

Summary Sheet II

EXPENDITURE BY TREATMENT RESOURCES AND MEASURES OF TREATMENT LOAD

TREATMENT RESOURCES	Total Expenditures	Inpatient Admissions	Outpatient Admissions	Inpatients Average Daily Census
Federal Hospitals	$ 7, 325, 011	930	160	1, 481
State Psychopathic Hospital	658, 485	471	1, 663	71
Mental Health Institutes	9, 028, 855	4, 262	1, 605	2, 493
Institutions for the Retarded	5, 130, 368	216	---	2, 141
Correctional Institutions, Training Schools and Soldier's Home	103, 350	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE
General Hospital Psychiatric Units	1, 423, 087	3, 859	163	156
General Hospitals with Psychiatric Facilities	NOT AVAILABLE	458	---	---
Private Psychiatric Hospitals	1, 439, 061	2, 060	211	277
Community Mental Health Centers	929, 872	---	4, 197	---
Private Residential Treatment Centers for Emotionally Disturbed Children	551, 173	119	---	101
Private Psychiatrists, Psychologists and Social Workers	2, 114, 560	---	32, 868	---
Nursing, Custodial and County Homes	10, 058, 421	---	---	7, 178
Non-Psychiatric Physicians	$11, 028, 213	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE

Report on Cost Study

November 24, 1964

This report was prepared in collaboration with The University of Iowa Bureau of Business and Economic Research. Certainly, cost is the concern of anyone who plans for services. A U.S. Public Health Service Publication states that the dollar savings of community treatment of mental illness are sizable. To gain some understanding of this we have studied the cost of the hospitalization phase of psychiatric illness in one state hospital and in one psychiatric unit of a general hospital.

These cost figures do not include costs before and after hospital treatment. Neither do comparative cost studies of this type say anything about factors possibly related to the differences in length of hospital stay. The cost and length of stay differences in two patterns of care may involve differences in the two institutions such as the legal status of the patients, the duration and severity of their illnesses, their economic, social and educational levels, community attitudes, and so on. Neither do these costs take into consideration loss of productivity and income of the patient.

It must be emphasized that the cost findings should not be considered typical of all hospitals in the state of Iowa. If any other hospitals had been studied these results might have been considerably different. Furthermore, the length of stay findings by diagnosis do not indicate the type of treatment provided. For example, hospitalization for drying out a patient with acute alcoholic intoxication would require approximately seven days; whereas if the treatment program included psychotherapy and rehabilitation, the length of stay might be considerably longer.

We have made no attempt to explain the differences in length of stay and total costs. These are subjects for discussion and further analysis.

Copies of this report are available upon request from the Iowa Mental Health Authority.

Schedule 1

COMPOSITE COMPARISONS OF AVERAGE DAILY COST, AVERAGE LENGTH OF STAY PER HOSPITALIZATION, AND AVERAGE TOTAL COST PER HOSPITALIZATION FOR A STATE MENTAL HOSPITAL WITH A PRIVATE HOSPITAL WITH A PSYCHIATRIC UNIT FOR A TWELVE-MONTH PERIOD

AVERAGE DAILY COST PER PATIENT

STATE HOSPITAL		PRIVATE HOSPITAL
Acute Treatment Ward	Continued Treatment Ward	Total
$10. 08	$5. 91	$28. 34

AVERAGE LENGTH OF STAY PER HOSPITALIZATION

	STATE HOSPITAL				PRIVATE HOSPITAL	
Admission Category	No. of Pt/Yr	Acute Treatment Ward	Cont. Treatment Ward	Total Days	No. of Pt/Yr	Total Days
New Admissions	304	76	20	96	467	12
Re-Admissions	452	78	33	111	273	15
All Other Admissions	260	74	86	160	--	--
TOTAL***	1, 016 Patients	76 (Av. Days)	42 (Av.Days)	118 (Av.)	740 Patients	13 (Av. Days)

AVERAGE COST PER HOSPITALIZATION

	STATE HOSPITAL				PRIVATE HOSPITAL	
Admission Category	No. of Pt/Yr	Acute Treatment Ward	Cont. Treatment Ward	Total Cost	No. of Pt/Yr	Total Cost
New Admissions	304	$766. 08	$118. 20	$ 899. 62*	467	$340. 08**
Re-Admissions	452	786. 24	195. 03	996. 61*	273	425. 10**
All Other Admissions	260	745. 92	508. 26	1, 269. 52*	--	--
TOTAL	1, 016 Patients	$766..08 (Av.)	$263. 56 (Av.)	$1, 029. 64* (Av.)	740 Patients	$373. 38** (Av.)

* Includes $15. 34 Transportation Expense

** Includes $4. 96 Transportation Expense

*** 10. 6% of the patients admitted to the state hospital were still in residence at the end of one year.

Socio-Economic Factors and the Length of Stay Per Hospitalization of Psychiatric Patients

Richard P. Vornbrock, ACSW, and Rosalio Wences, MA

SUMMARY

This preliminary study was conducted in collaboration with the Iowa Mental Health Authority to help determine the influence socio-economic and certain other factors may have on the duration of hospitalization for treatment of mental illness.

The study sample included the hospital records of 235 of the 333 first-admission patients to the State Psychopathic Hospital, The University of Iowa, for the year 1963. The records of children under the age of fifteen, court cases, and patients who left the hospital against medical advice accounted for the remaining ninety-eight first admissions not included in the study sample.

Three categories of length of stay per hospitalization were used: short hospital stay, 0-29 days; moderate hospital stay, 30-59 days; and long hospital stay, 60 days and over. Chi Square was used to test the possible relationship between the length of stay per hospitalization and measures of socio-economic status. In addition, other factors such as age, sex, marital status, distance of residence from the hospital, and the presence or absence of a psychosis were considered.

Results of the study revealed that length of stay per hospitalization is independent of education and occupational prestige with the exception that adolescent children of high occupational prestige parents tend to stay longer. The study findings also showed that the length of stay per hospitalization is independent of age, sex, and the distance of residence from the hospital. However, a greater proportion of single patients and patients with a diagnosis of psychosis were found in the longer hospital stay categories.

This study was carried out at the State Psychopathic Hospital and the results cannot be considered characteristic of all psychiatric inpatient facilities in Iowa. If patients admitted to other hospitals had been studied, the results might have been considerably different. Further studies in other hospitals are currently underway.

Copies of this report are available upon request from the Iowa Mental Health Authority.

Costs in Three Iowa Community Mental Health Centers

Verne R. Kelley, ACSW
December 16, 1964

Iowa Community Mental Health Centers strive to provide a good quality of service at a reasonable cost. Reliable cost figures, however, have not been available.

For this reason the Iowa Mental Health Authority conducted a time study and cost study of three Iowa Community Mental Health Centers in April, 1963. The time study revealed that 72.3 per cent of professional time was allocated for clinical services and 8.3 per cent of professional time was devoted to community services. Internal activities used the remaining 19.4 per cent of effort.

It is interesting to compare these findings with the Northland Mental Health Center at Grand Rapids, Minnesota. At the Center in Grand Rapids, clinical functions are allocated 40 per cent of professional time, compared to 72.3 per cent found in the three Iowa centers. Public Health functions also receive 40 per cent of staff time at the Northland Mental Health Center compared to 8.3 per cent by the three Iowa centers. For management and internal activities they are about the same: Grand Rapids 20 per cent, three Iowa centers 19.4 per cent.

In Iowa the Community Mental Health Centers are organized to treat psychiatric patients. The Northland Mental Health Center has emphasized public health functions as its greatest value to the three-county area it serves. The differences point to an important implication. A center which invests a large amount of professional time in treating patients should find it more compatible to include inpatient services and partial hospitalization.

The cost per hour for psychiatrists ranged from $11.67 to $25.45, for psychologists from $5.87 to $8.86, and for social workers from $4.74 to $8.86 per hour. Part-time staff direct cost was more per hour than for full-time staff in all but one instance. The average cost for a professional hour in direct patient service was $7.94.

Copies of this report are available upon request from the Iowa Mental Health Authority.

Community Agreements to Provide Mental Health Services

P. E. Huston, M.D., Verne R. Kelley, ACSW,
Joel Donovan, ACSW, C. Patrick Hardwick, M.A.

The concept of comprehensive mental health care implies that the various agencies and individuals who supply elements of this service coordinate their activities so that the patient will receive appropriate treatment and services promptly and as often as needed. The agencies involved, both public and private, need to understand the roles and policies of the others, to plan programs together, and to communicate with each other.

It seems clear that mental health centers and general hospitals in Iowa will become increasingly involved in more comprehensive mental health services. As a part of comprehensive planning, it was decided to collect information on existing agreements primarily for the purpose of making this information available to communities wishing to expand or strengthen their mental health services. Two surveys were made: 1) one of Mental Health Centers to discover the types of agreements they have to provide services to various groups, and 2) one of general hospitals to discover the types of financial agreements they have with departments of welfare for the care of indigent psychiatric patients.

SUMMARY OF MENTAL HEALTH CENTER SURVEY

Ten of Iowa's Mental Health Centers were surveyed by personal interview concerning their agreements and contracts for provision of services. It was found that these ten centers had 178 agreements, only three of which were written contracts, all others being verbal. Agreements existed with fifteen types of facilities or professions, such as schools, colleges, social welfare, physicians, general hospitals, mental hospitals, courts, corrections, county homes, and industry.

The services provided by the Mental Health Centers were financed through many sources which included county funds, community chests, schools, and courts.

The types of services are mainly for individual patients, either for diagnosis and/or treatment. Group therapy is also provided in schools and county homes. Lecture courses and case conferences are held for welfare workers, the police,

probation workers, mothers receiving aid to dependent children, visiting homemakers, etc. All of the ten centers surveyed have arrangements with state hospitals for after care and one center admits acutely ill patients to the county home for treatment.

There are many different types of contractual arrangements between the centers and the various agencies of the community. Some striking examples of cooperation are seen in many communities with respect to courts and corrections. A few examples of cooperation in this area show the character and types of many of the agreements in other areas.

One center listed an unique arrangement in which the local police are taught courses on the recognition and handling of disturbed persons. Another center reported an agreement with a district court to provide psychiatric examinations and recommendations for persons thought to be criminal sexual psychopaths. The fees were paid by the court. Another reports the arrangement with a mental health center for pre-sentence investigations. There is an example of a mental health center giving consultative services on a regular basis at pre-release conferences; while another provides group therapy for girls on parole from a correctional institution. This is carried out through an agreement with a parole officer.

In one school system the elementary principals meet regularly with the mental health center's psychiatrist. In another, teachers, nurses, welfare workers, school administrators, and mental health center staff meet once a month to consider the problems of children.

On another level of the educational system, one college pays the mental health center a flat rate per year for diagnostic and treatment services. Another college pays part of the cost and the remainder is paid by the student's home county, although it may not be affiliated with the center. In one community the mental health center's psychiatrist meets twice a month with the faculty of a school of nursing concerning curriculum development. The agreements are varied. They all have one element in common. They are based on the particular needs of the community.

The private practicing psychiatrists were not included in this survey. We feel it is important to point out that this segment of community psychiatric services also has many agreements and contractual arrangements with the various social agencies of the community. Arrangements for consultation with social welfare, industry, schools, courts, and correctional institutions are some of them. Many psychiatrists are involved in various phases of teaching, seminars, and workshops for staffs of the agencies.

Many more examples could be cited of arrangements and contractual agreements in the areas of schools, private physicians, private psychiatrists, social welfare, colleges, mental hospitals, or county homes.

SUMMARY OF GENERAL HOSPITALS SURVEY

Better than half of the surveyed hospitals have a contract, written or verbal, for the care of indigent patients. In most cases this applies to psychiatric patients who are kept in the hospital until arrangements can be made to transfer them to a state institution. These contracts chiefly call for minimal care and cover full charges, charges less discount, or full cost. Problems arose occasionally between welfare departments and hospitals on the amount of charges and such items as limits of days of care, criteria for indigency, and prior approval for admission with about equal frequency in the formal or verbal contracts. Most hospital administrators believed, however, that written contracts were preferred since both the county and the hospital were bound to specific terms.

The survey of contractual arrangements made by general hospitals for the care of indigent patients was confined to the financial consideration. Despite some of the difficulties encountered, such as those concerned with prior approval and determination of indigency, the attitudes of the hospital administrators in handling indigent psychiatric patients are to be commended. The limitation of care in a general hospital until a patient can be transferred to a state institution is consistent with the tradition of making the care of the indigent partly a state responsibility. As local communities accept more complete responsibility for indigent psychiatric care one would anticipate that general hospitals will be willing to share in this responsibility.

CONCLUSIONS

As a general conclusion to these surveys, it becomes apparent that local communities through both the general hospitals and mental health centers make agreements, verbal and written, to meet local needs as they arise for the care of the indigent patient. As the need for expansion and improvement for these services is demonstrated, past experience would indicate that local communities will meet the requirements for comprehensive care.

Copies of this report are available upon request from the Iowa Mental Health Authority.

Essentials of Coordination

John E. Graham, ACSW
March 9, 1965

Today the need for coordination is greater than ever as communities begin to mobilize local resources to meet their comprehensive mental health needs. Coordination of mental health services may be described as organized planning between agencies, involving complementary and reciprocal use of resources, to achieve a common goal.

The purpose of this study was to develop guidelines for improving coordination among community mental health services. Two hundred and fifty-five "critical incidents," or things actually done which were judged to affect coordination, were reported by 131 workers. The sample represented a cross section of health and welfare agencies in two urban communities in Iowa. Data tended to fall readily into five major categories which were set forth as essentials of effective coordination. The categories are listed below with examples.

1. Joint definition of agency roles. Coordination requires an adequate definition and acceptance of each agency's roles and responsibilities in providing services. For example, an unmarried pregnant girl asked a family case work agency for assistance in planning. The intake interview revealed a long history of emotional problems. A case conference was held with a mental health facility. Problems were defined and a common understanding of the role and responsibility of each agency was spelled out. The clinic accepted the girl for therapy while the family agency continued to assist her in respect to her pregnancy. Follow-up conferences were regu-

larly scheduled between the agencies to review progress and clarify goals.

2. Joint planning. Coordination requires that all concerned agencies be included in planning. For example, a public welfare worker felt better equipped to assist in a child's post-hospital adjustment as a result of being invited to the hospital discharge planning conference. A representative of special education was asked to help plan for the return and placement of the child, and this resulted in an appropriate placement in the local school program.

3. Joint definition of problem. Coordination requires that there be agreement on a definition of the problems for which services are being planned. Good definition was noted when a state children's home accepted a delinquent girl after a conference with the superintendent and the probation officer focused attention on the emotional aspects of her delinquency. In another instance, a juvenile judge working with a child welfare agency, a probation officer, and a school psychologist, were able to plan for a boy as a result of a consensus about the underlying problem. Similarly, a school principal agreed to take part in planning services with a pediatrics clinic when he understood how a child's emotional problems were affecting his school adjustment.

4. Timely and adequate communication. Coordination requires interagency communication which is timely and adequate. An example of good communication was illustrated when a mental health center, following a diagnostic evaluation, held a case conference with a child welfare agency. This emphasized the important features of the case and provided immediate answers to the questions about the need for institutional placement of the child. Another example of good communication occurred when informal contacts at a monthly luncheon allowed a school psychologist to exchange information about a child in treatment with the professional staff of a mental health center.

5. Flexibility of operation. Coordination requires flexible agency policies and services which are geared to meet community needs. An example involved two child welfare agencies where flexible policies permitted an exchange of foster homes avoiding the alternative of institutional placement. The flexible administration of agency policy enabled a county relief office to grant funds to an indigent patient for emergency care in a private psychiatric hospital until transfer to a state hospital could be arranged. As another example, a mental health center policy of providing consultation to community agencies enabled a case worker from the Department of Social Welfare to be more effective in her work with a depressed client. An interagency agreement made it possible for a vocational counselor to interview promptly new applicants for public assistance, evaluate their vocational potential, and plan for training.

Complete copies of this report are available on request from the Iowa Mental Health Authority.

Chapter IV
SCIENTIFIC DIVISION–COMMITTEE REPORTS

As a part of the planning process, six committees under the Scientific Division met regularly to consider the special problems of mentally ill adults, mentally ill adult offenders, alcoholism and drug addiction, the aged, children, and the mental health aspects of mental retardation. Each committee was composed of eleven to fifteen professional and lay members who were intimately concerned with the problem to be studied. Ad hoc subcommittees carried out surveys, reviewed the literature, and presented working papers on subjects such as financing, community resources, patterns of care, residential facilities, and agency roles. Lists of committee members and some of the subcommittee productions are included in the appendices.

For the sake of completeness, the six committee reports are presented in their entirety in this chapter and lists of their major recommendations follow the summary in Chapter VII. However, it must be remembered that even the full committee reports do not adequately reflect the degree of dedication, the personal investment, the endeavors, and eventual accomplishments of committee deliberations. Representatives from various agencies and organizations were brought together, in many instances for the first time, so it was no surprise when vested interests led to disagreements and conflicting views. However, once problems were out in the open, discussion usually led to compromise or understanding.

It is noteworthy that certain themes, with minor variations, emerged in common from all the committees. All embraced the desirability of developing mental health services at community level, as well as the idea of making such services comprehensive. Perhaps the need for coordination of community resources received more attention than any other topic, and in their later meetings each committee arrived at the same conclusion that mental health planning must be a continuing process.

Report of the Committee on Mentally Ill Adults

INTRODUCTION

At its first meeting, the Committee on Mentally Ill Adults decided that it would be necessary to review psychiatric facilities presently available for the care of the adult mentally ill in Iowa preliminary to any projection of needed facilities and personnel. Methods of mapping psychiatric services by county, and of obtaining data from private psychiatrists were determined. It was also decided to query representative mental health personnel for a statement of opinion regarding what should be done for the adult mentally ill in Iowa.

The committee, recognizing the need to develop a method for counting mental health manpower needs in both existing and future facilities, decided to include only those personnel working in psychiatric services. The Committee's definition of a psychiatric service was based on the assumption that it is not a psychiatric service unless each person who goes through the treatment procedure is seen by a psychiatrist. Results of the survey are contained in the report "Mental Health Facilities and Personnel in Iowa." Surveys of professional personnel made by the U.S. Public Health Service had been made available to the Iowa Mental Health Authority and these also were tabulated and summarized for the Committee's use.

In all, the committee of the whole met nine times and there were several subcommittee meetings. Earlier meetings were spent in reviewing numerous other studies and plans such as "Action for Mental Health," Canada's "More for the Mind," and the Program of the Council on Mental Health of the American Medical Association. It was immediately apparent that these reports contained many conclusions and recommendations which might be appropriate for Iowa, with only minor modifications.

PRESENT STATUS OF CARE IN IOWA

Many facts are available which indicate that a great deal has been accomplished during the past decade in developing better services for the mentally ill in Iowa. At the same time, it is apparent that there is even more to be done if Iowa wishes to continue its present trend toward providing efficient comprehensive psychiatric services as near the patient's home as possible.

Twenty years ago there were over 6,500 patients in the four state mental hospitals. There were three private mental hospitals, Psychopathic Hospital, and only one mental health center (Des Moines Child Guidance Center). Ten years later, the population of the state institutions had dropped to 5,336 and six additional mental health centers were in existence. However, conditions were still less than satisfactory as evidenced by a 1956 survey carried out by the American Psychiatric Association and the Governor's Committee on Mental Health. Their report was accompanied by numerous recommendations, some of which have been put into practice with good results and others which are yet to be accomplished.

Through sustained public support and legislative action, staffing in Iowa's mental health institutes has been greatly improved. In the face of increasing admission loads, (1,700 new cases and 2,500 returns per year) the total in-patient population has been reduced to only 2,018 in 1965. (See graph Appendix S.)

Iowa's Mental Health Centers served 1,115 patients in 1955 and the number increased to more than 8,000 for the year ending June 30, 1965 (4,405 were new cases). Legislative action permitting counties to tax themselves and local public and private support have resulted in the development of additional community psychiatric services, and since 1955 the number of psychiatrists in the state has increased from 64 to 108, half of these being in full or part-time private practice. (See "Mental Health Facilities and Personnel in Iowa.")

Twelve general hospitals in Iowa have separate psychiatric

units, with more being planned, and other general hospitals now accept psychiatric patients for short-term care. These twelve psychiatric units now admit approximately 4,000 patients each year and the number is increasing. Iowa's non-psychiatric physicians handle more and more emotional problems in their practices and are giving follow-up care to patients who have required hospitalization. By their own conservative estimates, one-fifth of their patients display significant or major emotional symptoms and 85 per cent of these are treated without referral to a psychiatrist. (See "Mental and Emotional Symptoms in Private Medical Practice.")

Such facts indicate that our state is already well on its way toward developing psychiatric services which are community oriented and hopefully more efficient and economical. Besides these primary psychiatric resources, of course, there are numerous other facilities and services which deal with various aspects of mental illness. These include family service agencies, ministers, schools, public health nurses, vocational rehabilitation, attorneys, psychologists, social workers, sheltered workshops, nursing homes, custodial homes, county homes, foster homes, county welfare departments, settlement houses, children's homes, training schools, reformatories, prisons, jails, probation services, special education, and perhaps many more.

COMMUNITY FOCUS FOR NEW SERVICES

Recognizing that this vast array of services is almost entirely located in "the community," the Committee on Mentally Ill Adults feels that this trend must be continued. The future direction should be toward locally controlled community psychiatric facilities, strengthening existing services and developing new programs in those areas of the state which are now devoid of primary psychiatric services. The Division of Hospital Services of the State Department of Health is responsible for projecting a "state plan" for the construction of community mental health centers in accordance with Public Law 88-164, and the committee is in favor of this planning approach.

STATE MENTAL HEALTH INSTITUTES

The Committee agreed that Iowa's four Mental Health Institutes will continue to serve a segment of the population. They should continue to carry out their present service and training responsibilities to improve their staffing and to raise their standards. Each institute should strive for accreditation by the Joint Commission on Accreditation of Hospitals. However, there should be no effort directed toward increasing the size of the state hospitals or extending their scope of activities. It is proposed that, as the over-all program develops, community organizations will assume more responsibility for follow-up care and the original screening of patients locally. A report from the Director of the Division of Mental Health dated November 23, 1964, is appended and covers the policies, goals, and future planning with regard to the Mental Health Institutes. These policies, goals, and plans, however, are subject to change and should receive high priority for review and recommendations in continued comprehensive mental health planning. (See Appendix F.)

FINANCING

A special sub-committee was designated to study the methods of financing mental health services in Iowa and its report is included in Appendix H. The Committee on Mentally Ill Adults believes that all available sources for financial support should be considered and that different patterns will emerge. At present, we know that many individuals are paying for their own psychiatric care, while others receive services which are payed for from federal, state, county, and charitable funds in varying amounts. Flexibility in the use of these funds is paramount and their administration should be in the hands of local communities regardless of source.

LEGAL ASPECTS

The Committee reviewed a report entitled "Synopsis of Iowa Statutes Regarding Commitment, Discharge, Guardianship, and Competency of the Mentally Ill." Though some changes in the law might seem desirable, it was felt by the Committee that we were not ready to make any specific recommendations. A more intensive study should be the responsibility of a continuing committee on mental health problems.

MENTAL HEALTH SERVICES

Early in the meetings, it was decided that the Committee on Mentally Ill Adults should extend its function beyond mental illness, alone, and touch upon the broader aspects of mental health. A subcommittee was appointed to review auxiliary mental health services and to make recommendations. (See Appendix G.)

COORDINATION

In Iowa, psychiatric personnel are no longer clustered at a few facilities. Treatment services, for the most part, are becoming decentralized and dispersed among centers of population.

Only twenty years ago, psychiatric service was largely concentrated in six public institutions and three private mental hospitals. Since then psychiatric service has grown and spread to many areas of the state. All but one of Iowa's twenty-five cities of 10,000 or more population have the services of private psychiatrists or are affiliated with a community mental health center. The total population of counties where community mental health center services are available, added to other counties in which there is located the office of a private psychiatrist, is 70 per cent of the state's population in 1960. Of those counties not affiliated with community mental health centers, only eleven do not have either a state hospital or a private psychiatrist in an immediately adjacent county.

In addition to these services which are primarily psychiatric, there are numerous other professions, agencies, and groups in every community whose important contributions to mental health programs must not be overlooked. General practitioners, attorneys, teachers, ministers, family services, welfare departments, and numerous others are involved, particularly in case finding, aftercare, and so-called preventive measures.

Close cooperation between concerned individuals and organizations is needed to achieve continuity of care through all phases of a patient's illness. A local coordinating group organized for the purposes of improving professional liaison and for community planning is desirable. Such a group can profitably make use of state and local fact-finding services. When the group makes plans relating to a mental health program, it is logical that local psychiatric personnel should

assume responsible leadership. Although the planning participants represent separate services, their work can be interrelated when their professional objectives are clear.

When joint endeavors are undertaken by state and local agencies their goal should always be the strengthening of services in the local community. State agencies must avoid positions of surveillance and authority over community mental health enterprises, since local autonomy and fiscal control are of utmost importance. However, an advisory and consultative role on the part of state agencies may be quite helpful when this type of service is requested.

TRAINING OF PERSONNEL

During the past several years there has been an increasing number of psychiatric personnel being trained at Psychopathic Hospital, in the Mental Health Institutes, and in our Universities, Colleges, and Schools of Nursing. There are now almost forty-five psychiatric residents enrolled in the three approved training programs in comparison with only seven or eight a decade ago. Unfortunately, less than half of the fourteen or fifteen residents completing training each year choose to remain in Iowa, the number falling far short of present needs. (A conservative estimate indicates a current state shortage of at least thirty psychiatrists.)

The committee recommends that training programs for mental health personnel be increased. In the case of Psychopathic Hospital, this will require additional physical facilities as well as an increase in the number of competent teaching staff. Continuing efforts must also be made to recruit professional personnel such as psychologists, social workers, and nurses into the mental health field.

Since the pool of potential trainees is limited, we must concentrate not only upon expansion of training programs, but also upon making mental health professionals more effective. Diagnostic evaluation, prescribing treatment, consulting, and supervisory functions must be emphasized in the training of future psychiatrists if the principle of medical responsibility is to be maintained. Only in this way can the treatment skills of non-psychiatric professionals be utilized to the fullest extent. In addition, it will be important for all psychiatric personnel to have a working knowledge of community organization, group dynamics, forensics, and program administration.

If these skills are to be emphasized, if psychiatry is to meet society's needs, an attitudinal change in our training programs is imperative. No longer can we stress the model of intensive and prolonged individual psychotherapy which has dominated the psychiatric scene for many years.

RESEARCH

Advance in the treatment of mental illness depends upon advance in knowledge. In Iowa, as in the rest of the nation, most mental health research has been conducted in a University setting where a wide variety of resources exist in an atmosphere of scientific inquiry and scholarship. The heavy pressure of service needs has invariably extinguished any flickering interest in research in our state hospitals, clinics and community agencies.

Although the research wing at Psychopathic Hospital was only completed in 1962, there is already obvious need for considerable expansion. Quarters are becoming too cramped for the many investigations being conducted in neurophysiology, neurochemistry, alcohol studies, evoked potentials, learning theory, aversive conditioning, and related areas. The limited number of beds in the hospital proper are barely sufficient for training needs, leaving no available space to house patients for clinical research. Additional research construction is urgently needed in the near future so that these important pursuits can be expanded.

The present community psychiatry movement is posing further questions and suggesting additional areas for investigation. Several projects in our planning have barely touched upon such topics as epidemiology, community organization, urbanization, agency administration, patterns of care, financing, etc. These areas warrant comprehensive study and call for involvement of not only the Department of Psychiatry, but other University Departments such as Psychology, Sociology and Anthropology, the School of Social Work, Business Administration, and others. In addition, such research should include the participation of numerous state and local organizations, agencies, and groups, including state hospitals, mental health centers, private psychiatrists, schools, correctional institutions, public welfare, public health, vocational rehabilitation, and general hospitals.

Institutions of higher learning should continue with their own intensive efforts and provide both opportunity and motivation for research on the part of students and trainees. At the same time, the University should assume a stimulative, consultative or collaborative role with other investigators throughout the state. Only in this manner can we even begin to properly evaluate methods of treatment and prevention and to avoid continued waste and ineffective utilization of our mental health resources.

FUTURE PLANNING

The Committee on Mentally Ill Adults is in complete accord concerning the necessity for continued mental health planning, as well as the necessity for the collection and dissemination of pertinent mental health data and information. Rather than continue the present planning structure, however, it is proposed that a central or master committee be organized with broad representation from mental health facilities, agencies, organizations, and groups. To facilitate future planning, this central committee could from time to time name ad hoc subcommittees for specific purposes or request that certain studies be performed by competent researchers or appropriate departments of government and higher education. In addition, it would be important for this committee to regularly review various mental health programs and progress that has been made in implementation of the comprehensive plan. Since the new Mental Health Authority legislation has provided for an expanded, broadly represented Committee on Mental Hygiene, it is suggested that this committee might well be given the responsibility for continued planning. Adequate funds must be appropriated in order to permit such a committee to carry out its intended functions.

Major recommendations of this committee are found at the end of Chapter VII.

Report of the Committee on Mentally Ill Children

INTRODUCTION

The Committee on Children assumed its task by first acknowledging the charge and then establishing a frame-

work around which to function. Previous state planning and recommendations were reviewed, general goals were set, and special subcommittees were appointed. Except for the mentally retarded (who were the responsibility of another special committee), the committee considered all children to be within its purview, and these were broadly defined as those persons, including delinquents, who are better served by a program or facility regarded as a children's service.

Including its initial meeting on January 24, 1964, the committee met on ten occasions, usually for up to five hours per session. Most meetings were held in different children's facilities where the professional personnel were invited to participate. Customarily the entire committee would first have a briefing session, then separate into subcommittees, and later come together for reports and discussion. Subcommittees were formed to consider the following areas: 1) Basic Community Services for the Child in his Own Home, 2) Services for Delinquent Children, and 3) Services for Emotionally Disturbed Children (including brain damaged) and for Dependent Children.

It was recognized that an attempt to gather factual data on the number of emotionally disturbed children in Iowa would be impractical, and almost impossible in a short time to establish valid statistics which would demonstrate the value of early care. Rather, it was decided to rely upon statistical and resource information provided by the many agencies and institutions serving children.

At the first meeting, the following goals were propounded to serve as guidelines for the committee: 1) encouragement of public recognition that mental health is influenced by both internal and environmental factors, 2) encouragement of communities to assume more responsibility for the care and treatment of children, and 3) improvement of coordination between state and community services.

COMMUNITY SERVICES

The children's committee favors the establishment or extension of locally sponsored comprehensive mental health centers so that all counties of the state are adequately served, and suggests that these centers employ professional staff with some training and experience in child psychiatry. Because of the ever-increasing demand for services, mental health centers and private practitioners must expand their role of consulting with schools, courts, welfare departments, public health nurses, ministers, and others. (See Appendix I.)

Early detection of emotional illness is important, and often the school is first aware of a problem. This emphasizes the desirability of school psychological services, which should be developed in districts where none now exist. For sparsely populated areas, the committee advocates regional school units to provide not only psychological services, but other specialized assistance, such as consultation in special education.

Efficient utilization of specialized services requires that their availability and limitations be a matter of common knowledge to all concerned. Ideally, each community develops its own unique system for keeping everyone well-informed. Today's increased family mobility necessitates rapid, effective communications among school systems and agencies serving children. For example, the use of standardized record forms would facilitate the discrete exchange of data, including certain privileged information.

In addition to these broad considerations, the committee proposes that certain other special needs be served at community level. Detention and diagnostic facilities for delinquent children should be improved or established in all areas of the state, and where they do not exist, nearby state institutions and their present staff should be encouraged to make their services available.* It is suggested that local agencies, in cooperation with the Department of Social Welfare, take advantage of the 1962 amendments to the Social Security Act to establish homemaking services which are desirable when a mother is absent from the home or unable to carry out her responsibilities. Other federal legislation provides funds for certain specified services to handicapped preschool children, and the Department of Public Instruction should encourage public schools to participate in this program.

Though the need for vocational training is widely known, few programs exist in Iowa. The committee recommends that the state encourage and subsidize the development of vocational training programs in local school systems to meet the needs of adolescents who seek such training or lack academic aptitude or interest. It is suggested that trainees be exposed to real vocational experiences provided through close liaison with industry and in accordance with employment opportunities. Acceptance of these programs requires that many parents be taught that each child's basic needs rather than parental aspirations should determine vocational goals. At the same time, parents must be helped to recognize the value of skilled and semi-skilled occupations.

THE FOSTER HOME CONCEPT

The committee feels that a child should be separated from his home only after judicious efforts to strengthen or rehabilitate the home have failed or offer no promise of success. When separation is necessary, diagnostic study should be given reasonable priority by mental health centers and other facilities as a basis for long-range planning for the child. In keeping with expert opinion, the committee also believes that a good foster home usually provides the most favorable environment for the development of most children who have lost their parents or whose homes are unsuitable and who are not available for adoption. It is urged that the state of Iowa officially recognize this concept through the Department of Social Welfare and the Board of Control, whose policies should encourage foster home placement rather than institutional custody. Additional state funds for foster home care are necessary, and extra financial consideration should be extended to attract good foster home parents and develop "professionalized" homes for hard-to-place children.

It is recommended, further, that changes be made in the law and administrative practice to eliminate financial advantage to a county in committing a child to a state institution for dependent children rather than placing the child in a foster home. At present, counties are relieved of all costs for the care of children of veterans and half the cost for others when they are committed to the Annie Wittenmeyer Home or the State Juvenile Home at Toledo. Similar changes

*A copy of the report on the Survey of Juvenile Probation Officers in Iowa is available on request from the Iowa Mental Health Authority.

are advisable to remove any financial advantage in utilizing a particular state children's institution.

The committee acknowledges that some children, especially adolescents, cannot adjust to a foster home or may not be accepted by foster parents. Thus, the establishment of half-way houses and group homes throughout the state is proposed for such children who cannot be suitably placed in substitute family situations.

RESIDENTIAL CARE AND TREATMENT

It is the committee's conviction that institutional care of children is justified only by special needs or problems, with prompt return to the community when warranted. Assuming, however, that his own home is unavailable or unsuitable, a child should be expeditiously transferred from an institution to a foster home when this change would be more beneficial. Such action is indicated for children presently in public and private institutions in Iowa, particularly the Annie Wittenmeyer Home and the State Juvenile Home.

Adequate staffing will be necessary to maintain close liaison between children's institutions and foster home programs at state and county levels, and if treatment is to replace custody, all children's institutions must be provided with sufficient funds to employ trained professional personnel, including child care workers, and to engage regular psychiatric consultants.

In support of the above philosophy, it is recommended that the Annie Wittenmeyer Home provide short-term diagnostic observation and become a treatment and training institution for younger children with a view toward preparing them for adjustment in a family setting. These objectives will require a significant reduction in the present census, many more trained personnel, a better staff-patient ratio, and more favorable working conditions (particularly the hours on duty). The committee advocates that the State Juvenile Home at Toledo provide the following services, as previously recommended in 1962 by the Governors Advisory Committee: (1) Short-term care for relatively normal, older children awaiting placement in a foster home or group care home. (2) Longer-term care and treatment for older, poorly-socialized or mildly delinquent children not in need of a specialized correctional setting. (3) Care and vocational training for older children who lack suitable homes and are "slow learners," to apply only when services are not available in the community.

To supplement inpatient facilities at Psychopathic Hospital (20 beds) and Independence Mental Health Institute (40 beds), it is recommended that a children's unit be established at the Cherokee Mental Health Institute. This would provide residential treatment for the western part of the state and at the same time furnish a valuable training experience for psychiatric residents. Consideration should also be given to replacement of the obsolete buildings now occupied by the children's unit at Independence. Except for these recommendations the committee is, for the present, opposed to the expansion of services for children at state institutions. Rather, the development of community services should be emphasized, and private hospitals, particularly general hospitals with psychiatric units, should be encouraged to establish units for children. The committee is favorably impressed by the residential treatment centers for children which are maintained under private auspices, and public recognition should be given to such centers as the Lutheran Children's Home in Waverly, the Beloit Lutheran Home in Ames, St. Mary's Children's Home in Dubuque, and the new facility, Orchard Place, in Des Moines.

In Iowa there is no public provision for brain-damaged children who are neither mentally deficient nor epileptic, but who are typically overactive, distractable, and difficult to control. To serve this special group, it is recommended that a change in legislation or Board of Control policy permit their placement in or commitment to a Board of Control Institution when hospital training or control becomes necessary or desirable in the joint-judgment of the Board of Control and the referring community agency. It is also recommended that this change in legislation or Board of Control policy authorize and provide treatment and training programs in state institutions until local communities, with the assistance of the Board of Control and other agencies, are able to establish adequate facilities and services. It is recommended that The University of Iowa Medical Center establish a special unit for research, training, and treatment of brain-damaged children. This would certainly not involve the provision of long-term care. This could be developed in the Department of Pediatrics in relation to the Hospital School for Handicapped and the State Services for Crippled Children, utilizing consultants from Special Education and Child Psychiatry as well as from Neurology and Orthopedics.

MANPOWER AND TRAINING

Although there is a dearth of available professional personnel to work with children, including juvenile offenders, the committee urges that staffs be increased in number and improved in quality. This includes a wide range of disciplines at every level of service, in the community and in institutions. Without qualified professional staffing, any other recommendations will be sharply limited in value. To help fill the manpower vacuum, there should be active support for the continuation and expansion of programs in training and research in children's mental health professions, such as the program in child psychiatry at The University of Iowa. The training of physicians (medical school and postgraduate) should stress not only basic psychiatry but instruction in dealing with the emotional needs of expectant parents, and preparation for parenthood. The need for periodic evaluation of all school-aged children demands an intensification of the training and recruitment of school psychologists, physicians, welfare workers, and allied disciplines. There must, also, be an extension and strengthening of programs (pre-service and in-service) for teachers, relative to the recognition, understanding, and handling of emotional problems of children. School administrators could assist by adopting organizational concepts which would free teachers of routine, nonteaching duties. All persons working with children should receive instruction regarding the roles of other professionals in order to develop an effective interprofessional communication.

While on the subject of manpower, there is another apparent need. The committee urges that one or more Iowa institutions of higher learning (public or private) develop a program for the training of child care workers who would function as substitute parents in the treatment of children. It is specifically requested that the Board of Regents give

this consideration. Such a program should be offered at two levels: (1) A career program for younger people combining academic and practical training (comparable to nurses training). (2) A shorter, practical training program with less academic emphasis for persons interested in improving their child-care capacities (comparable to practical nurses training).

PREVENTION AND PUBLIC EDUCATION

Every community should ultimately assume responsibility for public education in the field of mental health. It should assess the availability of mental health educational services, including parent education, and take steps to fill any gaps. Although consultation with state level mental health organizations is available, it is also important to secure the confidence and support of professional people living and working in the community. Social Welfare, Mental Health Centers, physicians, public health nurses, and educators should assume leadership roles in such educational programs. Perhaps the State Department of Public Instruction and the University Extension Divisions could assist in the development of a joint program for the education of parents in child and family development.

As a part of prevention, the committee recommends that school curriculums include training for the adolescent in basic behavioral science, including behavior toward the opposite sex, in the hopes of fostering the development of emotionally healthy interpersonal relationships, at home, at school, and in society. In the interests of good physical health, it is also recommended that the State Department of Health and state and local medical societies be encouraged to continue to inform patients of immunization needs and availability of services. Likewise, to cope with one of the known causes of mental retardation, it is suggested that state and local medical societies consider methods of routinely testing for phenylketonuria at every childbirth.* The excellent work of physicians in the community to date is to be commended.

RESEARCH, PLANNING AND COORDINATION

Over the months of committee deliberations it has been apparent that this project may terminate with many important facts still to be uncovered, many needs still unmet by the final plan, many agencies and resources still lacking coordination in the solution of common problems, and, lastly, no means to implement recommendations. The children's committee has given much time and thought to this impending problem and offers the following as a plausible solution. It is recommended that the Iowa Mental Health Authority assume continuing responsibility for establishing a central repository for materials (reports and recommendations) developed by mental health planning groups. A Research and Information Center should also be maintained by the Iowa Mental Health Authority for the evaluation and planning of patterns of treatment, care, and prevention in the field of mental health. The unmet needs of handicapped children should be determined on a regular basis by survey techniques and, appropriate agencies should be stimulated to provide necessary services. To this end, the Iowa Mental Health Authority should call meetings at regular intervals each year to initiate coordination techniques as part of the task of this office. There should be a complete assessment of the organization and policies of agencies serving handicapped individuals conducted by the appropriate, professionally qualified persons. It is desirable that such a study include recommended changes in the general structure and broad policies of the agencies involved.

The committee further recommends that the Iowa Mental Health Authority conduct continuing surveys concerning the availability of specialized services and facilities for handicapped children, including residential care and foster home placement. Other areas of research require attention, but may be beyond the province of the Mental Health Authority. For example, the financing and patterns of medical care should be studied by the State Legislature or its designate and steps should be taken to insure adequate medical care for the indigent and medically needy. Another study might be carried out in selected geographical areas to determine the proportion of families living on an economic level below that reasonably needed to maintain emotional security and self respect. The committee further recommends that the nature and function of various public relief agencies be studied by the Governor's Advisory Committee on Social Welfare with the view of developing a unified public welfare program.

As a conclusion to this report, it seems important to touch upon one of the more pressing needs in the area of mental health services for children, the need for coordination at all levels. Though it is quite correct to say that coordination is a community responsibility, there are relatively few communities where the services of all agencies and professional groups could not be improved through better coordination. In an attempt to deal with this problem it is proposed that the Iowa Mental Health Authority assume continuing responsibility for stimulating and organizing coordination meetings of state and local (public and private) agencies concerned with mental health. Since these added responsibilities will require an adequate professional staff, it is further recommended that the necessary funds be included in the Iowa Mental Health Authority budget.

Major recommendations of this committee are listed at the end of Chapter VII.

Report of the Committee on Mental Retardation

INTRODUCTION

The Committee on Mental Retardation, in recognition of the development of a Comprehensive Plan to Combat Mental Retardation, carefully reviewed its charge and agreed to pursue an approach which would focus on the needs of the mentally ill mentally retarded and also give consideration to the broad mental health implications of mental retardation.

This Committee held its first meeting on January 17, 1964. Nine additional one-day sessions and one two-day session were held. In addition to scheduled committee meetings, special reports were prepared by committee members covering the following subjects: Diagnostic Planning and Treatment Center for the Mentally Retarded; Pattern of Community Services for the Mentally Retarded; Community Residential Facilities Re-Defined; Social Service Role

*The 61st General Assembly enacted S.F.463 pertaining to the testing of every newborn child for phenylketonuria.

of the Community Project for Mentally Retarded; Vocational Rehabilitation and the Emotionally Disturbed and Mentally Retarded; Report on Special Education. (Copies of each of these reports, accepted by the Committee as working documents are included in the appendices.)

DEFINITION AND CLASSIFICATION SYSTEM

Mental retardation is not a diagnosis but a complex of symptoms. This fact complicates the development of a single definition acceptable to all disciplines. The Committee therefore supports a liberal definition of mental retardation as proposed by the President's Panel on Mental Retardation, which is as follows: "The mentally retarded are children and adults who, as a result of inadequately developed intelligence, are significantly impaired in their ability to learn and to adapt to the demands of society."

In order to encourage standardization of collection of data on the mentally retarded, the Committee embraces the classification system of the American Association of Mental Deficiency. A description of the levels of retardation, namely, borderline, mild, moderate, severe, and profound retardation, are outlined in "A Manual on Terminology and Classification in Mental Retardation," prepared by Rick Heber in Monograph Supplement to American Journal of Mental Deficiency, Volume 64, No. 2, September, 1959.

CONCEPT OF COMMUNITY

Approximately 3 per cent of the population are mentally retarded. This requires a large population base to support adequate local services and facilities to provide the necessary care and treatment. The demographic characteristics of the state of Iowa add to the problem of comprehensive planning at the community level. In view of this difficulty, the Committee agreed to approach its assignment through the concept of an ideal "community." The term "community," as used in this report, refers to a metropolitan area, a large county, or to a number of cities, towns, or counties which may gather together for cooperative planning and service.

UNDERLYING PRINCIPLE

The specific needs of mentally ill mentally retarded persons and their families are greatly dependent on conditions necessary to develop good mental health for all people. Thus emphasis was given to formulating the following principles which bring into perspective the philosophy of the community in its relationship to the mentally retarded.

1. The mentally retarded person, just as any human being, has human value, human dignity, and inherent human rights. Therefore, insofar as is feasible, the basic health, education, and welfare needs of the mentally retarded should be provided for out of the main stream of the community's health, education, and welfare programs.

2. An effective program of service for the mentally retarded is dependent upon the existence of an adequate basic program of community health, education, and welfare for all citizens.

3. Existing community health, education, and welfare services are generally applicable to the programs for the mentally retarded. These basic community services should be made fully available to the retardates. When necessary, modifications of existing programs can be tailored to meet the special needs.

4. Specialized services for the retarded are necessary to supplement basic health, education, and welfare programs. However, these special programs for the retarded must be viewed as supportive and supplemental.

5. Every "community" and health, education, and welfare agency therein must have a formalized structure upon which a sound pattern of coordinated planning and action can be based.

IMPLEMENTATION

Implementation of recommendations should rest with the departments of state and/or local governments having responsibility for the health, education, and welfare services to the population in general.

Recommendations of the Committee on Mental Retardation

EARLY DETECTION

1. It is recommended that, when indicated, children between three and five years of age be given a developmental assessment in order to identify abilities and disabilities that could affect future educational progress. (See Addendum.) It would be desirable to begin such screening with high-risk children such as prematures, younger siblings of children in special education, children of families who are economically and educationally deprived, handicapped children, and children who appear psychotic, mentally retarded, or grossly maladjusted. Responsibility for implementation should fall to the jurisdiction of the Department of Public Instruction and/or the Department of Health. It might also be advantageous to solicit the consultation of the Iowa Psychological Association and the Iowa Chapter of American Academy of Pediatrics.

EDUCATION

2. It is recommended that a program of orientation be directed to the total faculty and student body of each school emphasizing their responsibility for the understanding and acceptance of the handicapped student and the program.

3. It is generally recommended that the special class or classes in a given school district be a part of the regular attendance center for the appropriate age groupings, and that the special class program be considered an integral part of the total school program.

4. It is recommended that when the school finds special class placement appropriate for a child, a special effort should be made to interpret to the family the appropriateness of the placement and the individual benefits which accrue to the child.

5. It is recommended that school districts sponsoring special classes for the mentally retarded have available within their system a school nurse, and that the school nurse have a good orientation to mental retardation and to the implications of special education services.

6. It is recommended that all school districts have available the services of a professionally trained school social worker.

TRAINING

7. It is recommended that short-term workshops, seminars, and in-service programs be developed for the personnel providing services to the mentally retarded and his family. This includes personnel such as social workers, public health nurses, school personnel, etc.

8. To assure proper orientation of future professional personnel providing services for the mental retardate and

his family, it is recommended that colleges and universities training professional persons provide a basic orientation to the implications of mental retardation and the needs of the retardate and his family. These professions would include particularly: medicine, education, law, psychology, nursing, social work, and those in employment and rehabilitation counseling.

9. It is recommended that Iowa's two state institutions for the mentally retarded strengthen and expand their programs of in-service training and staff development, placing particular emphasis on the mental health needs of the mentally retarded. These institutions should assume responsibility for vigorous leadership in training specialists in mental retardation, particularly in those professional disciplines listed in recommendation No. 8 above. In addition, special workshops, seminars, lectures, short courses, and institutes in selected areas on mental retardation should be provided as a part of the on-campus training program provided for their staff and related professionals from Iowa, from the region, and the nation.

10. It is recommended that colleges and universities in Iowa and the state's institutions for the mentally retarded should intensify and expand cooperative and coordinated education and training efforts, particularly as they relate to training professional personnel who work in the field of mental retardation. Where appropriate, academic appointments of qualified institutional staff members to faculties of universities and colleges are recommended, together with part-time staff appointments and consultant appointments of college and university personnel to the institutional staff.

RESIDENTIAL CARE

11. It is recommended that the residential facility for the mentally retarded should be a rehabilitation, restorative, health, education, and welfare institution. It should espouse a dynamic philosophy of salvaging retarded individuals for family and/or community living before admission, after admission, and at any time along the way that this action becomes possible. The residential care facility should offer a series of specialized treatment, training, and care programs.

12. It is recommended that Iowa adopt, support, and promulgate the philosophy, principles, goals, and standards on residential care of the mentally retarded as they are presented in the following documents:

"Standards for State Residential Institutions for the Mentally Retarded," Monograph supplement to *American Journal of Mental Deficiency*, Volume 68, No. 4, January, 1964.

"A Proposed Program for National Action to Combat Mental Retardation"—The President's Panel on Mental Retardation. October, 1962.

COMMUNITY BASED SERVICES

13. It is recommended that residential centers and the community agencies, within the framework of the "Ideal Community" (See Appendix J), develop a sound pattern of coordinated planning and action.

14. It is recommended that basic community health, education, and welfare services be made fully available to the retardate and his family when specialized services are necessary. They should, in so far as feasible, be developed by and within existing health, education, and welfare programs. These services should be coordinated through a specified local agency. This "fixed point" within the community for coordinating services for the retarded might be located in a health center, mental health center, or mental retardation center.

15. It is recommended that mental health clinics should increase their services to the mentally ill mental retardates and their families and to all retardates and their families, when either are in need of guidance and counseling.

16. While an outpatient facility might well be established in the residential center, in general, outpatient treatment should be carried on in the community.

SPECIAL FACILITIES AND SERVICES

17. It is recommended that the unique needs of the mentally ill mental retardate be met by approaching their special problems across a broad front. This shall include:

A. Implementation of all of the other recommendations included in this report.

B. Strengthening, expanding, and adding direct services provided to the mentally ill retardate by community mental health facilities and other health, education, and welfare agencies.

C. Utilizing the psychiatric services of the Mental Health Institutes when appropriate, particularly through inter-institutional transfer from hospital-school to mental health institute.

D. Strengthening and enriching the over-all program of care and treatment provided at Glenwood and Woodward, with particular emphasis upon the special program and professional staff services required to meet the needs of the mentally ill patients cared for within those facilities.

E. Any laws in conflict with the above recommendations be repealed.

18. It is recommended that in planning for the security hospital, adequate consideration should be given to the need for facilities for the mentally retarded offender who needs security control.

19. It is recommended that the Executive Committee of Iowa's Comprehensive Planning for Mental Health officially adopt these recommendations as a part of the Iowa Plan for Mental Health. That the Executive Committee broadly disseminate this report, including the working papers in the appendices, to interested personnel, agencies, and organizations. It is further recommended that the report be sent to selected boards of directors and executives of Iowa's state and local departments, and agencies and organizations which are serving or might serve the mentally retarded, with the request that these boards and executives give consideration to future program enhancement and implementation in relation to those recommendations which may be applicable.

Addendum to Final Report of the Committee on Mental Retardation in Children and Adults

A majority of the members of the Committee on Mental Retardation in Children and Adults disagree with the wording approved by the Executive Committee for Recommendation No. 1 concerning early detection. The recom-

mendation now reads, "It is recommended that *when indicated** children between three and five years of age be given a developmental assessment . . ." The original recommendation read, "It is recommended that *all** children between three and five years of age be given a developmental assessment. . . ."

We sincerely hope that medical and other disciplines always perform evaluation and service "when indicated." However, there is nothing in the recommendation as to who decides when a development evaluation is indicated. The recommendation in its present form recommends a continuation of present practice, which we consider inadequate.

If there was a mandatory preschool evaluation of children, many unfortunate problems such as those concerning speech, hearing, sight, and mental retardation could be identified early and a program of treatment initiated. At the moment, the presence of these conditions is not recognized until starting kindergarten.

The committee recognizes that a specific screening device that will weed out more obvious impairments has not yet been generally accepted. It is desirable that such a screening device be developed utilizing the information gathered by the public health nurse, the social worker, and all disciplines associated with children. We further recognize that it might be more expedient to start by screening high-risk children, such as those listed in the recommendation.

The original recommendation of this committee was unanimous and we feel that this was one of the strongest and most necessary recommendations our committee made. The tremendous response to the Head Start Program over the past summer and the decision to continue the program in the future tend to intensify the need for such an evaluation.

We request that the Executive Committee include this comment with the Final Report of the Committee on Mental Retardation in Children and Adults.

Yours sincerely,
Committee on Mental Retardation

Report of the Committee on Adult Offenders

INTRODUCTION

The offender has long been an enigma to society. The tangible and intangible losses flowing from antisocial behavior deprive a large segment of society of its basic needs—family, home, work, religion, love, and the right to enjoy a comfortable life, to name a few.

Attempts to prevent or salvage these losses by the traditional method of punishment have been generally ineffective, while the rate of criminal offenses increases. More effective methods of treatment must be devised if society is to relieve itself of this burden. This traditional punishment method has been dictated largely in response to the emotional demands of society.

In view of current knowledge, it would seem more reasonable to look to proven and accepted concepts of human behavior as a means of understanding and modifying the motivation behind antisocial behavior.

An evaluation of the populations of the adult correctional institutions of the state of Iowa indicates that 10 to 15 per cent of the offenders are blatantly psychotic. Of the remainder, few lack significant psychological disturbances or deviation. These findings correspond with similar studies in other states.

The committee accepts as a basic concept the belief that the majority of offenders suffer from some type of psychosocial disorder. By definition, the psychosocial disorders include not only the usually accepted interpretation of mental illness such as the psychoses and neuroses, but also those personality defects demonstrated by an inability to make an acceptable adaptation to the laws, regulations, and customs of society.

The committee expresses concern regarding the general negative attitude of many people who are directly or indirectly associated with the offender as he proceeds through the legal and correctional processes. Improvement of the offender's mental health can be achieved only if he receives appropriate, rational, humane, and intelligent treatment, in addition to the necessary controls.

The committee recognizes that a most important aspect in regard to the mental health needs of the adult offender is primary prevention of these disorders. The committee has chosen not to consider this area because primary preventive measures will be covered by the recommendations of the committee dealing with children. It is recognized that the potentially most successful method of dealing with the problem of the adult offender is, as is true in most health problems, providing the necessary corrective experiences in childhood and avoiding the deleterious experiences.

The committee directed its studies, evaluations, and recommendations regarding the mental health of the offender with reference to warm, interpersonal relationships between the offender and those people entrusted with his care, to the mental health status of the offender, and the mental health services available to him throughout the legal and correctional processes. The study of this subject matter was divided into three phases: 1) preconfinement, 2) confinement, and 3) postconfinement.

PRECONFINEMENT

The impact of our legal processes on the mental health of the accused can be profound. The necessary chain of events includes apprehension, arrest, detention, arraignment, provision of counsel, bail, investigation and interrogation, assignment of the judge, fixing date of trial, preliminary hearings, trial sentencing, etc. In some instances, these practices are so disruptive of the offender's crucial family relationships, so damaging to the self-concept and self-esteem, and so shocking to the standards of justice embodied in the conscience that they inflict the precipitating and necessary cause for severe and irreversible psychic damage. These practices are often confusing and perhaps unenlightening to the public and disillusioning to society's faith in justice. Quite frequently the deterrent effects intended of these practices operates to produce the reverse of that intended. Neither justice nor moral or ethical considerations lend any credence to the proposition held by many people that the accused is no longer a human being and therefore, inappropriate, irrational, inhumane, or unintelligent treatment is justified.

LAW ENFORCEMENT AGENCIES AND PERSONNEL

Law enforcement personnel are generally the first contact

*Italicized for clarity.

of the accused with an official representing society, acting in our legal and correctional processes. The impression gained by the accused in this first contact is lasting. This impression in large part determines the subsequent attitudes and emotional tone of the accused and his reaction to subsequent rehabilitation procedures.

There are law enforcement agencies within the state that are well organized and administered. The personnel of these agencies are carefully selected on the basis of personal competence, intelligence, and ability to adapt to this type of work. The personnel are trained initially and on a continuing basis in the various aspects of police science and, to some extent, in the dynamics of human behavior.

Conversely, many law enforcement personnel are selected for these positions on considerations other than personal qualifications. They have little knowledge of progressive concepts of police science and little or no understanding of human behavior. Their interest in the offender is not that he should be rehabilitated, but only that he should be caught and evidence of his guilt extracted from him by any means. Too many of this category of law enforcement officers operate under the code of Hammurabi formulated in the year 2100 B.C., where we first encounter *lex-talionis*, the principle of punishment which demands retaliation for the crime committed. These attitudes are considered largely responsible for the negative, hostile attitudes and lack of respect for law and order exhibited by many members of our society.

JAIL, FACILITIES AND PERSONNEL

Surveys of county jails throughout the state of Iowa indicate that few of our jails meet the bare minimum standards prescribed by the National Jail Association. Many of the facilities are so antiquated that it is impossible to maintain acceptable sanitary and hygienic conditions. There are no provisions for segregation of prisoners so that the very young or first offender is thrown at the mercy of the hardened criminal. Nutrition is frequently inadequate. Treatment facilities and personnel are completely nonexistent. Prisoners languish in the midst of an atmosphere of degradation without any opportunity for constructive pursuits. All evidence points to the conclusion that the county jail system is a glaring example of man's inhumanity to man.

The personnel responsible for the prisoner and operation of the jail are, like many peace officers, selected on bases other than qualification for the job. Usually, they have one simple objective—that of seeing that the prisoner is securely confined till expiration of his sentence.

The committee condemns the nonrehabilitative aspects of our present county jail system and views the degrading atmosphere thereof as absolutely detrimental to the mental health of those incarcerated therein.

ATTORNEYS AND COURTS

The majority of defendants are not well educated, are relatively uninformed, and belong to a marginal socio-economic component of society. Many have had little or no contact with professional people prior to appearance in court. Therefore, adequate legal services should be made available to all defendants, whether from private sources or by use of the public defender system.

The committee recognizes that it is the duty of the legal profession and the judiciary to carry out the laws of the state. However, the interest of society, as well as that of the individual defendant, could frequently be better served if the rigidity of the law were tempered by a realistic application of knowledge of human behavior. It is the duty of all parties in legal proceedings to refrain from inflicting intentional psychic trauma upon the defendant, or if the defendant shows evidence of significant disorder, to arrive at a meaningful definitive disposition on an individual basis.

COURT PROCEEDINGS AND SENTENCING PROCEDURES

Just as the decorum of the personnel involved in the legal processes frequently influences the mental health of the defendant, so can the processes and procedures themselves have a positive or negative influence. The "bargained" sentence effected without sufficient explanation and with lack of understanding on the part of the defendant, and the apparent disparity of sentences without understanding the rationale, are but two examples wherein the defendant frequently feels that he has been the victim of injustice. A mentally disordered offender who passes through the legal processes without due consideration being given his disability, frequently is imprisoned simply on the basis of protection of society; whereas, a more appropriate disposition might have been made which would not only protect society, but, in addition, provide help for the restoration of the individual to a state of optimum mental health.

In an effort to overcome the many deficiencies and objections to our present legal system, the Advisory Council of Judges of the National Council on Crime and Delinquency suggested guidelines contained in the Model Sentencing Act. The rationale of the philosophy, an explanation of the objectives and sentencing procedures as recommended by the Council of Judges, are contained in the complete report.

The committee is in agreement with the philosophy and objectives of the Model Sentencing Act. Implementation of the guidelines set forth therein would not only enhance the preservation of the mental health of the defendant, but would greatly aid the rehabilitation processes.

Article II of the Model Sentencing Act refers to presentence investigations. Two bills previously introduced but not enacted by the Iowa Legislature would provide authorizing and enabling Legislation for implementation of presentence investigation. The first bill, Senate File #155 by Senator Turner, dated 1 FEB 61, entitled "An Act Authorizing Mental and Physical Examination and Treatment of Prisoners" (as amended by the Committee on Adult Offenders), is endorsed by the committee. The revision of the bill was made by the committee on the recommendation of a judiciary member who had consulted with several of the original authors.

The second bill, Senate File #382 by Senators Potter and Turner, dated 23 FEB 61, entitled "An Act Relating to Adult Probation Officers and Presentence Investigation," is endorsed by the committee. The portion relating to adult probation officers will be referred to later in relation to the subject of probation.

Section 4 of Article II and Section 6 of Article III refer to diagnostic reports. The term "diagnosis" is not to be interpreted in its ordinary limited sense of classification only. Diagnosis in this instance should include a broad evaluation

and longitudinal life study. All information which can contribute to the understanding of cause and effect, motivation, personality dynamics, assets and liabilities of the defendant, and any other information which can contribute to the court in determining the appropriate sentence and enhance planning a rehabilitation program should be included.

The 59th General Assembly in Chapter 127, Par. 22, of the Legislative Record, authorized the Board of Control to establish a diagnostic clinic. Section 218.97 of the Code of Iowa, entitled "Diagnostic Clinic," is quoted:

> The Board of Control is authorized to provide facilities and personnel for a diagnostic clinic. The work of the clinic should include a scientific study of each prisoner, his career and life history, the causes of his criminal acts, and recommendations for his custody, care, training, employment, and counseling with a view to his rehabilitation and to the protection of society.

Implementation of this section of the Code requires enabling Legislation in the form of an appropriation. Enactment of this legislation would provide the facility to carry out the diagnostic evaluation at the pleasure of the court as part of the presentence investigation.

The utility of a diagnostic facility and the intention of the courts to use same in connection with presentence investigations are indicated by a recent survey made by a member of the committee. Twenty-six courts were asked, "Would you favor the establishment of a Security Hospital for the care and treatment of the criminally and dangerously ill, and for use as a diagnostic facility to aid presentence investigation?" Seventy-three per cent answered in the affirmative.

Section 9 under Article III of the Model Sentencing Act lists probation as one of the sentencing alternatives. The bill submitted as Senate File #382, dated 23 FEB 61, by Senators Potter and Turner (referred to previously), would provide for mandatory presentence investigations in criminal cases and authorize enabling legislation for expanded statewide probation and parole services. Briefly, the bill authorizes "the judges of each Judicial District to appoint adult probation officers as shall be necessary to investigate, supervise, and carry out the probation, rehabilitation, corrective and supervisory powers of said court over persons within its jurisdiction . . . ." It is intended that the appointing judges would consult with the Director of the State Board of Parole regarding qualifications and fitness of applicants. It would be required that the training and supervision of the District Court Probation Officers would be delegated to the Director of the State Board of Parole. In private conversations conducted with several members of this committee, members of the judiciary indicated they are in agreement with this delegation of function. They expressed the opinion that it would lend consistency to the probation and parole programs. Further, supervision of probation agents by the State Board of Parole, "an independent agency," would relieve the courts of many pressures which might otherwise be exerted upon them. It is pointed out that while the presentence investigation is mandatory "unless the judge otherwise directs," it is to be made either by the probation officer or by the State Board of Parole. It is assumed therefore that the Board of Parole agents would perform their duties as probation officers in those Judicial Districts not appointing their own probation officers in accordance with the provisions of this bill. It is to be noted particularly that while the presentence provisions of the bill become mandatory with its passage, the provisions for appointing the probation officers do not.

It is the consensus of the committee that probation functions are lagging in many areas of the state and that increased use of probation by the courts would result in fewer commitments to the institution by rehabilitation through community resources. The use of probation keeps the family intact and off the relief rolls with inestimable savings to the taxpayer. It has also been proved in areas where probation has increased that there is a marked decrease in crime. Presentence reports, whether provided by agents of the Board of Parole or by Probation Officers of the Court, are almost a necessity for the guidance of the court to make probation selective. Institutional commitment should only be resorted to where it is clearly felt that the offender needs treatment in an institutional setting, would be a menace to society or himself, or where probation has proven to be ineffective.

It is intended that probation officers should provide services toward the ultimate objective of rehabilitation of the offender. It would seem appropriate that generally these personnel should have training in one of the behavioral or social sciences, education, correctional administration, sociology, or theology. Whenever possible, this training should be at a minimum of a B.A. degree level, and preferably at an M.A. degree level. Professionally trained probation officers can be expected to provide professional services in addition to surveillance. Probation officers should be able to obtain additional training in techniques of counseling and guidance at the community mental health and counseling centers.

CONFINEMENT

The committee endorses the philosophy of Corrections for the state of Iowa as found in the manual of the Board of Control of Institutions, Section 5.01.4, entitled "Iowa Correctional Policy."

The committee's study of the mental health of the adult offender classified the psychosocial disorders of such offenders into two major categories as follows:

1. *The Mentally Disordered Offender.* Those who are overtly psychotic or who exhibit disabling neuroses or disabling personality disorders, and those with organic brain disease or damage such as the mentally retarded and epileptic.

2. *The Socially Disordered Offender.* Those with character disorders, the unsocialized, and those who for whatever reason, have been unable to master the techniques of living in a manner acceptable to society and in conformity with the law.

Those offenders included in the first category are sufficiently ill mentally to require hospitalization for the psychiatric treatment of their disorder. Those in the second category ordinarily do not require hospitalization and can generally be treated in the prison setting under appropriate circumstances, which will be detailed later in the report.

The committee views diagnosis and evaluation as the first

*Copies of these bills are available upon request from the Iowa Mental Health Authority.

step in the treatment and rehabilitation process of the incarcerated offender. As pointed out earlier, this diagnosis would not be limited to classification only, but would include a broad evaluation and longitudinal life study. All factors which can contribute to the understanding of cause and effect, motivation, personality dynamics, situational stresses, the assets and liabilities, etc., of the offender should be included. In short, any information which would aid in the planning of the rehabilitation process for the offender should be included.

A diagnostic facility such as that authorized in Section 218.97 in the Code of Iowa should be established. All persons convicted of felonies should pass through this facility upon their commitment to incarceration unless they have been in the facility for presentence investigation. Other adult offenders may be sent to this diagnostic facility for evaluation at county expense.

The staff of the diagnostic facility representing all behavioral and social science disciplines would evaluate all offenders and make recommendations which would serve as a guide for the treatment and rehabilitation of each offender. These recommendations would be transmitted to the correctional facility in which the offender is transferred for incarceration.

The diagnostic facility would serve an equally important research function, thus providing a wealth of material which would help develop insights into the relationships between the personality dynamics and the causes of crime, as well as the development of new techniques of treatment and prevention.

PSYCHIATRIC CARE AND FACILITIES FOR THE MENTALLY DISORDERED OFFENDER

Presently, the severely mentally disordered male offender is confined to the Security Hospital located within the walls of the Men's Reformatory at Anamosa. This facility is grossly inadequate as a hospital for this type of patient. Due to the nature of the building itself, patients cannot be segregated by age, category, or for specialized treatment. Facilities for occupational and recreational therapy are minimal. The atmosphere resulting from being a part of the Reformatory is certainly not conducive to the treatment of the mentally ill. The physical arrangements of the building itself also largely negate the opportunity to conduct valid and meaningful research. In addition, it is felt the location of the Hospital within the walls of the Reformatory, itself, has had a deterring effect on the recruitment of the needed professional staff.

It is the opinion of this committee, from its own observations as well as from an examination of the evidence from other states, that the mentally ill offender should be treated in a facility completely separated from any of the correctional institutions. This facility should be combined with the diagnostic and reception center, since they would compliment each other. Such a combination would have a very important advantage in the efficient use of the professional staff, as well as affording the staff more diversification of professional activity, this latter point having been found to be an important consideration in the recruitment of new professional staff members.

An ideal location for such a facility would be near The University of Iowa. This would permit utilization on a consulting basis of University medical and paramedical personnel in diagnosis, treatment, and professional supervision. It is visualized that the University could lend significant assistance in research. The facility would also serve the University as a valuable resource in postgraduate training programs in law, medicine, psychology, social work, sociology, etc.

It is felt that this facility should be a part of the Division of Corrections and directed by a qualified psychiatrist. However, patients from other Board of Control institutions who become unmanageable by reason of uncontrolled aggression, thus requiring greater security, could also be transferred to this facility.

In addition to evaluation and treatment of the mentally disordered offender, this facility would be a center for much-needed research toward the understanding of the causes of criminal behavior and the development of more effective treatment techniques for offenders in general. Hopefully, this research would aim particularly toward developing treatment programs for the socially disordered offender, commonly known as sociopath or psychopath. Thus far, treatment processes and techniques for this large group of offenders have been notoriously unsuccessful. New techniques in both prevention and treatment must be devised since this type of offender is seen with increasing frequency and is a source of great difficulty both within the prison and within the community. It is this group also who have such a high degree of recidivism.

In order to minimize the stigma associated with the term "criminally insane," it is felt that the name of this new facility should be as innocuous as possible. Iowa Medical Facility has been suggested.*

THE CORRECTIONAL INSTITUTIONS, TREATMENT AND REHABILITATION SERVICES

Regarding the institutions at Rockwell City, Anamosa, and Fort Madison, the committee endorses the statement of correctional policy as previously quoted from the Board of Control manual. The Board should be given every support in translating this policy into actual practice in the institutions concerned. Unfortunately, we feel there is a long way yet to go before these institutions are functioning at their maximum potential. We will outline our conception of the more important steps involved in continuing this transformation from prisons which serve mainly to protect society into correctional facilities which not only protect society but also provide effective treatment and rehabilitation of the offender. To begin with, we feel that the names of these institutions should be changed to more closely identify with modern correctional philosophy. Each institution should be designated a "correctional facility" or "correctional center" rather than a "prison" or "reformatory." Likewise the chief administrative officer of each facility should be called the "superintendent" or "director" rather than the "warden."

The most important element in a successful correctional program is the purposeful and cohesive functioning of the entire staff group in such a way as to permit and encourage emotional growth on the part of the inmates. This type of organization is analogous to the concept of the "therapeu-

*The 61st General Assembly appropriated $5,610,000 to the State Board of Control for capital improvements, including a proposed maximum security hospital.

tic community" so successfully used in the treatment of the mentally ill. Of prime importance to the effective initiation and maintenance of such a program is the leader of the staff group, the superintendent. He must be an exceptional individual, capable of providing strong and enlightened leadership, trained and experienced in modern personality theory and socio-psychiatric treatment techniques, as well as in modern correctional philosophy, and concerned with the cultivation of emotional growth in both his staff and in the inmates. His formal training should be at least through the master's degree level in one of the behavioral sciences.

Under the therapeutic community concept, the treatment process involves the function of every staff member within the institution. The treatment philosophy of the superintendent must be developed, implemented, and supervised by a professionally trained clinical staff, headed by a clinical director. This can be done most effectively by assigning each clinical worker to supervise a small group of nonprofessional employees (presently called "guards"), who in turn are assigned to supervise a relatively small group of inmates in every aspect of their daily living. Employees in other specialized areas of inmate supervision, such as education, vocational training, work details, and recreation, must also be under the supervision of the clinical staff so that the over-all institutional management of each inmate can be closely coordinated and therapeutically oriented. The clinical staff will include persons with postgraduate training in the behavioral sciences, such as psychology, social work, correctional administration, sociology, and psychiatric nursing. As outlined above, the primary responsibility of the clinical staff will be to provide day-to-day, ongoing supervision and training for the rest of the institutional staff through formal and informal, individual and group conferences, focused on dealing with the emotional needs of the inmates. A secondary responsibility will be to work directly with inmates in conducting psychological testing, counseling, individual and group psychotherapy, and other specialized procedures. A third responsibility will be to work with persons important to the inmate from his environment outside the institution, such as his family, employer, parole counselor, and pastor. Therapeutic activity with the family is an area in which the clinical staff could most profitably expand their functioning, since many inmates who seem significantly rehabilitated in their institutional adjustment can quickly be led back into antisocial behavior patterns if such patterns persist in the family structure to which they return on parole. As far as Iowa's correctional institutions are situated at present, they are woefully understaffed with clinical personnel. Funds should be made available at the earliest possible time to provide adequate professional complements.

A remaining barrier against an effective treatment program in our correctional facilities is the continued existence of an artificial separation between custodial and clinical staff. Many of the present custodial officers find it difficult to change the philosophy and methods which they have used for years, and which stem from outmoded concepts of punitive and degrading handling of inmates. Some of them will be able to change their approach through adequate education and staff development supervision, while others will be unable to do so because of their own personality limitations. A first step in upgrading the functioning of these workers would be a change of title from "guard" to "correctional officer," which would indicate that their function is more than simply turning keys and preventing escapes. Another important step, which we are happy to note is receiving current legislative attention, is to increase the pay of correctional officers to the point where capable, well-motivated, and reasonably mature individuals can be more consistently attracted to this line of work. A significant stimulus toward higher caliber employee performance would be an arrangement encouraging the acquisition of further education on a part-time basis, leading toward promotion and greater responsibility. Scholarships or some other form of subsidy would enable certain correctional officers with adequate aptitude to continue university training and eventually become members of the clinical staff. For the foreseeable future, it appears that each state will have to develop and train most of the people to meet its needs in this area because of the general shortage of trained clinical personnel.

Regular consultation services from recognized private or university practitioners in the fields of psychiatry, psychology, and social work should be available to the superintendent and clinical staff of each institution.

The purposes of the treatment and the rehabilitation program are many. Simply stated, it is hoped that when the inmate leaves the correctional institution he will have attained self-respect, will have a willingness to accept personal responsibility, will have obtained an education or training which will enable him to provide himself and/or his family with a livelihood, and that he will be motivated to master the techniques of living which would permit him to function in a manner acceptable to society and comfortable to himself. Ideally, a program of this sort should be individualized. Some offenders will need assistance in overcoming emotional problems, others are unsocialized and will need to learn techniques of socialization. All of the modalities of treatment available through the disciplines represented by the professional staff will need to be used according to the individual need of each offender. Psychiatric consultation or hospitalization will be available if indicated. Hopefully, the professional staff would gain the confidence of the nonprofessional therapeutically oriented employee and provide supervision whether it be formal or informal.

In addition to religious counseling, it is visualized that the clergy could provide courses in social ethics and marriage and family relationships. Marriage counseling would be effective in salvaging a significant number of marriages and homes. Constant contact should be maintained with each inmate's family by members of the staff, if at all possible and contact between the inmate and his family should be fostered in every appropriate instance.

The professional staff should aid each offender in post-release planning, whether it be on parole status or at expiration of sentence. Each offender after leaving the institution should be permitted to contact or maintain an ongoing relationship with his resource person within the institution. Quite frequently "emergency action" on the part of this resource person will help the inmate over an acute situation arising in the process of his readjustment in society.

One of the major deficiencies of many of the offenders is education. Approximately 80 per cent of all offenders in institutions in Iowa under the age of twenty-two are drop-outs from school. The committee believes the rehabilitation program must include educational opportunities for those

who are capable of taking advantage of same. Each offender should be offered the opportunity of at least completing his high school education if he spends sufficient time in one of the correctional institutions to permit this. On the other hand, there are some offenders who simply, because of lack of interest or inability to learn, must have their educational opportunities directed toward vocational training. A considerable number of the younger men have the capacity, and it is appropriate in many instances that their educational training include both academic achievement of a high school diploma as well as vocational training. There is still another group who have completed high school, are motivated, and have the capacity for college-level work. The committee views as necessary the establishment of a relationship between each institution and an institution of higher learning for the purpose of providing education at the college level for those who could benefit.

It has been the practice in both adult male institutions to assign a rather large group of inmates to the various industries. Many of these jobs are menial and require no special knowledge or training. It is difficult to find substantiating evidence that any significant number of men who do work in existing industries follow this same type of work upon leaving the institution. Perhaps it is time that the current prison industries undergo an objective evaluation for the purpose of determining the contribution that they do or do not make to the correctional process.

A virtually untapped source of services which would fill a large void in present treatment programs in the state's correctional institutions is the Federal-State Program of Vocational Rehabilitation. This program has helped to restore productivity and independence to virtually millions of Americans who have been vocationally disabled through illness or injury. Although certain criteria for eligibility must be met by each individual, the commitee has been advised that the eligibility requirements are quite liberal and the interpretation is broad. The committee has been further advised that if a diagnosable psycho-social disorder is present, the great majority if not all offenders could be considered eligible for vocational rehabilitation services.

Initiation of a program of vocational rehabilitation in the correctional institutions rests entirely with the state with appropriation of sufficient funds to establish such a program. Although the federal government assists by providing matching funds, the basic appropriation must be made from state funds. Federal matching in Iowa for this program is at the rate of $63.18 federal dollars, to $35.62 state funds, or almost a two-to-one ratio.

Although there are several methods of carrying out a program of vocational rehabilitation for the offender, preferably a program of vocational evaluation and training should be established within each institution so that the individual's work skills are carefully evaluated and practical vocational training made available while he is in the institution. A less desirable method is sending the offender, upon being released either on parole or at expiration of sentence, to the Vocational Rehabilitation Center in Des Moines or to a training facility with whom the Division of Vocational Rehabilitation has a contractual agreement.

Financing of this program can actually be accomplished in two ways. State funds can be appropriated directly to the Division of Vocational Rehabilitation and these funds matched by the federal government on approximately a two-to-one basis. The Division of Vocational Rehabilitation would then enter into a cooperative agreement with the institution to initiate and operate the desired work evaluation and training program, utilizing the facilities already available in the institution and providing the additional staff and equipment necessary. An alternative would be for each institution under the Division of Corrections, with Board of Control approval, to budget funds which could be turned over or made available to the Division of Vocational Rehabilitation. These funds would then be the basis for obtaining matching federal funds for the establishment of a program of vocational rehabilitation within the institution. The technicalities involved in the second plan make direct appropriation to the Division of Vocational Rehabilitation a far more desirable procedure.

Vocational rehabilitation programs of this type have been established in at least one federal correctional institution and in state institutions in Arkansas and Oklahoma. They have been reported as extremely effective and have materially reduced the high rate of return to these institutions. This committee gains the impression that the Division of Corrections has not had the opportunity of utilizing one of the greatest sources of practical vocational evaluation and training that should be made available in each of our correctional institutions.

POSTCONFINEMENT

Probably the most critical period of the rehabilitative process of the incarcerated offender is when he is released from the institution and re-enters society, passing from the confines of the structured atmosphere to a life of relative freedom. It is at this time that the true test of his ability to carry out his intentions, as well as apply from a practical standpoint all of the training he has received in the correctional process, occurs. The anxieties generated by the uncertainty of success are quite frequently overwhelming and contribute to recidivism. Successful reintegration into society is quite frequently dependent upon availability of supportive resources.

Offenders leaving the adult correctional institutions in the state of Iowa are in two categories. First, those who are granted parole prior to expiration of sentence by the Iowa State Board of Parole, and, secondly, those who are released at expiration of sentence.

Those offenders who are granted parole must have a guarantee of employment of maintenance prior to leaving the institution and must remain under the supervision of the parole agent for an indefinite period of time. The caseload of the present parole staff is grossly in excess of that considered to be practical. Even so, many of the parole agents successfully approach the ideal by utilizing other community resources and agencies. It is incumbent upon all parole agents to use all facilities and services at their disposal to provide for the guidance and counseling of the parolee.

Presently, offenders who complete their sentences, less work and good behavior time, leave the institution without supervision or any legal restraint. They may or may not have employment. A considerable number leave the institution without any planning whatsoever. Quite frequently these offenders served their entire sentence because they refused to cooperate with the treatment and rehabilitation program, limited as it might be at the present time. They

carried negative attitudes with them into the institution, maintained them during confinement, and retain them as they leave. Recidivism among this group is quite high. Of all offenders, these probably need supervision the most. Supervision for the offender leaving the institution upon expiration of sentence could be provided under a "conditional release law." A model of this law is quoted from Section 19, Article VI, of the Standard Probation and Parole Act:

> "A prisoner having served his term or terms, less such work and good behavior credits as have been earned, shall be deemed as released on parole until the expiration of the maximum term or terms for which he was sentenced."

In most instances this would place these offenders under the jurisdiction of the Parole Board and subject to supervision if such were deemed necessary.

Some offenders upon leaving the confines of the institutions find the transition of their status and re-entry into society extremely difficult, even under close supervision, guidance, and counseling of the parole agent. It is suggested that for certain offenders, prerelease centers and half-way houses could provide additional resources to help them make this transition. These facilities could be sponsored by state agencies, community service organizations, or church groups. Adding this feature to the total rehabilitation process has been quite successful in instances where it has been used. In addition, an expanded parole system with district offices established throughout the state would promote efficiency and facilitate more effective counseling for parolees and probationers. The qualifications for parole agents should be administratively upgraded to provide counseling in addition to proper surveillance. This can be accomplished by more realistic salaries made possible by sufficient funds granted the Iowa Board of Parole to carry out its program. Each parole agent should be required to supervise no more than fifty parolees and probationers, and even a less number if the demands for presentence investigation by the courts become heavy.

The committee believes that those prisoners released by expiration of sentence need supervision even more than those released on parole and should be required to accept this provision for the protection of the public. Legislation should be adopted, as mentioned above, and funds appropriated to the Board of Parole to implement such a program. Also, Iowa can look to such "half-way houses" as St. Leonard's House in Chicago and Dismas House in St. Louis as excellent examples of these programs, as well as those in Los Angeles and Minneapolis now being sponsored by the Friends Church. Service organizations, fraternal groups, or churches could then be encouraged to undertake similar programs in Iowa.

For the released offender still in need of continuing mental health service because of emotional disorder, we recommend increasing involvement of existing community mental health and counselling services. Such services are currently being developed in certain Iowa communities. For example, one mental health center is providing consultation services at prerelease conferences in a correctional institution to acquaint parolees with the services available. Another center is providing group therapy for girls on parole.

GENERAL COMMENTS

Crime is one of our greatest social problems. A great majority of criminals suffer from some type of psychosocial disorder and impairment of mental health. The committee believes that a significantly greater number of offenders can be rehabilitated by the use of appropriate treatment and rehabilitation modalities. To this end the committee has made recommendations which are considered to be necessary.

Recommendations

LAW ENFORCEMENT AGENCIES AND PERSONNEL

The Committee recommends that:

1. A task force composed of representatives of law enforcement agencies and other organizations such as those representing the behavioral and social sciences (all having a valid interest in the treatment of the accused or the offender) be established to make recommendations with respect to qualifications, training, and critria for selection of law enforcement personnel.

2. That those law enforcement agencies presently engaged in ongoing training programs continue same, being constantly cognizant of the need to utilize new knowledge in this area.

3. That since a large number of law enforcement agencies do not fall within the category mentioned within recommendation '2,' it is recommended that consideration be given to the establishment of an Academy of Police Science for the state of Iowa. This academy would recommend standards for and participate in the training of every category of peace officers in the state, from the isolated constable in a small town to the personnel of the well-organized and well-trained departments of our largest city.

4. That every peace officer expand the concept of his function to include not only law enforcement but crime prevention. (The unique opportunities offered the police officer to utilize his knowledge of human behavior can have a profound salutary effect and prevent irreversible psychic damage to the accused.)

5. That all training programs convey a basic knowledge and understanding of human behavior to enable peace officers to broaden the concept of their function.

6. That the various law enforcement agencies utilize already existing facilities such as mental health agencies and members of the various professional disciplines for use as consultants as a means of increasing the efficiency of law enforcement as well as assisting the individual officer in more completely fulfilling his role.

JAIL FACILITIES AND PERSONNEL

The committee recommends that:

1. Regional jails or institutions supervised by trained correctional administrators sponsored by several counties be established for the confinement of those persons whose sentences do not require confinement in one of the state correctional institutions.

2. That present county jails be utilized only for persons awaiting trial and that no person be confined in a county jail more than ninety days.

3. That regional institutions should be so designed that those confined therein could be separated by category to

insure better control and reduce the degradation of the inmate.

4. That present jails should be remodeled to conform with the above recommendations.

5. That county health officers should be made responsible for the general health and welfare of the offender and use all available community resources toward this end.

6. That those responsible for jails enlist the help of all available community resources, both public and private, particularly the mental health centers, to develop an active rehabilitation program.

7. That all personnel involved in the operation of jails throughout the state be selected on the basis of personal qualifications and be provided with adequate training in keeping with the functions expected of them.

8. That rehabilitation and constructive pursuits be the primary objective of the jail. To this end it is recommended that the Legislature be encouraged to consider passage of a bill such as the Huber Law in Wisconsin. This would permit selected inmates to pursue their normal occupations, provide a livelihood for their families, and minimize the disruption of family relationships.*

COURT PROCEEDINGS AND SENTENCING PROCEDURES

The committee recommends that:

1. The Model Sentencing Act of the Advisory Council of Judges of the National Council on Crime and Delinquency receive the immediate favorable consideration of the Legislature.

2. Senate File #155 (56th General Assembly) by Senator Turner, dated 1 FEB 61 (as amended by the Committee on Adult Offenders), entitled "An Act Authorizing Mental and Physical Examination and Treatment of Prisoners," receive favorable consideration by the Legislature.

3. Enabling Legislation be passed for implementation of Section 218.97 of the Code of Iowa entitled "Diagnostic Clinic," not only for services outlined in Section 218.97 of the Code, but also to provide diagnostic services for the courts in connection with presentence investigations.

4. Sufficient funds be allocated to the Board of Parole to carry out such presentence and probationary services as will be necessary to effectively activate a total probation and parole program, including mandatory presentence investigation reports in all criminal cases coming before the courts.

CONFINEMENT

The committee recommends:

1. That the philosophy of corrections for the state of Iowa as found in the Board of Control of Institutions Manual, Section 5.01.4 entitled Iowa Correctional Policy, must be adopted by every employee of the Division of Corrections if they are to be effective and each is to serve a useful purpose.

2. That a diagnostic and evaluation facility as authorized in Section 218.97 of the Code of Iowa be established.

3. That a treatment facility for the mentally disordered offender be established in conjunction with a diagnostic facility and be located near The University of Iowa. This would replace the present Security Hospital located at the Men's Reformatory, Anamosa.

4. That this facility be designated as the "Iowa Medical Facility."

5. That the existing institutions be renamed "correctional facilities" or "centers."

6. That the administrative head of each institution should be an exceptionally well-qualified and well-trained individual who should be designated as "Superintendent" or "Director," rather than "Warden."

7. That the title of Custodial Officer or Guard be changed to "Correctional Officer," that the salary levels of these individuals be substantially raised, and that they be provided increased opportunities for training and advancement.

8. That the professional staff of each institution be charged with the responsibility of developing and implementing effective treatment and rehabilitation programs for the offender and training programs for the staff to the end that all employees within each institution would be functioning in support of the treatment effort in the manner of the "therapeutic community" concept.

9. That those responsible for daily management and those clinically trained personnel responsible for more technical aspects should be in one department, answering to one clinically trained person, who is responsible for the total management or program of the inmate.

10. That each employee have the opportunity to engage in educational pursuits which would permit him to advance to a higher position. To facilitate this, time should be made available, and scholarships, honorariums, or some subsidy should be provided to those who wish to engage in educational pursuits directed toward improving personal competence.

11. That the present recommendations of the correctional institutions as to the increase in personnel and their salaries be adopted.

12. That educational opportunities for inmates should not be limited to academic achievement at the high school level. Provision should be made for academic opportunities at the college level.

13. That sufficient funds be appropriated to the Division of Vocational Rehabilitation to enable this very necessary program to become a reality in each of our correctional institutions.

POSTCONFINEMENT

The committee recommends that:

1. The Legislature provide the Board of Parole with funds to at least double its present staff.

2. Legislation be passed to create a "conditional release" system for all prisoners not paroled but who are released by expiration of minimum sentence, the system to be administered by the Board of Parole and necessary funds appropriated to the Board for its implementation.

3. Consideration be given to the establishment of "Prerelease Centers" to be separate facilities, but operated in conjunction with the existing correctional institutions at Fort Madison and Anamosa.

4. Enabling legislation be passed to charter half-way houses when operated by private but nonprofit organizations for the relief, rehabilitation, and welfare of former inmates of the correctional institutions and jails.

*The 61st General Assembly enacted H. F. 622 pertaining to the temporary release of prisoners to work, to attend school, and for other specific purposes.

5. Use of local mental health and counseling services should be developed for those parolees who could benefit from outpatient guidance and counseling beyond that provided by the parole agents. Similarly, these services should provide in-service training in guidance and counseling techniques for probation and parole agents.

Report of the Committee on Alcoholism and Drug Addiction

NATURE AND EXTENT OF THE PROBLEM OF ALCOHOLISM

The majority of the state's one million drinkers contribute little to the alcoholism problem. Alcoholism is limited to about 5 per cent of all drinkers. Application of the Jellinek formula to 1963 liver cirrhosis deaths in the state yielded a total of 53,190 alcoholics, approximately 3 per cent of the adult population. Most of the alcoholics (80-85 per cent) are married, have a family, and are employed. The male-female ratio among alcoholics is 5 or 6 to 1. Though alcoholism is distributed throughout the state, the rate is higher in urban areas. Approximately one-third of the state's alcoholics are located in the following seven counties: Polk, Linn, Woodbury, Scott, Dubuque, Black Hawk, and Pottawattamie.

Alcoholism has its origins in factors which exist not only in the individual but in society, and, in turn, the disease, itself, adversely affects both the alcoholic and society. It leads to the most disabling physical, psychological, interpersonal, and economic consequences for the individual alcoholic, and each alcoholic affects the lives of five or six other persons. Thus, indirectly, one-quarter of a million Iowans are affected. The cost of alcoholism in terms of emotional damage to the family cannot, of course, be estimated. The divorce and separation rate of problem drinkers is significantly higher than that of the general population. Reduced efficiency and absenteeism among alcoholic employees is a problem for industry. Drunkenness and alcoholism contribute to traffic accidents. Persons arrested and tried for intoxication are a great expense to the community. It has been estimated that the problem costs the people of the state of Iowa $20-$25 million annually, which approximates the state's revenue from the sale of beverage alcohol.

The 50,000 Iowa alcoholics may be classified in three categories according to their state of health and personal resources for rehabilitation.

1. 2,000-3,000 homeless, jobless, skid row alcoholics for whom jail is a revolving door. They are without friends, families, and finances. Most of them have a degree of physical or mental deterioration and are poorly motivated to seek treatment.

2. 10,000-12,000 cases of established alcoholism with some physical damage to their state of health. They are not chronic police offenders and usually have better personal resources such as job, family, etc., to assist them toward rehabilitation.

3. 35,000-40,000 alcoholics without apparent physical damage who, in general, have jobs and families and are more or less functioning members of the community.

In 1956 the American Medical Association passed a resolution which recognized alcoholism as an illness which should have the attention of physicians. All alcoholics suffer some physical or mental damage, although it may be subclinical for many years. The population of alcoholics is not homogeneous and the needs of the alcoholic vary in type and in accordance with the stage of the illness. Anyone who drinks to excess may develop an acute illness such as intoxication or delirium tremens, which must be treated as a medical emergency. In addition, the alcoholic is prone to accident and infection. At times alcoholism may be a symptom or consequence of another mental illness. Chronic alcoholism is associated with cirrhosis, brain syndromes, and other physical and mental disorders. In view of these medical complications, a thorough medical and psychiatric examination is necessary at the time of referral. The social consequences of alcoholism extend far beyond the field of medicine and attention to these factors must necessarily involve many different agencies, including legal, religious, employment, welfare, etc.

CURRENT MANAGEMENT AND TREATMENT OF THE ALCOHOLIC

A recent study was designed to further illuminate the scope and nature of the problem of alcoholism in Iowa and to assess current procedures and resources in the management of alcoholics. A mailed questionnaire survey of Iowa agencies and professionals expected to encounter alcoholics yielded the following information.

A small proportion of community agencies and professionals are conducting the bulk of treatment. The usual procedure is to refer the alcoholic elsewhere. In order of frequency, referrals are made to Alcoholics Anonymous, community mental health centers, community general hospitals, psychiatrists, physicians, and clergymen. Approximately one-half of referrals were to medical facilities and one-half to nonmedical. Only a small proportion from one agency to another were ever completed. A small fraction of those who followed through with the referral were actually treated. (Failure to follow through with referral or with treatment is a recognized characteristic of the alcoholic.) Among the general population and among the agencies studied, many do not accept the disease concept of alcoholism without qualification.

In 1955, 1,627 patients with a diagnosis of alcoholism were admitted to hospitals in Iowa. This represented 3.7 per cent of the estimated 44,000 alcoholics in the state. The Mental Health Institutes admitted 421 cases, three private mental hospitals admitted 317 cases, and the general hospitals admitted 889 cases. Over 90 per cent of these admissions were made by only 15 per cent of the hospitals in the state.

During the past five years the State Mental Health Institutes admitted or readmitted approximately 600 patients with a diagnosis of alcoholism annually. In 1963, they admitted 630 cases. Two private mental hospitals and the Psychopathic Hospital admitted 170 cases. It was estimated that general hospitals admitted 1,317 cases. A total of 2,117 patients were admitted with a diagnosis of alcoholism. This represented a rather small percentage of the population of alcoholics in 1963.

Fifty-one general hospitals reported on their admission policy in respect to alcoholics in 1963. Four do not admit alcoholics, nineteen (37 per cent) admit on an emergency basis, six (12 per cent) admit if ordered by staff physician, and twenty (39 per cent) admit without restriction. If the remaining hospitals not responding to the questionnaire are

no more favorably inclined toward the alcoholic, it is likely that less than one-third of all general hospitals admit without restriction.

The information presented above would seem to indicate that existing facilities throughout the state capable of providing help for the alcoholic are not properly geared to do so and are not being utilized to their fullest extent. Non-acceptance of alcoholism as an illness, together with concern for social, economic, and welfare damage caused by the alcoholic may have alienated the alcoholic as a person from sources of help. In order to meet the needs of the alcoholic, community attitudes of indifference and negativism must give way to programs of positive rehabilitation. A condition so widespread as alcoholism demands that services be developed locally rather than limiting efforts to a single agency or to some distant, isolated, state-operated facility which lacks the total resources available at the community level.

RECOMMENDED SERVICES FOR THE ALCOHOLIC PATIENT

Adequate services for the alcoholic patients in Iowa should be as close to home as possible and with the least disruption of the patient's family life and employment. This is best achieved within the concept of community comprehensive mental health care with emphasis on integration of psychiatric and other medical services, on continuity occurring between the general hospital and the community, and on continued care and support by various community services. Outpatient treatment, short-term hospitalization, and long-term rehabilitation should be available at the community level.

All alcoholics suffer damage, though it may be subclinical for years. A thorough medical and psychiatric evaluation is recommended at the time of referral. Ideally, this should be conducted by personnel who have had some training in the management of the alcoholic patient. The team approach, utilizing a physician-psychiatrist, psychologist, and social worker, is desirable in conducting this evaluation. Very few communities will have such personnel available except where mental health centers are located, and extension of these centers is strongly urged. The initial medical examination and recommendations of a physician are nevertheless essential.

Provision for short-term hospitalization for the acutely ill alcoholic is an important element of comprehensive care. Such short-term inpatient care is best provided through a psychiatric unit in a general hospital or in the general wards of the community hospital.

Outpatient services for continuing treatment of the alcoholic in the community should be available through the local mental health center or a private physician. The mental health center should provide continuity of care between the general hospital and the community. In addition to its treatment services, the outpatient program should provide consultation for physicians, courts, industry, and other agencies who come in contact with the alcoholic.

The ongoing treatment of the alcoholic extends beyond the field of medicine. A total community program must include not only groups directly interested, such as Alcoholics Anonymous, but many other agencies, associations, and individuals. Establishing roles for these agencies and coordinating their individual contributions is a community responsibility. Leadership and direction for such a program should come from the community mental health center.

Large urban communities have a greater number of alcoholics and must consider the development of long-term rehabilitation programs. The patients involved in such programs may require the benefits of a half-way house, preferably under the sponsorship of a local philanthropic or denominational agency. State financial support may be needed, but the administration should remain under a local association, nonprofit corporation, municipality or other local public agency. Close liaison must be maintained with the mental health centers and hospitals in order to preserve the continuity of treatment.

The half-way house program is offered as an aid to rehabilitation of the alcoholic patient prior to full return to the community and acceptance of total economic responsibility for himself. It need not be an elaborate facility, but should provide food and lodging at a minimum cost to the patient. A large house within easy reach of employment is considered most suitable. The facility should be supervised by a person with a demonstrated interest and ability to work with alcoholic patients. The half-way house should have a program to assist the alcoholic with his problem, and this is best provided through group discussion and close cooperation with the mental health center, local A.A. groups and other community agencies. This type of facility can best serve the patient who has no serious physical or psychological impairment, and who has retained his work skills, but who is temporarily without finances and family support to aid him in re-establishing himself in the community.

The more seriously disabled alcoholic patient, whose immediate medical needs have been served, needs a somewhat different therapeutic environment. This group will include the deteriorated alcoholic and the chronic police offender who has become a burden to the community. Before returning to the community this patient needs to demonstrate his ability to work in a sheltered environment under adequate supervision. The county homes of the state seem admirably suited for this purpose and offer an appropriate level of employment. One model of such a program for this type of patient already exists in Jasper County, where the mental health center staff coordinates the local medical, psychiatric, social welfare, and rehabilitation services with full support of all involved county agencies and officials.

The motivation of the alcoholic to seek treatment is often poorly sustained. Industry can indirectly provide incentive by making treatment a condition for retention of employment. Some industrial policies and programs have worked well, as exemplified by the Bantam Shield Program at Waverly, Iowa.

When other measures fail or the alcoholic is a threat to family or society, legal recourse is available for compulsory treatment. Even in this event, treatment should be available at the community level.

The recommendations outlined above emphasize the need to provide comprehensive services for the alcoholic locally, to expand existing medical services, and to develop new psychiatric services where none exist. Currently there are 154 general hospitals in the state of Iowa, eighteen of which are equipped to provide inpatient psychiatric care. These eighteen hospitals are distributed through fifteen counties serving more than 50 per cent of the total population of Iowa. Thirty-six psychiatrists, seven psychologists, eight

social workers, and sixty-seven nurses staff these community psychiatric facilities.

In addition, there are sixteen mental health centers serving forty-four counties and 58.2 per cent of the total population. Another two mental health centers are in the planning stage and will serve nine more counties and another 4.8 per cent of the population. These mental health centers are staffed by seventeen psychiatrists, twenty-six psychologists, and thirty-four social workers, many of whom also provide service to the inpatient psychiatric units in general hospitals.

The development of the community mental health centers and the growth of private practice of psychiatry in the last decade is a big step in the direction of comprehensive mental health care and speaks well for further development and expansion of services at the community level. The Iowa Mental Health Authority has provided invaluable assistance in establishing these mental health centers, and the Psychopathic Hospital, through its residency training program, has provided many psychiatrists to staff and direct these centers. The basic framework of facilities and personnel capable of providing services to the alcoholic is already offering psychiatric services to a majority of the population. The job now at hand is the further development of therapeutic programs and the expansion and coordination of available community services.

FINANCING

The services of the Community Mental Health Centers should be available to all citizens. Those able to pay the cost of care should be required to do so, and others should pay part or none of the cost, depending upon their financial resources.

Blue Cross, Blue Shield, and commercial insurance companies are urged to expand benefits for mental illness to include treatment for alcoholism and to pay for care in a private office, in Community Mental Health Centers, in general hospitals, and in State Mental Health Institutes.

The statutes currently requiring strict separation of county administered funds, e.g., Poor Fund, County Mental Health Fund, State Institution Fund, etc., should be amended to permit the County Board of Supervisors to pay for care for those unable to meet the costs, regardless of where it is provided. The most appropriate site for the care should be determined by the family and the attending physician. The ongoing treatment of the patient may require the use of a variety of facilities. These can only be determined after evaluation and examination of the individual patient.

State funds are now transmitted to counties for care of the mentally ill patients discharged from State Mental Health Institutes into the county home, foster home or nursing home. Application of these funds to a half-way house program is desirable in some of the large urban centers.

Iowa statutes should allow for the maximum utilization of federal funds in meeting mental health costs. Federal matching funds for categorical assistance programs (ADC, old age assistance and to the needy, blind, etc.) in the state of Iowa are currently administered by County Departments of Social Welfare. It is appropriate that state and local agencies should include in their respective budgets funds for providing comprehensive community mental health care or meeting the cost of such care when purchased from private sources.

It has been estimated that Iowa's alcoholics contribute close to one-half of the state's revenue from the sale of beverage alcohol. In addition, license fees from operators of beverage outlets provide revenue. Consideration should be given to legislation which would make available some of this revenue for financing community alcoholism programs. Finally, professional and labor organizations, union and management groups, service clubs, colleges, and religious denominations are concerned with the welfare of their individual members and the community as a whole. Support of a local alcoholism program either through service, financial donation, or contract for professional services by these groups is strongly recommended.

EDUCATION IN THE FIELD OF ALCOHOLISM

In order to obtain a broad overview of Iowa's educational efforts, information was sought from the following sources: (1) State Commission on Alcoholism, (2) Mental Health Centers, (3) The University of Iowa, (4) Mental Health Institutes, (5) Division of Corrections, (6) Department of Public Safety, (7) Liquor Control Commission, (8) State Teachers College, (9) Veterans Administration, (10) Alcoholics Anonymous, and (11) Department of Public Instruction.

Professional Education

In general, the programs in this category are the responsibility of the University and the Mental Health Institutes. Students receive lectures, clinical demonstrations, and opportunities to examine and treat alcoholic patients under the supervision of the medical staff at Psychopathic Hospital and the College of Medicine.

In addition to lectures and seminars, residents in psychiatry receive supervised experience in the management and treatment of the alcoholic, and a period of rotation throughout the alcohol outpatient clinic of the Psychopathic Hospital.

Alcoholism has been a frequent subject of the annual refresher courses conducted by the College of Medicine and the American Academy of General Practice, and of various clinical meetings at the state and county medical society level. Since 1960, the Alcohol Research Clinic at the Psychopathic Hospital has provided consultative services to physicians throughout the state. A special exhibit on alcoholism has been prepared by the Psychopathic Hospital. In addition, a number of films dealing with the clinical management and treatment of this condition have been made and distributed widely. One film is directed specifically toward physicians. Speakers on the topic of alcoholism are available for various county medical society meetings, and clinical and research reports are published in state and national journals.

In the required courses for students in the School of Social Work the topics of Alcoholism and Drug Addiction as they relate to social work are discussed. In field work practice, students may work with families of the alcoholic.

Law students in their senior year receive two hours of lectures on alcoholism and drug addiction from the staff at the Psychopathic Hospital.

There are no formal courses or instruction for nurses, but they do receive in-service training in the management of the alcoholic patient as they rotate through the various clinical services.

Students in recreational therapy, occupational therapy,

and paramedical fields attend a course at the Psychopathic Hospital in which is included two hours of lecture-demonstration on the topic of alcoholism and drug addiction.

A two-hour seminar for graduate students and a three-hour seminar for undergraduates is offered in the College of Liberal Arts.

Residents in psychiatry at the Mental Health Institutes receive in-service training in the management and treatment of the alcoholic patient. The institutes have a special ward for alcoholic patients and residents rotate through this service. They are supervised by senior staff members. Teaching on the topic of alcoholism is carried out through lectures and seminars. Residents have an opportunity to work with Alcoholics Anonymous and other outside agencies.

It is desirable to extend the educational programs presently conducted at the University and the Mental Health Institutes to local medical groups and mental health centers throughout the state. Specifically, the University and Psychopathic Hospital might prepare instructional materials in the form of films, seminars, lectures, or visits to the clinics. The emphasis should be upon techniques and methods of treatment and management of the alcoholic which can be applied at the local level. Extension of these services from the University and Psychopathic Hospital will require additional personnel and financing.

Public Education

The major objectives of the program for Alcoholism in Iowa are: 1) reduction of the incidence of the disease through prevention and, 2) treatment and rehabilitation of all alcoholics.

As we pursue these objectives, provision for treatment facilities is not enough. Only a small portion of available resources in Iowa are now utilized. This is certainly related to the fact that over 80 per cent of the population do not fully accept alcoholism as a disease. Even among the professions there is apathy and prejudice.

There must be a change in attitude about alcoholism to bring about a community atmosphere conducive to the acceptance of treatment and rehabilitation by the alcoholic, his family, associates, and employers. An extensive public education program is essential not only to bring about this change in attitude, but also to provide a means of continuing and expanding prevention.

Public education is carried on primarily at the community level and should be a community responsibility. In general, it is recommended that the subject of alcoholism be appropriately included in all community health education programs. Alcoholism should have an appropriate place in the health education in public schools. Development of adult education programs for key community groups including nurses, ministers, law enforcement officers, welfare workers, and personnel from local businesses is strongly recommended. Leadership and cooperation in these programs must come from the local medical society, mental health centers, community health officers, and public health agencies.

Although public education is primarily a community effort and a community responsibility, it cannot be fully developed without the assistance of state-level programs. The Iowa Association for Mental Health, the Iowa Mental Health Authority, the State Psychopathic Hospital, the Iowa Medical Society, the Board of Control, and the Alcohol Commission have public education programs. These programs need further coordination and development.

The Alcohol Commission has taken some progressive steps in the area of public education, which is one of its primary functions. It can provide leadership for future state-level programs and to do so it will need increased appropriations.

LEGISLATION

In the Code of Iowa, Section 321.281, third offenders for operating a motor vehicle while intoxicated are mandatorily sentenced to Iowa State Prison for one to five years. This is inconsistent with the acknowledgement that alcoholism is a disease. Almost without exception these offenders are alcoholics. A recent tabulation revealed seventy-five of these offenders at Iowa State Prison, where there is no organized professional therapy program. While the committee recognizes that alcoholism is a treatable disease, it also recognizes that society must be protected from deviant behavior sometimes associated with this disease. In order to satisfy the interest of society and the treatment needs of the individual, modification of Section 321.281 of the Code of Iowa is needed to permit courts discretionary sentencing or commitment to a treatment facility, or probation or parole up to five years. (This section of the Code was amended by the 61st General Assembly to permit commitment to an institution for treatment any person convicted of a second, third, or more offense of driving while intoxicated.)

RESEARCH

The 56th General Assembly of Iowa appropriated from the Liquor Control Act Fund a sum of money to the College of Medicine at Iowa City, Iowa, for the study of the problem of alcoholism within the state under the direction of the Committee for Research on Alcoholism. Dr. Harold A. Mulford of the Psychopathic Hospital in Iowa City conducted a broad sociological survey of alcoholism in Iowa. A report of this survey was presented to the legislature and published in 1957. Subsequently, the Director of Psychopathic Hospital, recognizing the importance of continuing research, established the Division of Alcohol Studies, which became a Psychopathic Hospital sponsored center for the study of alcoholism.

Further studies have added to our knowledge of alcoholism in the state of Iowa. In 1960 an Alcoholism Research Clinic was initiated at the Psychopathic Hospital for the purpose of clinical research and to provide a population of alcoholic patients for study in the training of medical students, residents in psychiatry, and for postgraduate medical education. The Division of Alcohol Studies and Research Clinic continues to publish research reports and provides training for professional personnel.

There is a need for continuation of these projects. The committee on Alcoholism recommends that immediate consideration be given to expanded research programs to include joint projects with mental health centers and state facilities, such as demographic, epidemiological studies and evaluation of treatment methods. In order to implement the above there is need for additional personnel and appropriational support at the Psychopathic Hospital.

NATURE OF ADDICTION AND HABITUATION TO DRUGS

In order to provide a rational basis for mental health

planning with respect to problems of addiction and habituation, it is necessary to make some general formulations about the prevalence, distribution, and general nature of the problems. Although there is an extensive amount of literature on the subjects of addiction and habituation, the prevalence and distribution are still not clear, and the full natural history in specific individuals remains obscure. Certain characteristics of addiction, however, have long been recognized and are commonly accepted. These are tolerance, dependence, and relapse. As a person uses a particular addicting drug repeatedly and regularly, its effectiveness diminishes and an increasing dose is necessary to produce the desired effect. This is referred to as "tolerance." Dependence is thought to be both physical and psychological. When physical dependence has been established, abrupt withholding of the addicting drug will cause the appearance of a physical illness known as the abstinence syndrome. The symptoms are peculiar to each drug and their intensity is related to the dosage level. The onset of the syndrome can be postponed by continuation of the drug, and the symptoms can be relieved by a single dose. This characteristic is thought to be very important in perpetuating the pattern of repeated ingestion of the drug. Psychological dependence, on the other hand, has to do with "relieving," "escaping," or "solving," life's problems. Cameron states that "narcotics come as close as any drugs yet found to being a panacea, solving different problems for different people, and different problems for the same person at different points of time." The propensity to relapse is poorly understood; physical and psychological factors are involved to some extent but social factors may be even more contributory.

Certain drugs cannot be taken regularly without creating a high degree of tolerance and physical dependence. These are now designated as addiction producing drugs and include narcotic preparations. Another group of drugs through pharmacological effects, which certain people regard as desirable, lend themselves easily to the formation of a "psychological habit." Physical dependence and abstinence characteristics are not well developed as in the first group. Such drugs are called habit-forming and include many widely used sedatives and hypnotics. Among the narcotics considered to have addictive potential are cocaine, opium, and its derivatives and synthetic equivalents. Habit-forming drugs include a wide variety of preparations. The most important are barbiturates, amphetamines, and marijuana. It must be emphasized that people become addicted or habituated to many drugs and substances other than those listed above.

Much research must be undertaken to further our knowledge in conceiving the etiology of narcotic addiction. Current thinking is that multiple factors interact in its causation. In a 1957 report, the Council on Mental Health of the American Medical Association noted that many studies from different locations showed that addiction, especially of youths, is largely confined to particular areas of certain cities. These are the poorest areas, with the worst housing, lowest income, most unstable family structures, highest delinquency rates, and where populations of certain minority groups predominate. The low socioeconomic environment is important, but by no means decisive since addicts are also found elsewhere. The same report implicated psychological factors.

For a number of reasons, narcotics addiction tends to be associated with crime. Some addicts are known to have committed criminal acts before they become addicted; others become engaged in criminal activities only after becoming addicted, mainly to obtain funds to support their habit. The late Paul Hoch was of the opinion that "as long as poverty, slums, unemployment, and similar depressed conditions exist, addiction will flourish." He believed that crime and drug addiction are "simultaneous results" of the same generative factors. A proportion of addicts (so-called medical addicts) have become "accidentally addicted" to narcotics in the course of treatment for a medical illness. These patients probably comprise a small percentage of the total population of addicts and are usually known to medical and legal authorities.

EXTENT OF ADDICTION AND HABITUATION TO DRUGS IN IOWA

The number of narcotic addicts in the United States is estimated at 40,000 to 60,000. Compared with the estimate of problem drinkers (4½ million), this is a small group. The number of people habituated to drugs is unknown. Narcotic addicts are concentrated in a few large cities, namely New York, Los Angeles, Chicago, and Washington, D.C. However, isolated cases may be encountered anywhere.

The committee attempted to assess the extent of narcotic addiction and drug habituation in Iowa. Information was obtained from the Federal Bureau of Narcotics, the Food and Drug Administration, Department of Health, Education, and Welfare, the State Mental Health Institutes, the State Psychopathic Hospital, physicians in practice, the Iowa Board of Parole, the U.S. Parole Board, and the pharmacy examiners.

A report of the number of narcotic addicts in the state of Iowa was obtained from the Federal Bureau of Narcotics. According to the Bureau's statistics, which reported active narcotic addicts in the United States as of December 31, 1963 by state, the state of Iowa had a total of twenty-four active addicts. This was an increase of only two addicts as of a report dated December 31, 1962. This increase of only two addicts in one year fails to indicate any great extent of narcotic traffic or areas of concentration, and therefore does not present any problem which should be cause for concern. It is believed that the excellent cooperation between the state and federal narcotic enforcement agencies in Iowa has contributed to this low rate of narcotic addiction. Also, the Iowa Uniform Narcotic Drug Act, as well as the present Federal Narcotic Laws, have been very effective in helping control the narcotic situation, acting as a deterrent to any trafficking in narcotics in the state.

A review of the admissions to the four state Mental Health Institutes and to the State Psychopathic Hospital was undertaken in an attempt to determine the number in which drug habituation, or drug addiction, was a factor. Because these cases are grouped under various diagnostic categories, it was impossible to obtain accurate figures. However, based on a survey of the records, it is estimated that these institutions admit less than six addicts and less than thirty patients habituated to drugs each year.

The following three surveys of physicians have recently been completed in the State of Iowa.

1. Two hundred ninety-one Iowa physicians composed of general practitioners and specialists reported on 29,412

consecutive and different patients seen in medical practice. A total of twenty-eight patients were reported to have a problem with drug addiction or habituation. Six were males and twenty-two were females. No patient was under twenty years of age. Seven were referred for psychiatric care and nineteen were treated by the physicians themselves.

2. Forty-eight physicians (twenty-eight in rural practice, sixteen in urban and four in combined urban and rural practice) reported their opinions in another survey. In response to the question, "Do you believe narcotic addiction is a problem in your area?" forty-four physicians reported "no," three reported "yes," and one couldn't be sure. To the question, "Is periodic or occasional use of drugs for stimulation or some form of thrill experience a problem in your area?" forty-one responded "no" and seven said "yes." (Unpublished Survey.)

3. A separate survey involved twenty-seven physicians representing urban areas where problems of addiction or habituation are more likely to be encountered. Only three of the group felt that narcotics addiction was a problem in their area and only four expressed concern about drugs used for stimulation or thrilling experience. (Unpublished Survey.)

The Director of the Iowa Board of Parole is of the opinion that there is practically no problem with narcotic drugs such as morphine and heroin. The U.S. Probation Office for the Southern District of Iowa reported that during the past four or five years there have been only about a half-dozen known cases of various types of drug addiction among young offenders. They indicated that addiction to heroin and morphine has become practically nonexistent. While no actual figures were available from the Iowa Board of Parole concerning the use of nonnarcotic drugs by nearly 1,300 men under supervision, it was estimated that not more than 2 or 3 per cent were actually experimenting with these drugs. In general, it was not considered to be a significant problem. Some years ago commercial inhalants containing amphetamine were used by a few inmates of institutions, but this practice has now been controlled.

Information received from the Food and Drug Administration pertaining to nonnarcotic drugs in Iowa indicates that the Administration has no accurate figures available regarding the volume of illegal traffic in this state. There is, in their opinion, no basis to conclude that the traffic is any greater or less than it is in other states of approximately equal population.

The statutes and regulations so necessary for the control of narcotic drugs have, in general, made procurement for the addict very difficult. Since he must obtain drugs from an illegal source, it is assumed that he will endeavor to protect his source of supply and not reveal his habit to legal authorities. Therefore, the addict is not likely to come to the attention of physicians unless he develops an abstinence syndrome or a toxic condition. This, of course, only compounds the problem of trying to accurately determine the number of addicts in Iowa.

MANAGEMENT AND SERVICES

The information received from the various state and federal agencies indicates that narcotic addiction is well under control in Iowa and does not constitute a problem at the present time. The study of admissions to the State Mental Health Institutes and the State Psychopathic Hospital, and the surveys of physicians in medical practice, support this opinion. The committee believes on the basis of the available information that narcotic addiction is not currently a serious problem in Iowa, and detailed planning of special services and facilities for such a limited need is not practical. However, some services must be provided for the occasional addict and patients habituated to drugs. Hospitalization is required in the initial phase of treatment for withdrawal. Voluntary admission is of little value as seventy-five per cent of the patients wish to leave before they are over the disturbing effects of the period of withdrawal. A small percentage of strongly motivated patients can be withdrawn in an open setting, but their selection must be made with great care. They should be admitted to the hospital on the same basis as any other psychiatric patient. Many cases should be treated in a closed setting, preferably a maximum security setting, but this will be of little value if not coordinated and integrated with community rehabilitation services.

The nonmedical use of drugs such as barbituates and amphetamines and the role that they play in highway deaths, juvenile delinquency, and violent crime has drawn comments from both President Johnson and the late President Kennedy. G. R. Larrick, Commissioner of Food and Drugs, stated before a senate subcommittee that both types of drugs are subject to widespread abuse. He spoke in support of federal legislation which was later passed as Public Law 89-74, establishing special controls for depressants and stimulating drugs.

CONCLUSIONS

The committee believes, on the basis of available information, that the problems of addiction and habituation to drugs in Iowa are very limited at the present time. In view of this, no detailed planning of special services and facilities are proposed. However, the committee recognizes that continued control of addiction and habituation to drugs requires a diversified approach because of the complex nature of these problems. It requires strict measures of social control made possible by state and federal laws regulating narcotic and nonnarcotic drugs.* It also requires medical treatment which is coordinated and integrated with community rehabilitation resources.

Pending federal legislation directed toward better control of illegal traffic in nonnarcotic drugs is to be welcomed provided that the purpose of the legislation is fulfilled, e.g., control of illegal sales, distribution, and possession. The subcommittee is concerned, however, that such legislation should in no way interfere with the legitimate prescribing of such drugs for patients by licensed professional personnel and should in no way interfere with the proper medical treatment of the unfortunate person who becomes addicted or habituated to drugs.

Report of the Committee on Mentally Ill Aged

INTRODUCTION

This Committee's area of concern has been the aging population of Iowa, and the problem is a major one. No other group has been more thoroughly studied during the past fifteen years than the aged. We seemingly know much

*The 61st General Assembly enacted S.F. 285 pertaining to the illegal possession and sale of prescription drugs.

about the increasing numbers of older Americans, their health, employment, housing, happiness, and financial status. Yet within this wealth of information there are very few valid research findings concerning the special needs of the aged. To date, most of our conclusions as to their special needs are based on assumptions which spring from tradition and society's feelings and biases. Many of these assumptions about physical deterioration, maladjustment, effect of retirement, loss of status, and so forth must be constantly reviewed. This committee has made some general formulations based on currently available information about the incidence, location, and general nature of the mental health problems of the aged in order to provide a reasonable basis for mental health planning.

SOME CHARACTERISTICS OF THE POPULATION OF OLDER IOWANS

According to the U.S. Census figures, Iowa had a total of 327,685 persons aged sixty-five and older in 1960 representing 11.9 per cent of the state population and the highest proportion in the nation. Projections quoted by the President's Council on Aging forecast a 9 per cent increase in this age group to 357,000 in 1970. Assuming that these projections are correct, the percentage would then be 12.3 per cent, but several other states by that time would have higher percentages of older people. Another projection by Saunders indicates that the number of aged sixty-five and over may rise to 355,000 in 1970 (12.2 per cent) and 372,000 (12.8 per cent) by 1975.* In planning for services, it is certainly important to consider that Iowa ranks first in the nation and that persons aged sixty-five and older may be increasing in number.

On the other hand, the problem should not be magnified, for the actual number of senior citizens is not overwhelming. A recent study of population projections carried out at Iowa State University indicates that as of 1965, there are 341,653, which is 12.1 per cent in this age group and that by 1970 the number may drop to 338,898 (11.8 per cent) rather than increasing. By 1975 a growth to 346,671 is expected, but the percentage of aged in the total state population may diminish to 11.6 per cent and by 1980 the percentage may drop to 11.3 per cent. These figures are totals of population projections made for each of the ninety-nine Iowa Counties. Since implementation depends upon planning in each county, regardless of statewide totals, county population estimates are important considerations for planning of local services.

Looking at the entire state, it is apparent that the so-called "rural-urban shift" has resulted in higher ratios of older people in those counties with declining populations. However, if percentages are ignored, the actual numbers are small in the rural counties and large in the more populated areas. For example, Wayne County has only 1,865 persons sixty-five and older while Linn County has 14,254.

Certain economic considerations, too, are important for planning, although recent developments in the war on poverty may indicate that income alone is not a reliable yardstick. It is known that 32.7 per cent of men and 11.5 per cent of women aged sixty-five and older are still in the labor force in Iowa. Around two-thirds receive social security benefits and one-half have some other source of income in retirement. Although relatively few consider themselves to be poverty stricken, we know that 31,051 persons (9 per cent of the people sixty-five and older) are on old age assistance, receiving total payments of $31,680,213 annually. Since it may be important for planning to consider living arrangements and housing, attention is called to a 1960 survey of over 1,300 older Iowans. At least 80 per cent of the people in the sample were living in their own homes and only about 5 per cent were living with their children or other relatives. Most (80 per cent) were well satisfied with their living arrangements, though many admitted that keeping their own homes entailed certain physical and economic hardships because their houses were older and unnecessarily large.

Though the aged may experience certain stresses more often than younger persons, their basic needs are common to all people. These include the various emotional needs such as affection, sense of security, recognition, social status, work satisfaction, etc., and the well-known survival needs of food, clothing, and shelter. Also in common with other people are their needs for medical and psychiatric services.

MENTAL ILLNESS AND THE OLDER IOWAN

The frequency of disease in people over sixty-five does not increase substantially, but it is known that the aged are more likely to suffer from chronic diseases such as arthritis, heart trouble, and arteriosclerosis.

A recent survey of physicians in Iowa revealed that approximately 15 per cent of the people who seek medical attention are aged sixty-five and over. This percentage is comparable to the percentage of the state population. Though it is often assumed that people sixty-five and over experience more mental illness the incidence of serious emotional disturbances is no greater than among younger age groups. According to the survey of physicians, approximately 30 per cent of the people of sixty-five and over who seek medical attention have an emotional component to their illness. This number is actually lower than the incidence of an emotional component in the age group thirty-five to sixty-four.

A glance at the statistics of State Mental Health Institutes will show that 366 persons sixty-five and over were first admissions during the year ending June, 1964. This is approximately 27 per cent of all first admissions. Since 1955 the total number and percentage of persons sixty-five and over admitted to the state hospitals has shown a gradual decline. Also, the number of elderly persons in residence at the state hospitals for the year ending June, 1964, was 657, approximately 26 per cent of all inpatient residents, and this, too, has shown a steady decline since 1955. Although the population of chronic patients already in mental hospitals is aging and continues to be a major internal geriatric problem for the hospitals, a greater number of elderly people are being cared for in their own communities.

The large number of elderly people under the care of physicians in the state of Iowa is certainly recognized. As previously stated, a survey of 291 Iowa physicians shows 15 per cent of their patients to be sixty-five years of age and older and 30 per cent of these have significant emotional problems. Other Iowa physicians (303) responding to a questionnaire indicated that they had 8,098 patients in nursing homes, custodial homes, and county homes, most of

*A report of the Iowa Commission for Senior Citizens, by Harold Saunders, Professor of Sociology, The University of Iowa.

them being elderly and 3,453 of them considered to be mentally ill.

During the past fifteen years there has been an increase in the number of psychiatric facilities located in Iowa's communities. Currently there are at least eighteen general hospitals which admit patients for psychiatric treatment. There has also been an increase in the number of aftercare facilities for chronic and elderly patients. A recent comprehensive survey by the Iowa Mental Health Authority of county homes, nursing homes, and custodial homes revealed that there are about 810 of these facilities with approximately 24,500 beds. According to the survey, there are currently 22,500 people in those facilities and 18,000 (80 per cent) are sixty-five and over. In most nursing and custodial homes over 95 per cent of the people are sixty-five and over, whereas in county homes they total less than 35 per cent. A few nonprofit combination nursing and custodial homes have less than 10 per cent in this age group. The average age of people in surveyed aftercare homes is eighty, and women make up 68 per cent of the total number.

There are some differences in the needs of people in these aftercare homes which are certainly related to the age factor. For example, in nursing homes, 16 per cent are able to care for themselves and 27 per cent are confined to bed. On the other hand, in county homes 51 per cent are able to care for themselves, less than 6 per cent are confined to bed. Also, in nursing homes the admission rate is 50 per cent and less than 16 per cent remain in the home five years or more. In county homes the admission rate is 30 per cent and 44 per cent have been there five years or more. Another important difference is in the number of persons displaying emotional symptoms. Twenty per cent of the people in nursing homes are stated to be suffering from a mental illness, while in county homes the number exceeds 73 per cent. These are believed to be conservative estimates, since it is known that many people suffering from physical diseases have a significant mental or emotional component to their illness.

In addition to the 18,000 persons aged sixty-five and over in aftercare homes in Iowa, those in Veterans Administration facilities and various state institutions bring the total to 20,000. Of these, at least 6,000 or 30 per cent, are incapacitated primarily because of mental illness. Defining the many needs of this group is not so difficult, since their whereabouts are known and they can be counted. Likewise, it is relatively simple to specify what should be done to improve their situation.

On the other hand, there are over 320,000 elderly Iowans living alone or with relatives, in retirement homes or in foster homes, and in general hospitals who are not so easily counted or evaluated. Only extensive research and additional community surveys can give us valid information concerning their needs and the hidden numbers who may be suffering from mental or emotional illness.

COMMUNITY SERVICES

In the state of Iowa there are 154 general hospitals. Twelve of these have psychiatric units and at least six others admit psychiatric patients to the general wards. More psychiatric units are currently being planned. Adjacent to general hospitals there are approximately thirty long-term facilities providing treatment in keeping with the capabilities of the adjacent hospital.

There are fifteen community mental health centers in Iowa and several more are being developed. Most of these centers are located in the larger urban areas, but services are made available to many of the surrounding counties. These mental health centers are staffed with psychiatrists, psychologists, and social workers.

In the area of long-term care facilities, Iowa has 414 nursing homes, 280 custodial homes, 33 combination nursing and custodial homes, and 83 county homes. According to the Commissioner of the State Department of Health, Iowa is in danger of overbuilding these homes. In view of recent population projections, his statement should be given serious consideration.

The development of psychiatric services in general hospitals and community mental health centers, and the growth of private practice in psychiatry during recent years, clearly shows the trend toward the development of comprehensive community mental health care in Iowa.

It is the consensus of the committee that insofar as possible aged people needing mental or emotional counseling or treatment be provided such care as close to their own homes as possible with the least amount of disruption of their family and community life. The committee recognizes that in the older population, patients have a wide range of illness and disabilities from minor to severe and often a complex mixture of physical and psychological disorders. However, their needs in general for mental health services are the same as for the general population. Therefore, full attention must be given to the mental health needs of the aged in state and local comprehensive community mental health planning.

In view of the wide range of problems that the group of aged patients presents, it is essential to have coordination and integration of available services. At the time of referral, a thorough psychiatric and medical evaluation is recommended. The team approach utilizing a physician, psychiatrist, psychologist, and social worker is desirable in conducting this evaluation. However, neurology, surgery, internal medicine, general practice, rehabilitation, and welfare are a few of the other professional services that must be integrated and coordinated in the care of the aged. These professional services are now available in Iowa's larger urban communities, and considerable progress has been made in those communities in which there are psychiatric hospital facilities and mental health centers. Further development and expansion of these centers and hospital facilities is underway and should be encouraged.

Many aged patients will occasionally require admission to a hospital for diagnosis and treatment of a physical or psychiatric abnormality. These patients should be admitted to a community general hospital with the objective of accomplishing diagnosis and treatment in a relatively short period of time and then to return the patient to an outpatient service, a long-term residential care unit, or to his home.

In addition to short-term hospital facilities, a number of different long-term care settings are required, depending on the degree of physical or mental disability of the patient and the resultant amount and kind of medical or psychiatric care needed. Some community general hospitals in Iowa have wards for these patients with chronic and severely disabling disorders requiring continuing medical care on a

long-term basis. Staffing for these wards should include not only medical but psychiatric services. More of these long-term hospital settings are needed in Iowa, particularly in the larger urban areas.

The severity and degree of disability for a large number of the aged is not so great as to require hospital care. A recent survey by the Iowa Mental Health Authority reveals that there are approximately 18,000 people aged sixty-five and over in nursing homes, custodial homes, and county homes. These people have varying degrees of physical and mental disabilities and the services of these facilities are essential. Although many of these aftercare homes are new, well-staffed, and are expanding their programs, a great many are old, understaffed, and unable to meet minimal standards of safe care and housing. Many of the aftercare homes should have regular medical and psychiatric consultation services as well as public health nurse services, rehabilitation services, and continuous attention to activities, socialization, and the general amenities. This committee strongly urges that the State Department of Health be provided sufficient appropriational support and personnel to re-examine and expand its services relating to the licensing, inspection, and regulation of aftercare homes in order to promote and ensure adequate care of the aged and convalescent persons in such homes. The committee also urges that county homes be licensed as nursing or custodial homes.

A large number of the aged who have disabilities live in their own homes, in foster homes, or with relatives. Many of these persons look after themselves but may require a fair degree of support and supervision by community services which can provide assistance with meals and housekeeping and special attention to the provision of activities and socialization. In addition, consultation services and acute hospital services should also be available to the family or foster home. Continuing provision of special services, such as visiting nurses to give injections, social service assistance in solving day to day problems, etc., may be needed. A major factor in making home care possible may be provision of day centers to which the aged may go not only for treatment but for activities and socialization.

Psychiatric and medical consultation services should be made available to all medical and nonmedical community agencies and organizations providing or assisting in the care and treatment of the aged mentally ill. In some, these services are often lacking in the longer-care settings. Community psychiatric services must assume responsible leadership for these consultation services, preferably through the community mental health centers, to allow closer integration with community social services, public health nursing, rehabilitation services, and general practitioners.

FINANCING

The most effective treatment of each individual patient requires the availability of one or more of a variety of facilities. The most appropriate site for care should be determined by the family and the attending physician after the individual patient has been evaluated and examined.

The Iowa statutes which require strict and limited use of county funds, such as the county home fund, poor fund, mental health center fund, and state institution fund, should be amended to allow the county board of supervisors to pay for the care of those unable to meet the costs, regardless of where it is provided.

Federal matching funds for categorized assistance programs in the state of Iowa are currently administered by county departments of social welfare. The new federal medicare program for the aged will undoubtedly have a major impact on all patterns of financing care for the aged. This committee believes that all available sources of financial support for the care of the aged should be given continuous attention in ongoing planning to assist in the development of the most effective controls as may be needed to assure the highest quality of care economically provided in view of the changing patterns of financing and services.

MANPOWER AND TRAINING

The successful development and expansion of newer and existing mental health services requires not only additional competent personnel to provide these services but an intensification of training programs at all levels. Students in medical school should receive additional training in the care of the mentally ill aged as well as in the chronic diseases in general. The need for improvement of medical school training in this area was highlighted by the survey of physicians caring for patients in aftercare homes. These physicians also declared their need for additional emphasis on geriatric problems in postgraduate educational programs. The special short courses and training programs for nursing home administration should be expanded and made available to all personnel providing services in aftercare homes. The State Psychopathic Hospital, the Institute of Gerontology, the Mental Health Institute, the Commission on Aging, the Iowa Nursing Home Association, and perhaps others should make joint endeavors to plan training programs, institutes, workshops, and seminars which will most effectively reach all persons involved in the care of the elderly. The training of physicians and psychiatrists should be modified and improved to enable them to utilize their skills most efficiently when working through others who provide direct care. At the same time medical responsibility must remain with the physicians.

RESEARCH

During the period of this committee's deliberations the Iowa Mental Health Authority has conducted a number of research projects as part of the total comprehensive planning endeavor. These research projects have provided valuable information to the planning committee, but, more importantly, we recognize that we have barely touched upon such problem areas as chronic illness, patterns of care, financing, epidemiology, urbanization, and rehabilitation and treatment potentials. These problem areas need comprehensive study and should involve not only the State Psychopathic Hospital but other University departments such as Sociology and Anthropology, Psychology, Hospital Administration, Bureau of Business and Economic Research, Institute of Gerontology, School of Social Work, and others. In addition, other state and local organizations, private and public, should be involved. Such research efforts will ensure maximum utilization of all available research funds.

Chapter V
GOVERNMENTAL AGENCIES DIVISION–REPORT

The Governmental Agencies Division of Comprehensive Mental Health Planning in Iowa consisting, essentially, of the present coordinating and planning group set up under the statutes and policies governing the Division of Mental Health of the Board of Control, was assigned the task of coordinating the ongoing mental health programs and communicating to community agencies technical and administrative developments of local mental health plans.

The Governmental Agencies Division met regularly every three months beginning December, 1963, through June, 1965 —seven meetings of the Division. In addition, there were numerous subcommittee meetings. At the quarterly meetings various state departments and agencies presented résumés of the services they were prepared to offer in the field of mental health, and much enlightening discussion revolved around how various communities' services were coordinated. A list of invited participants is included in Appendix D, and major recommendations of the Governmental Agencies Division have been extracted at the end of the final chapter.

STATE DEPARTMENT OF HEALTH

1. Mental Health Planning and Services should be related to general public health services.

2. Plans and operation of mental health facilities and services at local and community levels should, in all instances, be coordinated with general health services and specific activities as indicated above and, wherever possible, should be based on utilization of common support and administrative and overhead services.

3. Specific planning and operation of mental health services should include consideration of maternal and child health activities, public health nursing, hospital and community health facilities, services for the chronically ill and aging, infectious diseases control, and health education.

4. It is considered essential and urgently recommended that the State Department of Health be kept fully informed of all mental health planning and activities and that these be fully coordinated with Health Department programs.

DEPARTMENT OF PUBLIC INSTRUCTION

It is recommended that the Department of Public Instruction provide strengthened leadership in the development and upgrading of local school services and programs which can create a desirable mental health climate in public schools and effect close liaison between the school and specialized community services designed to meet the mental health needs of children.

DEPARTMENT OF SOCIAL WELFARE

Clarify the role and responsibilities of the Department through its state and county departments, as follows:

State Department

1. Provide, in cooperation with other state departments and community agencies, leadership in the development of mental health services.

2. Coordinate the various programs administered by the State Board with respect to Iowa's Comprehensive Mental Health Plan. This includes the development of policies and procedures which contribute to a sound mental health program.

3. Provide staff at the state, regional, and local level with assigned responsibilities for mental health services.

4. Provide staff training in the area of mental health services.

5. Participation in research and demonstration projects relating to mental health services.

County Departments

1. Early identification of mental health problems and assistance in the referral of persons having emotional problems to mental health diagnostic resources.

2. Help to individuals with mental and emotional problems, and their families, which includes family and individual counseling and referral to community resources. Such services are appropriate to the needs of mentally ill persons at different ages and levels of illness.

3. Assistance to families and individuals for preadmission and aftercare services relating to institutional care.

4. Public Assistance grants to individuals and families in need of financial help, and as a part of the total plan for stabilizing the family.

5. The provision of supplemental or substitute parental care for children and adults through such programs as day care, foster family care, homemaker services, and nursing home care.

6. The inspection and licensing of foster family and custodial homes which provide care for mentally ill children and adults.

7. Assistance in obtaining legal protection for mentally ill persons when this is appropriate.

8. The development of a staff in county departments with specialized skill in serving mentally ill persons and their families.

9. Responsibility for coordinating and interpreting local services to mentally ill persons.

BOARD OF PAROLE

It is recommended that the Board of Parole seek the advice and help of the Committee on Mental Hygiene in establishing policies for securing mental health services for parolees.

VETERANS ADMINISTRATION, KNOXVILLE

It was recommended that the liaison between the Veterans Administration, state institutions, practicing physicians, and community agencies be strengthened.

Recommend a "Coordinating Council" in each community.

Recommend adequate post-hospital care and follow-up services after the patient returns to the community.

DIVISION OF MENTAL HEALTH,
BOARD OF CONTROL

Subcommittee of Superintendents of the Mental Health Institutes and Hospital-Schools for the Retarded:

1. Continue our consultative role to the community, and

enlarge our scope by offering services to persons with leadership roles in the community. As in the past, we will offer workshops on mental health to private practitioners of medicine, teachers, county board officers, nursing home personnel, stewards, matrons and other county home personnel, members of the clergy, and others.

2. We recommend the coordination of welfare and service agencies in larger communities in order to plan for continuity of service to mentally ill patients before, during, and in post-hospitalization phases. A better liaison would then be created between these agencies and the state residential facilities.

3. We stand ready to offer support to the communities and urban areas for the creation of sheltered workshops, half-way houses, and other community facilities which will smooth the way for the patient's return to the community as a useful citizen.

4. The comprehensive mental health center should have facilities for the care and treatment of geriatric patients. In addition, all present facilities in private, county, and state facilities should be modernized and upgraded. In the years to come, with the remarkable results of medicine in prolonging the life span of man, the geriatric patient may pose more problems than any other facet of the population.

5. In order to implement the Comprehensive Mental Health Program there must be an over-all evaluation of needs for professional manpower. The problem of the need for professional manpower has to be related to the present training programs in the mental health field in the state of Iowa, all of which must be strengthened and correlated. This includes strengthening and broadening the ongoing training programs at the Mental Health Institutes, the Hospital-Schools for the Retarded, and at the University. In order for the future psychiatrist to learn psychiatry in a broad spectrum, there should be a strong interrelationship in the teaching programs between the University Psychopathic Hospital and the Mental Health Institutes, allowing for experience both at the University setting and at the State Hospital. In order to implement this doctrine we recommend that top echelon qualified psychiatric staff at the Mental Health Institutes be tendered professorship appointments in clinical psychiatry. This strengthening of the training programs should not be only for medical but for paramedical personnel as well, so that the concept of the treatment team in the community may be implemented.

6. It is further recommended that the proposed maximum security hospital have provision for the evaluation, diagnosis, and treatment for the "acting-out" youngsters and defective delinquents, as well as adult offenders.

7. In view of the urgent need for the treatment of emotionally disturbed and psychiatric children, we recommend that residential and outpatient facilities be expanded not only at the Mental Health Institutes but also as part and parcel of the proposed Comprehensive Mental Health Centers.

8. We further subscribe to the philosophy that as sufficient comprehensive care develops in the community, that the Mental Health Institutes and Hospital-Schools for the retarded will assume, develop, and intensify their role as consultant-training facilities and resources for the treatment of difficult and long-term patients on both an in and outpatient basis.

PROFESSIONAL ADVISORY BOARD AND COMMITTEE OF DIRECTOR

1. Recommend that there be no deviation from the basic philosophy of the ongoing plans for mental health and mental retardation, in that the local communities, acting through the initiative and leadership of the citizens residing within the community, are to provide in the local community the services required by the mentally ill and mentally retarded person resident within the community.

2. Such services are to be planned, developed, and administered by local citizens in the manner that the presently existing general health services are predominately planned, developed, and administered. They are to remain as completely free of all governmental direction, regulation, and control as possible, but especially free of state and federal control.

3. Recommend that all governmental agency people living in and/or working in local communities work with the local power structure to effect the earliest possible implementation of such planning and health program development.

4. Recommend that the comprehensive plans within this framework, characterized by the utmost local autonomy and self-sufficiency, recognize and accept the roles of county, state, and federal government in aiding and advancing the development of mental health and mental retardation services.

5. Recommend that county government redirect its emphasis, through seeking to foster, develop, and utilize services provided by local citizens in local facilities as planned by local citizens under the initiative and leadership of local persons; that the tax resources presently being expended for the services provided by state agencies should, as much as possible and as soon as possible, be redirected to support local services, and the support presently given the state agencies will automatically be reduced as soon as adequate services can be provided locally, and the number of cases referred to the state diminished.

6. Recommend that local community people and state agency people seek to clearly establish the irreducible minimal role which state agencies should play in providing health services in the communities, and how community agencies can play a maximal role.

7. Recommend that the developing plans and programs of the several state agencies which relate to the local communities in so far as they aid, strengthen, and advance locally administered health services, be considered part of the comprehensive mental health plan.

8. Recommend that the role of governmental agencies, both federal and state, is to "phase out" of providing direct community health services as rapidly as can be done and yet contribute maximally to the strengthening of the services which can be developed and provided locally.

9. Recommend integrated higher education, training, and research. In order to develop clinically oriented training programs and research, the state must have an effective liaison with local community health services, or must provide limited direct health services. The state will continue to provide clinical services for the unusual and the difficult case referred from the local community, which service shall be integrated with teaching, training, and research. The state shall also coordinate teaching, training and research

with the local service agencies in the larger communities of Iowa by integrating such education with local health service agencies.

SUBCOMMITTEE ON COORDINATION OF MENTAL HEALTH SERVICES

1. The formation of Local Coordinating and Planning Councils for Mental Health and Mental Retardation. The primary purpose of such a council would be the coordination of services of all agencies which offer help to the mentally ill and the mentally retarded. It would represent all the agencies involved and should be a council which helps educate the community to the services offered by these agencies. An additional purpose should relate itself to assisting in the resolution of interagency disputes and certainly assisting in the promotion of interagency coordination. A final purpose would be the prevention of mental illness and mental retardation and the promotion of positive mental health.

In order to effect such a council, it is recommended that the community consultant staff of the four mental health institutes and the two schools for the mentally retarded be expanded. It is recognized that with the present community consultant staff, effective work with local coordinating and planning councils would not be possible.

The community consultants' responsibility to the local coordinating and planning council would be one of an enabling and stimulating nature. The first objective of such a council would necessarily be care to patients and their families. The community consultants would not be responsible for performing the tasks of the council, but merely to enable local persons to perform these responsibilities.

Agencies that might be represented on such a council would include the following: the county medical societies, county officials (boards of supervisors, county clerks, county auditors, county attorneys, stewards and matrons), commissions of hospitalization, the visiting nurse associations, school psychologists, local hospitals, private practitioners, mental health clinics, local departments of social welfare, local associations for mental health and retarded children, representatives from county, nursing, and custodial homes, from vocational rehabilitation, special education, private agencies, and other facilities offering service to the mentally ill and the mentally retarded. In order for the council to effectively coordinate services for the mentally ill and the mentally retarded, sanction needs to be obtained from each state agency for local participation in such a council. The task of the Council could relate itself to a variety of services, to decisions on policy matters, and the priorities of both.

2. The formation of a Data Processing Facility for collecting central information related to the mentally ill and the mentally retarded. Such a processing facility could collect identifying information such as name, address, birth date, family composition, county of legal settlement, dates of services offered, and the name of the agency or agencies offering service. Members of the data processing facility would have this information available to them upon relatively short request. Modern computing methods have made this possible. Such a data processing center could cut down tremendously on the effort needed to obtain information and understanding of former services to patients and their families.

Such a data processing facility might be operated through the newly developed Iowa Educational Information Center at The University of Iowa. Information to be collected is not intended to include diagnosis. Information would be available only to agencies and persons who were contributing members of the facility.

3. It seems very important to recommend that major services for the mentally ill and the mentally retarded be coordinated through an administrative structure which allows for maximum programming and maximum service to patients, their families, and the communities in which they live. It is further recommended that a representative policy making Mental Health Committee be established to formulate policies for the above program and services.

DIVISION OF CORRECTIONS

1. Career people are needed at all levels of corrections who can understand, be trained, and have a healthy influence on offenders at any level of the correctional process.

2. If the criminal code were revised so an indeterminate sentence could be used, then the length of sentence could be adjusted to the needs and problems of each inmate. The sentence could fit the criminal and not the crime.

3. The inmate-staff ratio should approach that of mental hospitals.

4. The role of correctional institutions should change from custodial to something resembling a mental hospital of today because 95 per cent of offenders need treatment related to the causes of their criminal behavior.

5. Rename prisons and reformatories "Correctional Institutions."

6. Treatment, rehabilitation or recovery is the answer in giving protection to society on release of inmates. It should be the concern of the people, who are directly and indirectly connected with the offender, to insist that they receive appropriate, rational, effective, and intelligent treatment. Prevention of crime and treatment of the offender is good mental health practice.

7. Pre-sentence investigations: Psychiatric evaluations are often useful and helpful to courts and may indicate problems and needs of treatment for the offender.

8. The use of public defenders should stipulate adequate counsel and treatment needs.

IOWA NURSING HOME ASSOCIATION

It was recommended that Nursing Home Administrators be subjected to an original and periodic orientation process and that there be professional follow-up to assure the service is being competently performed.

IOWA PHARMACEUTICAL ASSOCIATION

Recommends that:

1. Wherever appropriate, the paramedical services of the profession of pharmacy be utilized in:
   a. The support of efforts to establish and insure adequate community mental health facilities.
   b. The dissemination of mental health information and literature.
   c. Providing services as pharmacy consultants in establishing adequate standards, controls, storage, and handling, necessary records of drugs administered to patients in community health centers and in mental health institutions.
   d. Insuring that prescribed drugs are legally dispensed

utilizing normal distributional channels in the total best interest of safe therapy for patient health and welfare.

2. That the profession of pharmacy be provided the opportunity to coordinate this element of service with welfare agencies to insure that those eligible for mental health care under public assistance programs receive such care.
3. That the profession of pharmacy be provided the opportunity to develop a program of prepaid prescriptions, if legally feasible. The program, under third-party payments by the county board of supervisors, would provide prescribed drugs to mental patients receiving care in community mental health centers through community pharmacies. Such a program would reduce the total cost of drugs for mentally ill that are not eligible under existing public assistance programs.

COMMITTEE OF THE WHOLE

Recommends that particular emphasis be made that local facilities meet with county boards of supervisors as they are the people who handle the money. We need to work with the county officers as to how they are to use the money.

Recommends that the Executive Committee make specific recommendations as to the implementation of the Comprehensive Mental Health Plan.

Recommends that the Iowa Association for Mental Health, as a nongovernmental agency, be responsible for calling together annually the various groups for a review of what has been accomplished by way of implementation, and that local chapters of mental health initiate community meetings to organize mental health councils on how to implement programs.

Respectfully submitted,

James O. Cromwell, M.D., Coordinator
Director, Division of Mental Health
Board of Control of State Institutions
September 28, 1965

Chapter VI
VOLUNTARY AGENCIES DIVISION–REPORT

Throughout the comprehensive mental health planning project are reflected the contributions of the state's voluntary agencies. The Iowa Association for Mental Health was assigned and accepted a coordinating role in disseminating information, gaining public support, and implementing the various recommendations. The first leadership conference was held in October, 1963, at which time the planning project was explained. Again, early in 1964, a large part of the Association's annual meeting was devoted to exploring the complexities of providing continuity of services at the community level. Activity by the Association and various other voluntary agencies has been continuous and ongoing as the project developed. The Mental Health Association has realized that success in this assignment depends upon gaining the support of the people who must finally approve and pay for these services. Efforts at every level are being generated to demonstrate, evaluate, modify, and develop the suggested recommendations. Without positive endorsement and commitment of the agencies involved, the interested public can very easily become confused and uncertain.

The annual meeting in 1966 will again be in large part devoted to ways and means of implementing the findings of the planning project.

Voluntary agencies employ a multiplicity of methods to implement programs. Many of their activities must be directed toward the goal of public information. During the actual planning process, members of the voluntary agencies were actively involved as members of fact-finding committees. This participation gave them a background of the total planning process. Likewise, staff members of the project served as members of the professional advisory board of the State Association for Mental Health, providing a two-way flow of communications. As printed materials pertaining to comprehensive services became available, these were distributed to the mental health centers, and other community agencies. One very effective instrument for public information has been the Mental Health Association's Newsletter with a circulation of 6,500. Through this media the public has been informed of many of the developments in planning.

During the past legislative sessions, considerable effort was devoted to the support of legislation favorable to an expanded mental health program. The legislature passed enabling legislation providing participation in mental health and mental retardation facilities construction. There was also a bill designating the Psychopathic Hospital under the Board of Regents as the Iowa Mental Health Authority. Still another bill provided for a maximum security hospital. Permissive legislation was passed raising the levy for mental health care, from .375 mills to .50 mills for community mental health centers and from .375 mills to 1 mill for care of mentally ill in county homes and nursing homes.

This legislative action will further enhance the development of better community mental health services.

It is important that opportunities be provided for citizens and local communities to become involved and accept the major responsibility for emerging patterns of psychiatric services. To accomplish this, every available means of informing the public must be employed. A film is being planned. A "multi-fold," a brief summary of recommendations, a bibliography of printed materials and pamphlets in the mental health field, and a current list of films available for showing are being compiled. These will provide information to be consumed at the local level.

To further facilitate the process of informing the public, a state-wide speakers' bureau is being planned. A positive feature of this bureau would be a saving of professional staff man hours which can be channeled into the areas of research and training.

Coordinating the resources of agencies, such as the League for Nursing, the Pharmaceutical Association, American Legion, auxiliaries, federated women's clubs, county supervisors, board of control, law enforcement, and many other groups will be a major responsibility of the Mental Health Association. The overlapping of memberships in the various service groups facilitates communication, thereby multiplying the effectiveness of a total joint effort.

From the earliest stages of the planning project, when reports of a committee were available, the results were given to the public through progress reports. The project staff has presented reports to many civic organizations and service clubs. The Mental Health Association has continued to provide the local associations with information around which numerous local-level programs have been constructed.

Many people and organizations have been and will continue to be involved in the process of implementation. As the number of participants increases at the various community levels, the greater will be the acceptance of newer concepts and functions. It is not possible to attempt a timetable for the development of this activity. The degree of involvement, the urgency of the needs, and the availability of resources will be prime factors governing the degree of implementation. The task has been defined, the knowledge and skills are available. The process is underway.

Chapter VII
SUMMARY AND MAJOR RECOMMENDATIONS

Iowa's first mental health program began in 1854 when plans were undertaken to build state mental hospitals, the first of which was dedicated at Mt. Pleasant in 1861, a month before the Civil War. The program was in keeping with the public attitudes, scientific knowledge, population factors, and the economic and cultural characteristics of Iowa and the nation at that time. Between 1860 and 1930 Iowa's population grew from 674,913 to 2,470,939 but remained rural. Four state mental hospitals were built and located so as to serve four equal areas of the state, and most of Iowa's county homes were also built during that time. Following the economic depression of 1929, an attitude that mental disease was incurable developed within society and the medical profession itself. As a result, the state mental institutions became larger and larger, and acquired massive administrative problems. There was overcrowding, financial limitation, and under-staffing. During the early 1940's the state of the mentally ill confined within an institution was seen as similar in many respects to that so vividly described by Dorothea Dix one hundred years earlier.

During the past twenty years, however, many changes and advances have occurred as an increasing number of citizens have been devoting extensive efforts to develop a modern mental health program in Iowa. The public and medical profession have become more appreciative of the importance and significant extent of mental and emotional problems in the population at large. Advances in science, health care, and health education have stimulated the health expectations of individuals, and with the economic growth of the country, people have become more able to pay for services they need and want. The population of Iowa has become predominantly urban although its growth in total number has been minimal. The government has continued to play an increasing role in health care. Private psychiatric practice has grown markedly. Greater numbers of people receive psychiatric treatment in Iowa's communities each year as community mental health centers have been opened and psychiatric services have been provided in general hospitals. In addition, many other mental health services have been developed in communities to assist in the care of the mentally ill. Resident patients at the state hospitals have declined steadily in number. Training programs in psychiatry have expanded. The number of scientific publications by mental health professionals has greatly increased and many state laws have been passed to keep pace with modern changes. The enormous expansion and development in the field of mental health in Iowa during the past twenty years is certainly apparent, and there are indications that we may expect even greater growth in the immediate future.

The two-year project "A Comprehensive Mental Health Plan for Iowa" has drawn to a close, and in its place is seen evolving a continuous planning process. No "master plan" has been forthcoming, but rather, a philosophy and program for action supported by current findings, deliberations, and recommendations, which represent the efforts of hundreds of dedicated Iowa citizens.

The philosophy of providing mental health services at community level is both a reflection of a growing national trend and an extension of Iowa's traditional "local responsibility." It is now an accepted fact that it is better to provide psychiatric treatment near to the patient's home with as little disruption of his employment and family life as possible. One need only survey recent growth and distribution of private psychiatry and community mental health centers in Iowa to recognize that Iowa is definitely participating in this national trend.

The program for action, which is also evident throughout the nation, is based upon the concept of "comprehensive mental health services," to be provided in the community under a unified system of care. To support and encourage the "comprehensive concept," Congress has authorized both construction and staffing funds to the states for aid in establishing mental health centers which are required to provide certain services. To qualify for construction funds, which in Iowa are administered by the State Department of Health, a center must provide at least five essential services: 1) inpatient care, 2) outpatient care, 3) partial hospitalization, 4) twenty-four-hour emergency care, and 5) consultation and education. Though not absolutelv required, full comprehensive care also includes 6) diagnostic service, 7) rehabilitative service, 8) precare and aftercare, 9) training, and 10) research and evaluation. Though these services need not be "under one roof," the center must assure "continuity of care" which permits easy movement of the patient from one type of treatment to another as his needs change. This is the key provision of the mental health centers program.

Staffing funds, though primarily for assistance in initial staffing, will also be made available to existing mental health centers as "seed money" for the development of new services to round out a comprehensive program. Eligibility will require at least the five previously named essential elements and proof that funds will be available to bridge the gap between federal support and total program cost.

In Iowa, it is apparent that many areas of the state already have a broad spectrum of mental health services and that coordinated planning and integration would produce a comprehensive program with all the essential elements. Private psychiatrists and psychiatric units in general hospitals play key roles in providing these services and must be involved in both planning and coordination. Existing mental health centers, though primarily outpatient clinics a few years ago, are providing more consultation and education, more follow-up care, screening of commitments and court evaluations, and are beginning to plan seriously for inpatient service and partial hospitalization. Other areas now devoid of primary psychiatric services have expressed an interest in establishing their own mental health centers or in obtain-

ing services from adjoining areas. In still other communities without mental health centers, private psychiatry has expanded to provide not only direct services but consultation to physicians and agencies such as welfare, schools, courts, etc. This interest in local care is definitely growing. As the cost of hospitalization in our state institutions increases in keeping with better staffing and improved treatment programs, more and more communities are considering the advantages of local care and will soon become more selective in their hospitalization procedures.

The Comprehensive Mental Health Planning Project officially began on July 1, 1963, after several months of intensive preparatory work on the part of the Mental Health Hygiene Committee, which later expanded to become a nine-member Executive Committee. A central staff was employed and all known interested agencies, groups, and individuals were contacted to gain their support and representation. Certain changes were made in the original planning procedure so that, ultimately, three active working divisions were established.

The Governmental Agencies Division, coordinated by the Director of the Division of Mental Health, met every three months and had broad representation from professional and lay organizations, state departments, county officials and agencies, the Board of Control, Mental Health Institutes and others. The present and future roles of these various groups were discussed with particular emphasis on coordination of services at all levels and the need for continued planning. Major recommendations of the Governmental Agencies Division are listed following this summary.

The Voluntary Agencies Division, directed by the President of the Iowa Association for Mental Health, has played a vital role in developing public interest through state and chapter meetings of the association and regular reports in the IAMH Newsletter. Progress reports on the planning process have been presented at numerous meetings of agencies and organizations throughout the state. A wide variety of appropriate printed materials has been distributed. Concerned groups have supported a successful legislative program including a bill raising the limitations on county mental health funds, enabling legislation for construction grants, a bill for a new security hospital, and a bill to re-establish the Iowa Mental Health Authority under the Board of Regents at Psychopathic Hospital. As a part of implementation, the Voluntary Agencies Division plans to hold area informational meetings to promote the broad aspects of community-based mental health care. Films, pamphlets, and leaflets are being prepared and made available, and a statewide speakers bureau will be developed to insure that all people are properly informed.

The Scientific Division was established to approach specific mental health problems and was made up of representatives from various university departments, state and voluntary agencies, and numerous professional organizations and individuals. Working committees were formed to cover the areas of mentally ill adults, mentally ill adult offenders, alcoholism and drug addiction, the aged, children, and the mental health aspects of mental retardation. Meeting every four to six weeks, each committee of eleven to fifteen members considered its particular area from the standpoint of need, facilities, manpower, the law, administration, financing, public and professional education, research, prevention, and coordination. As the participants deliberated, it became apparent that more and more information was necessary to provide a sound basis for decision-making and planning. Subcommittees carried out surveys, reviewed the literature, and presented working papers on such subjects as financing, community resources, patterns of care, residential facilities, and agency roles. In addition, a number of reports were prepared and special research projects were conducted by the central office staff and various departments of The University of Iowa. When minutes of committee meetings and informational material became available they were reproduced and widely distributed so that each person involved in planning might know what everyone else was doing.

While Mental Health Planning was in progress, other things were happening. In the fall of 1963, Congress passed legislation authorizing funds for planning comprehensive action to combat mental retardation (P.L. 88-156) and funds for the construction of community mental health centers and facilities for the mentally retarded (P.L. 88-164). Since March, 1964, Mental Retardation Planning (administered through the Board of Control) has involved several hundred additional knowledgeable people and has required close liaison with other planning activities. In April, 1964, the 60th General Assembly passed enabling legislation naming the State Department of Public Health as the agency to administer Federal Construction Funds for both mental health centers and facilities for the mentally retarded. Thus, the Health Department has been made responsible for developing state plans which must interlock with those administered by the State Board of Control and the Iowa Mental Health Authority. The staffs of all three planning operations have worked together very closely and there has been considerable overlapping of membership on boards and committees. Also, there has been wholehearted cooperation in the collection and exchange of data in specific areas of common interest.

Although space does not permit a complete review of projects of the Scientific Division, many of the findings are of interest and important from the standpoint of planning. A statewide inventory of "Mental Health Facilities and Personnel in Iowa" emphasizes the trend toward providing services at community level. Though admissions to Iowa's four mental health institutes continue to increase (1,700 new cases and 2,500 returns per year) the total inpatient population has been reduced to slightly more than 2,000 in 1965. Fifteen Community Mental Health Centers are now available to more than half the state's population, and serve over 8,000 patients per year (4,400 new cases). There are now well over 100 psychiatrists in the state, half of these being in full or part-time private practice. Twelve psychiatric units in general hospitals have a total of approximately 4,000 admissions per year with an average length of stay of seventeen days. Maps accompanying the full report of this survey show that facilities and personnel tend to follow the same distribution as the population of the state.

A report on "Iowa Population Trends and Characteristics" further accentuates the fact that local psychiatric services have naturally developed in accordance with population growth. Historical and projected data are presented to show

that increase in population and industrial development are largely confined to the eastern half of the state. Of interest, also, in the southernmost two tiers of counties is the consolidation of farms, the declining population, the increased proportion of persons over sixty-five years of age, and the increasing number of small towns that are diminishing still further in size.

Iowa's full-time medical practitioners were surveyed for the purpose of determining the prevalence of emotional symptoms found in their patients. Two hundred ninety-one physicians reported on over 29,000 patients and indicated that 18.5 per cent of them displayed significant or major emotional symptoms. Of those having an emotional component to their illness, at least 85 per cent were treated by the practicing physician. Referral for psychiatric treatment was advised in 11 per cent, with less than half the patients accepting. The results of the study indicate that physicians in general practice constitute one of the largest single manpower resources for the treatment of mental and emotional conditions. The authors of this report suggest that more attention should be given by medical education to improve the training of general physicians and specialists in the treatment of these patients.

In another survey, over 25 per cent of Iowa's general practitioners reported on more than 8,000 of their patients being cared for in county homes, nursing homes, and custodial homes. Forty-two per cent of these patients were considered to be mentally ill. The physicians commented freely about the physical adequacy of these "after-care" homes as well as the type of care provided, and though there were many criticisms, there were equally as many complimentary remarks. Perhaps the most frequently reported shortcoming, in both new and old facilities alike, was the absence of meaningful activity and rehabilitative measures. More than half the responding physicians agreed that medical schools should give special emphasis to the training of students in treating the elderly and chronic mentally ill patients, such as those commonly found in county homes, nursing homes, and custodial homes. The complete report of this survey of physicians in Iowa is filled with many more stimulating comments, ideas, and suggestions, providing much food for thought for all persons concerned with mental health.

A study conducted in three different mental hospital settings has demonstrated that attitudes of nursing staff toward individual patients are influenced a great deal by the circumstances surrounding the patient's entry into the hospital. For example, the voluntary patient is regarded as more attractive and attitudes toward involuntary patients vary depending upon who has taken the action to force the patient into the hospital. Attitudes of personnel, in turn, influence the course of treatment, the relationships with other patients and family members, and perhaps even affect the length of hospital stay.

In another project, twenty-six district court judges in Iowa were personally interviewed regarding basic problems in the area of mental health and the law. Their responses indicated a marked need for the education of law enforcement personnel and court appointed counsel concerning the handling of the mentally disordered offender. Increased use of mental health services in the legal process was suggested, and most judges favored the building of a new security hospital for use as a diagnostic facility as well as a treatment center for dangerous and criminally ill patients. Other recommendations made by the district judges included clarification of the sexual psychopath statute, an emergency detention statute for mental patients, restoration of rights to patients on convalescent leave (with proper medical evidence), and increased safeguards of adoptions involving mentally ill patients. In addition to this "Judicial Survey," two other reports were prepared for the use of planning committees, "A Summary and Index of Iowa Statutes Concerning Support of the Mentally Ill and Retarded," and "A Synopsis of Iowa Statutes Regarding Commitment, Discharge, Guardianship, and Competency of the Mentally Ill."

In collaboration with The University of Iowa Bureau of Business and Economic Research two studies were completed pertaining to the costs of treatment for mental illness. In excess of fifty million dollars is expended each year in Iowa for care and treatment of the mentally ill, exclusive of expenditures for drugs. Approximately 45 per cent of these funds come from private sources and 30 per cent from county taxes, indicating that regardless of where treatment is obtained, it is predominantly supported by local finances. A comparison of costs per hospitalization in a state hospital and a psychiatric unit in a general hospital shows that dollar savings of community treatment are sizable. Though the daily expense in a local hospital may be higher, a much shorter average length of stay results in less total cost. In this particular study conducted in 1964, the average length of stay in a state hospital was ninety-six days with a total cost of $899.62, and in the private hospital the average length of stay was only twelve days with a cost of $340.08. This, of course, does not consider costs before or after hospitalization or loss of productivity and income of the patient. Since most authorities feel that long periods of hospitalization lead to chronic dependency of patients, it becomes apparent that economy is not the only advantage of short-term hospitalization in the community. It has also been reliably reported that with adequate screening and availability of outpatient services, many psychiatric patients would need no hospitalization at all. Likewise, with proper follow-up care, for patients discharged from the hospital, readmissions might be kept to a minimum.

In still another approach to treatment costs, a time study was conducted in three community mental health centers, revealing that 72.3 per cent of professional time was spent in clinical services, 8.3 per cent in community services, and 19.4 per cent in administration and internal activities. The average cost for a professional hour in direct service at the time of the study was $7.94. These findings are of particular interest since a number of mental health centers in other states give much less time to direct patient service and more time to consultation and education.

A preliminary study of first admissions to Psychopathic Hospital was conducted to help determine the influence of socio-economic and certain other factors on the duration of hospital stay. Results revealed that neither education nor occupational prestige affected the length of stay per hospitalization with the exception that adolescent children of high occupational prestige parents tended to stay longer.

Neither was length of stay influenced by age, sex, or distance of residence from the hospital. However, a greater proportion of single patients and those with a diagnosis of psychosis were found in the longer hospital stay categories. Similar unreported reviews of state hospital patients have tended to confirm these findings, in spite of the prevalent opinion that patients of low socio-economic status have more chronic illness and remain in the hospital longer.

In keeping with the concept of comprehensive community mental health care, it was decided to survey ten of Iowa's mental health centers by means of personal interview concerning their agreements and contracts for provision of services. Though no center fulfilled the criteria for being completely comprehensive, there were many agreements (mostly informal) with at least fifteen different types of agencies or professions, including public schools, colleges, social welfare departments, physicians, general hospitals, mental hospitals, courts, corrections, county homes, and industry. It should be noted that centers were doing relatively little follow-up care of discharged hospital patients or screening of those destined to be committed to the mental health institutes. Such a wide range of services made available by mental health centers indicates their responsiveness to community needs. Here, it should be noted that other psychiatric resources in the community were not included in this particular survey. There are many other important arrangements, and private practicing psychiatrists, in particular, provide services on a regular basis to most of the previously mentioned agencies and groups.

Throughout the planning process, it was repeatedly stated that many communities had a multiplicity of mental health resources, but that they lacked coordination. It was alleged that communities had diverse agencies offering similar services, often to the same patients, without being aware of the expensive duplications.

Today the need for coordination of these resources seems to be greater than ever as communities begin to mobilize local resources to meet their mental health needs. In order to help develop guide lines for improving coordination, a study was made of "critical incidents" in health and welfare agencies of two urban communities in Iowa. As a result, certain essentials of effective coordination were formulated. "Good coordination requires an adequate definition of agency roles as well as a definition of the problem for which services are being planned. All concerned agencies must be included in planning, and interagency communication must be timely and adequate. In addition, coordination requires that agency policies and services be flexible and geared to meet community needs."

Had time permitted, several other informative project reports could have been prepared by the central office staff. Considerable data was gathered on Iowa's nursing homes and county homes by both mail survey and direct visits to a random sample of 10 per cent of the homes. Though a report has not been completed, the information from these surveys was available for planning. Data was also collected on two five-year follow-up studies involving both hospitalized psychiatric patients and those treated on an outpatient basis. The reports on these projects should be forthcoming in the near future.

It is impossible in this summary to further condense the final reports of the six committees under the Scientific Division without losing many important ideas, reflections, and suggestions. For this reason it is urged that these reports be read in their entirety by those persons concerned with providing services to the mentally ill. Though major recommendations of each committee are listed following this summary, there are numerous others which warrant consideration.

The Committee on Mentally Ill Adults gave much time to the examination of Iowa's needs and resources and reviewed other studies and plans including "Action for Mental Health" and a Canadian report entitled "More for the Mind." Acknowledging the present trend, the committee agreed that the future direction of mental health in Iowa should be toward locally controlled community psychiatric facilities, strengthening existing services and developing new programs in those areas of the state now devoid of primary psychiatric services. The need for continued mental health planning was given high priority, and the committee made a number of suggestions concerning the ways in which this might be accomplished. Rather than retain the present planning structure, it was proposed that a central or master committee be organized with broad representation from mental health facilities, agencies, organizations, and groups. Since the new Iowa Mental Health Authority legislation enacted by the 60th General Assembly provides for an expanded, broadly representative Mental Hygiene Committee, it was suggested that this committee be given the responsibility for continued planning. Such a central committee might, from time to time, name ad hoc subcommittees for specific purposes and request that certain studies be performed by competent researchers or appropriate departments of government and higher education. In addition, it was felt that this committee should regularly review various mental health programs and follow progress in the implementation of comprehensive planning recommendations.

Financing of mental health services received special attention of the committee and recommendations were made on the utilization of funds from all available resources, including extended health insurance benefits. The importance of flexibility and local administration of funds was stressed and it was pointed out that certain state laws and local policies might require changing to accomplish these ends.

Several recommendations were made by the Committee on Mentally Ill Adults which were directed toward meeting the growing need for psychiatric service. Local coordinating groups, organized for purposes of improving professional liaison and for community planning were suggested. It was emphasized that close cooperation between concerned individuals and organizations would be needed to achieve continuity of care through all phases of a patient's illness. Though increases in training and research programs were advocated, it was felt that this alone would not solve the manpower shortage. With such a limited pool of potential trainees, it was proposed that training programs be planned which would make our mental health professionals more effective in community work. In addition, it was advised that mental health research efforts should be extended beyond the bounds of higher education to include state hospitals, mental health centers, private psychiatry, schools, public welfare, and other agencies throughout the state.

The Committee on Mentally Ill Children concurred with

many of the recommendations of the previous committee, particularly those on community-based care, coordination of resources, manpower development, training and research, and the necessity for continued planning. Because of the special needs of children, additional topics received considerable attention. The desirability of psychological services in every school system was stressed, as well as a need for improved communications between schools and various community agencies. Vocational training should be available to certain adolescents seeking such training or lacking academic aptitude or interest.

It was felt by the committee that Iowa is lagging far behind in the use of foster home placement of children, leading to overcrowding and a custodial atmosphere in Annie Wittenmeyer Home and the State Juvenile Home. Since counties now have certain financial advantages in utilizing state institutions for children rather than foster homes, it was recommended that the law be changed in order to discourage this procedure. Although additional hospital beds for children were proposed, it was also suggested that other types of residential care be developed, such as half-way houses and group-care homes.

Two special children's groups drew attention from the committee. Detention and diagnostic facilities for delinquent children should be improved or established in all areas of the state, and where they do not exist, nearby state institutions should be utilized. There is an immediate need for treatment and training programs for brain-damaged, hyperactive children who are neither mentally deficient nor epileptic. In addition, it is recommended that a special unit be established at The University of Iowa Medical Center for research, training, and treatment of brain-damaged children.

The Children's Committee was more specific than others with regard to the continuation of planning and recommended that the Iowa Mental Health Authority serve as a research, planning, and information center in the field of mental health. Moreover, the committee advocated an active role on the part of the Iowa Mental Health Authority in organizing meetings to promote coordination of state and local (public and private) agencies concerned with mental health.

The Committee on Mentally Ill Adult Offenders directed its studies to the mental health status of the offender and to the various services available to him throughout the legal and correctional processes. The committee expressed concern regarding the general negative attitude of many people associated directly or indirectly with the offender who needs appropriate, rational, humane, and intelligent treatment, in addition to necessary controls. Chief among the recommendations of this committee was that the state of Iowa build a new facility to replace the present Security Hospital at Anamosa for diagnosis, evaluation, and treatment of mentally disordered offenders. Funds were appropriated bv the 60th General Assembly for the establishment of such an institution by the State Board of Control. As presently planned, the hospital would be built near The University of Iowa to permit close collaboration between the hospital staff and University personnel in treatment, training, and research.

The committee also advocates an Iowa Academy of Police Science, the establishment of regional jails to supplant an antiquated county jail system, and enactment of the Model Sentencing Act by the Iowa General Assembly. Within Iowa's Correctional System it is urged that the philosophy of treatment in addition to custody be adopted, that administrative heads be well-trained, and that competent professional staff carry out treatment and rehabilitation programs in the manner of the "therapeutic community." In considering the post-confinement period, the Committee on Adult Offenders proposes that legislation be passed to create a "conditional release" system, that "pre-release centers" and half-way houses be established, and that local mental health and counseling services be developed for parolees who might benefit.

The Committee on Mental Retardation, which was set up prior to the organization of the Mental Retardation Planning Project, limited its considerations to the mental health aspects of mental retardation. Most of its membership ultimately became involved in Iowa's Comprehensive Plan to Combat Mental Retardation, and many of their ideas, suggestions, and working papers have been profitably utilized in that project. Feeling that, with few exceptions, the needs of the mentally ill mentally retarded are similar to those of all people, the committee emphasized that such patients and their families should be served through existing health, education, and welfare programs in the community. It was recommended that the services of mental health centers be made fully available to the retardate and his family and that the State Mental Health Institutes be used when appropriate.

The programs for care and treatment provided at Glenwood and Woodward should be strengthened and enriched and educational programs for personnel should be expanded and intensified in colleges, universities, and the state institutions. Also, short-term workshops, seminars and in-service training programs should be developed for personnel providing services to the mentally retarded and his family in the community.

Early developmental assessment of children, though perhaps difficult to accomplish, was recommended by this committee as an ultimate goal. In addition, there were proposals for school nurses and school social workers in all districts and a plea for integration of special classes in total school programs where feasible. As with all other committees, of course, there was the universal recommendation for coordinated planning and services at all levels.

The Committee on Alcoholism and Drug Addiction devoted less time to drug addiction and concentrated on the problem of alcoholism which costs the people of the state of Iowa at least twenty to twenty-five million dollars annually. Of the 50,000 Iowa alcoholics, very few ever receive any kind of treatment, and many go unrecognized. As many as 70 to 80 per cent, without apparent physical damage, are employed and have families. Fifteen to twenty per cent show some degree of physical damage but are not chronic police offenders, and about 5 per cent are homeless, jobless, skid row alcoholics for whom jail is a revolving door. Problem drinkers account for many of the divorces and separations, much of the inefficiency and absenteeism in industry, and many of the automobile accidents. Alcoholism leads to the most disabling physical, psychological, interpersonal, and economic consequences, and each alcoholic affects the lives of five or six other persons. The cost of alcoholism in terms of emotional damage to families cannot, of course, be estimated.

The committee is of the opinion that a condition so widespread as alcoholism demands that services be developed locally. This is best achieved within the concept of comprehensive community mental health care with emphasis on integration of medical and psychiatric services with the services of various other agencies. Outpatient treatment, short-term hospitalization, and long-term rehabilitation should be available at community level. Coordination of all these services is imperative, and, in addition, it is important to provide medical and psychiatric consultation services to non-medical community agencies and organizations assisting in the treatment and rehabilitation of alcoholics.

The committee also made a number of recommendations concerning improvement of educational programs on alcoholism for the public and special groups, and proposed that professional training and research programs on alcoholism be increased and improved.

Information received from various state and federal agencies suggests that narcotic addiction is well under control in Iowa and does not constitute a problem at this time. The issue of habituation to non-narcotic drugs is more difficult to assess, because such drugs are more readily available. On the other hand, there are relatively few hospital admissions for treatment of habituation, and there is no reason to conclude that illicit traffic in nonnarcotic drugs in Iowa is any greater or less than it is in other states of similar population. The committee does recommend that continued attention be given to the problems caused by addicting and habituating drugs by means of periodic surveys and by appropriate professional and public education.

The Committee on Mentally Ill Aged saw one of its major recommendations come to fruition before its final report was written. The 60th General Assembly enacted legislation to create a State Commission on Aging and appropriated $25,000 per year to finance its activities. For the most part, other proposals of this committee centered on the provision of all types of service for the aged within the community including short-term and long-term hospitalization, residential care, foster home care, outpatient services, day care, and home visiting services. Continued licensing, inspection, and regulation of nursing homes was felt to be necessary to insure the adequate care of the aged and convalescent persons, and it was recommended that county homes be licensed as nursing homes and custodial homes.

In line with other committee reports, it was also recommended that public education programs in the field of mental health be intensified and that mental health training and research programs be developed and expanded with particular emphasis on preventive measures, and the treatability and rehabilitation of the aged mentally ill.

As has been repeatedly emphasized, planning never comes to a close, it is a continuing process. Plans of today may be obsolete tomorrow. Comprehensive plans for one community may, for many reasons, completely fail to meet the requirements of another community. Yet, planning for adequate mental health services which will meet the needs of all citizens of Iowa is of prime importance.

Agencies, organizations, groups, and individuals at federal, state, county, and community level must plan together, defining roles, surveying needs, and sharing resources. The trend toward providing mental health services in the community should be developed and extended so that the mentally ill person may receive continuity of care near to his home, with as little disruption of employment and family life as possible. For this trend to be successful, the concept of "Comprehensive Mental Health Care" needs to be incorporated into the planning for all areas of the state. A comprehensive program will eventually provide inpatient care, outpatient care, partial hospitalization, emergency service, consultation and educational services, diagnostic service, rehabilitation service, precare and aftercare, training and research, and evaluation.

As we move into the phase of implementation, many questions have been only partially answered. Other questions cannot be answered at this time and require further consideration in continued planning at state and community levels. What is the meaning of "comprehensive" for any particular community? What will be the role of various agencies and professional persons in a coordinated mental health program? Can a "comprehensive" program be well coordinated, even though the essentials are operated under different auspices, i.e., a mental health center, a general hospital, and private psychiatry? What can be done about the shortage of mental health personnel in Iowa? What about the financing of mental health centers? In which situations should federal funds be used? Should the state of Iowa subsidize the operation of community mental health centers as many other states are doing? What, if anything, should be done about areas of the state which will not or cannot assume responsibility for care of their own mentally ill? Do any of our laws pertaining to the mentally ill need to be changed? With such an emphasis on community mental health services, what should be the role of Iowa's Mental Health Institutes? Should one or more of them be closed? What should be the role of county homes and nursing homes? How can good standards be maintained in such aftercare facilities? These are questions, plus many more, which will be encountered and, hopefully, resolved by future planners and implementers of community mental health programs throughout the state.

Certainly, if this trend toward Comprehensive Community Mental Health Services is to become a reality in Iowa, there is no time or place for complacency. Every concerned citizen should become more involved, not only in planning, but in implementation. Mental health needs must be further surveyed, services must be expanded and coordinated, and local facilities and care must, in some instances, be brought up to higher standards, commensurate with human dignity. Even the most sparsely populated areas of the state have resources which could be utilized to greater advantage, and those areas having a variety of mental health services show a need for coordinated planning.

MAJOR RECOMMENDATIONS OF THE GOVERNMENTAL AGENCIES DIVISION

It is recommended:

1. That mental health planning and services be coordinated with other health, education, and welfare services and programs.
2. That the Department of Public Instruction promote programs which will create a desirable mental health climate in public schools and effect close liaison with community mental health services.

3. That the State Department of Social Welfare contribute to the Comprehensive Mental Health Planning effort through leadership, adequate staffing, staff training, and participation in research and demonstration projects relating to mental health services.

4. That County Departments of Social Welfare participate in early identification and referral of persons with emotional problems and assist such persons and their families by means of counseling, public assistance grants, foster or nursing home care, obtaining legal aid, and information concerning various local services.

5. That the Board of Parole consult with the Mental Hygiene Committee concerning services for parolees.

6. That adequate follow-up care be provided patients released from Veterans Administration Hospitals through better liaison with state institutions, practicing physicians, and community agencies.

7. That Iowa's state institutions continue their consultative role to the community and continue workshops on mental health for concerned individuals and groups in the community.

8. That health, education, and welfare programs in larger communities be coordinated in order to plan for continuity of service to mentally ill patients before, during, and in post-hospitalization phases.

9. That comprehensive mental health centers provide adequate services to geriatric patients and that geriatric facilities, whether private, state, or county, be modernized and upgraded.

10. That the needs for professional manpower be regularly evaluated and steps be taken to strengthen and correlate the on-going training programs for all disciplines at the mental health institutes, the hospital-schools for the retarded, at the University, and in the community.

11. That the proposed maximum security hospital provide services for "acting-out" youngsters and defective delinquents, as well as adult offenders.

12. That residential and outpatient facilities for children be expanded not only at the Mental Health Institutes but in the community.

13. That as sufficient comprehensive care develops in the community, the state institutions intensify their role as consultant and training facilities and resources for the treatment of difficult and long-term patients.

14. That services to the mentally ill and retarded be rapidly developed and administered in the community with as little governmental direction, regulation, and control as possible.

15. That county government redirect its emphasis and tax resources toward the utilization and support of local facilities and services.

16. That state agencies and representatives of the community seek to establish the irreducible minimal role which the state should play in providing mental health services.

17. That the role of governmental agencies, both federal and state, is to "phase out" of providing direct community mental health services.

18. That communities develop local coordinating councils for mental health and mental retardation for purposes of public education and prevention as well as interagency coordination.

19. That a data-processing facility be formed for collecting central information relating to the mentally ill and mentally retarded.

20. That a representative policy-making mental health committee be established for the coordination of major services for the mentally ill and mentally retarded.

21. That correctional facilities become treatment-oriented rather than custodial institutions.

22. That the staff of correctional institutions be "upgraded" and increased in number.

23. That the criminal code be revised to permit utilization of the indeterminate sentence.

24. That pre-sentence investigations include psychiatric evaluations.

25. That nursing home administration be subjected to a periodic orientation process concerning the care of the mentally ill and mentally retarded.

26. That the profession of pharmacy be utilized in mental health planning and public education and as consultants on problems of drug usage and control.

27. That local facilities and services involve County Boards of Supervisors in planning.

28. That the Iowa Association for Mental Health be responsible for an annual gathering of the various groups to review progress in the implementation of comprehensive planning.

MAJOR RECOMMENDATIONS OF THE COMMITTEE ON MENTALLY ILL ADULTS

It is recommended:

1. That future efforts be directed toward the development of locally controlled community psychiatric facilities, strengthening existing service, and extending programs to those areas of the state which are now devoid of primary psychiatric services.

2. That Iowa's Mental Health Institutes improve their staffing and raise their standards in order to meet the requirements for accreditation by the Joint Commission on Accreditation of Hospitals.

3. That local planning for psychiatric services and facilities should be included as a part of planning for other health facilities.

4. That several counties with limited resources should join in common effort to inaugurate and support the operation of appropriately located community mental health centers.

5. That local community mental health services assume responsibility in assuring that persons have adequate psychiatric examinations before commitment to state mental institutions and that local communities develop services for follow-up care of patients released from state mental institutions.

6. That sufficient secretarial and clerical personnel be provided in order to permit professional personnel to perform professional functions.

7. That clinical psychiatrists work in a number of mental health settings.

8. That psychotherapy be considered as appropriately performed by any member of the clinical team, assuming that his professional training has been adequate and that treatment is carried out under proper psychiatric supervision.

9. That the psychiatrist have the authority and final responsibility for the diagnosis, care, and welfare of the patients under treatment by the clinical psychiatric team.

10. That equivalent professional standards, adequate salaries, professional direction, and ongoing program evaluation be maintained in each and all agencies which are in or become incorporated into the Comprehensive Mental Health Plan for Iowa, including Mental Health Centers, County Public Welfare Agencies, and Family Service Agencies.

11. That psychiatric services to non-medical community agencies, such as Family Service and Public Welfare, be on a consultative basis.

12. That a rehabilitation service be considered as an essential part of the treatment and after-care program and that this service maintain close liaison with appropriate community services.

13. That local or regional planning groups be organized on an area or population basis so that representatives may jointly plan for coordinated psychiatric services, defining roles, bridging any gaps, and establishing program priorities.

14. That state agencies play advisory and consultative roles and avoid positions of surveillance and authority over community mental health enterprises.

15. That the State Plan for Construction of Community Mental Health Centers as projected by the State Department of Health be supported.

16. That any future mental hospital facilities be built in close proximity to a medical center.

17. That no psychiatric inpatient service exceed a psychiatric bed capacity of 300.

18. That no more large mental hospitals or additions in bed capacity to existing large mental hospitals be built in Iowa. This does not preclude the replacement and/or modernization of existing mental health facilities.

19. That additional psychiatric units in general hospitals be established to meet the needs of centers of population.

20. That the provision of psychiatric services in general hospitals on a larger scale be given consideration in planning new hospitals, especially where government grants are involved.

21. That psychiatric units in general hospitals be a minimum of thirty beds.

22. That psychiatric units should be maintained as other departments in general hospitals.

23. That a psychiatric unit in a general hospital serve as one of the essential elements of a comprehensive community mental health center, the other elements being outpatient care, consultation, twenty-four-hour emergency service, and part-time hospitalization.

24. That the County Home Law should be revised to bring the county home into the mainstream of medical care.

25. That any new county homes to be constructed should have close relationships with the professional activities of a general hospital serving the area.

26. That hospital insurance plans be extended as fully as possible to provide care for acute and chronic psychiatric patients in appropriate facilities.

27. That the current method whereby cost of care in State Mental Health Institutes is paid from the institution fund of each county be continued.

28. That all available sources for financial support of local mental health services be favorably considered so long as administration of these funds is in the hands of the community.

29. That Iowa Statutes be revised to permit maximum utilization of available funds, regardless of source, in providing mental health services in the community.

30. That each mental health professional group establish a career development plan for those engaged in mental health services.

31. That training programs for mental health personnel be increased in number, size, and quality.

32. That the number of psychiatrists being trained in Iowa be doubled in the next three to five years.

33. That training programs be changed so as to produce mental health professionals who are proficient in diagnostic evaluation, prescribing treatment, consultation, supervision, community organization, group work, and program administration. Community mental health facilities and programs should be utilized more extensively in providing this type of training.

34. That mental health research be increased not only at Psychopathic Hospital but in other departments of the University and the various state and local psychiatric facilities.

35. That research efforts be extended to include the many areas brought into focus by the community mental health movement such as epidemiology, prevention, program evaluation, patterns of care, financing, urbanization, etc.

36. That the Mental Hygiene Committee assume responsibility for continued Comprehensive Mental Health Planning on a state level.

37. The policies, goals, and plans of the Division of Mental Health receive high priority for periodic review and recommendations in continued comprehensive mental health planning.

MAJOR RECOMMENDATIONS OF THE COMMITTEE ON CHILDREN

It is recommended:

1. That except where institutionalization is required, comprehensive services at community level be developed and made available for all handicapped children regardless of ability to pay.

2. That the state encourage and subsidize the development of vocational training schools to meet the needs of certain adolescents.

3. That the state of Iowa officially recognize the advantages of good foster home care over institutional care for most children and take steps to offset the financial inducement which present law provides to counties to place their dependent children in state institutions rather than in foster homes.

4. That efforts be made to convert the Annie Wittenmeyer Home and the State Juvenile Home from custodial institutions to diagnostic and treatment facilities by significant reductions in census and improvements in staffing.

5. That an additional children's treatment unit be established at the Mental Health Institute at Cherokee and that the obsolete buildings of the Children's Unit at Independence be replaced. (Appropriations authorized by the 61st General Assembly.)

6. That change in legislation or Board of Control policy permit brain-damaged children to be placed in or committed to a Board of Control Institution.

7. That a special unit be established at The University

of Iowa Medical Center for research, training, and treatment of brain-damaged children.

8. That training and recruitment of children's mental health professionals and allied disciplines be intensified and that staffs of children's facilities and agencies be increased in number and improved in quality.

9. That public education in the field of mental health be intensified with emphasis on local responsibility and involvement of professional people living and working in the community.

10. That the Iowa Mental Health Authority:

(a) Maintain a central repository for materials (reports and recommendations) developed by mental health planning groups.

(b) Serve as a research, planning, and information center in the field of mental health.

(c) Assume responsibility for organizing meetings to promote coordination of state and local (public and private) agencies concerned with mental health.

(d) Include necessary budgetary provisions for implementing Recommendation No. 10.

MAJOR RECOMMENDATIONS OF THE COMMITTEE ON ADULT OFFENDERS

It is recommended:

1. That there be established a task force on the qualifications, training, and criteria for selection of law enforcement personnel.

2. That there be created in Iowa an Academy of Police Science.

3. That law enforcement agencies and probation and parole officers utilize mental health personnel for consultation and inservice training.

4. That regional jails be established to carry out programs of rehabilitation* under the supervision of trained correctional administrators and utilizing the help of community resources.

5. That the Model Sentencing Act be enacted by the Iowa General Assembly.

6. That legislation be enacted authorizing mental and physical examinations and treatment of prisoners.

7. That the Board of Parole receive sufficient appropriations for a total probation and parole program.

8. That the state of Iowa build a new facility to replace the present Security Hospital at Anamosa for the diagnosis, evaluation, and treatment of mentally disordered offenders.**

9. That the administrative head of each correctional institution be well trained, and that he employ professional staff to carry out treatment and rehabilitation programs in the manner of the "therapeutic community."

10. That the Division of Vocational Rehabilitation receive sufficient appropriations for an effective program in each of our correctional institutions.

11. That legislation be enacted for a "conditional release" system to be administered by the Board of Parole.

12. That employees of correctional facilities have the opportunity to engage in educational pursuits which would improve personal competence and permit advancement to a higher position. Some form of subsidy and time for studies should be permitted.

13. That educational opportunities for inmates of correctional institutions should include academic opportunities at the college level.

14. That the Board of Control should authorize a prerelease center to be established separately but in connection with state correctional facilities. (Such a facility was opened in December, 1965, at River View Farm near Newton to serve inmates from the Iowa State Prison and the Iowa State Reformatory.)

15. That the Iowa General Assembly pass enabling legislation to charter private but non-profit half-way houses for the rehabilitation of former inmates.

MAJOR RECOMMENDATIONS OF THE COMMITTEE ON MENTAL RETARDATION

It is recommended:

1. That when indicated, children between three and five years of age receive a developmental assessment. (See addendum to committee report.)

2. That special class programs be an integral part of total school programs.

3. That all school districts have school nurses and trained school social workers.

4. That short-term workshops, seminars, and inservice training programs be developed for the personnel providing services to the mental retardate and his family.

5. That colleges and universities training professional persons provide a basic orientation concerning the needs of the retardate and his family.

6. That Iowa's two state institutions for the mentally retarded strengthen and expand their various educational programs.

7. That colleges and universities in Iowa and the state's institutions for the mentally retarded intensify and expand cooperative and coordinated education and training efforts.

8. That residential centers and the community agencies within the framework of the "Ideal Community" develop a sound pattern of coordinated planning and action.

9. That basic community health, education, and welfare services, including mental health clinics, be made fully available to the retardate and his family.

10. That services to the mentally retarded in the community be strengthened and expanded.

11. That services of the State Mental Health Institutes be utilized by the mentally retarded when appropriate.

12. That the program of care and treatment provided at Glenwood and Woodward be strengthened and enriched.

13. That planning for a new security hospital include consideration of the mentally retarded offender.

MAJOR RECOMMENDATIONS OF THE COMMITTEE ON ALCOHOLISM AND DRUG ADDICTION

It is recommended:

1. That state and local planning for the development and distribution of psychiatric services and facilities for the treatment and care of alcoholics take place in conjunction

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*The 61st Iowa General Assembly passed H.F.622 to give district courts authority to permit county jail prisoners to leave the jail to work on their jobs during normal working hours, to seek employment, to attend school, to receive medical treatment, or, in the case of women, to keep house.

**The 61st Iowa General Assembly passed HF.684 to appropriate $5,610,000 to the State Board of Control for capital improvements, including a maximum security hospital.

with planning of community comprehensive mental health centers.

2. That local treatment be emphasized. There should be no large single facility for the care of the majority of the state's population of alcoholics.

3. That hospitalization for the treatment of acute alcoholic intoxication be provided in the community, in a general hospital, or preferably in a psychiatric unit of a general hospital.

4. That adequate outpatient services for alcoholics be provided by expanding the programs of existing mental health centers and extending such services to new areas.

5. That adequate rehabilitation services for alcoholics be provided by developing:

(a) Rehabilitation programs in existing community facilities such as county homes and nursing homes.

(b) Half-way house programs in larger centers of population such as Des Moines, Cedar Rapids, and Davenport.

6. That local services of hospitals, mental health centers, and other agencies be coordinated to promote maximum effectiveness and to insure that the alcoholic patient receives appropriate help in his community through all phases of his illness without interruption.

7. That medical and psychiatric consultation services be made available to non-medical community agencies and organizations assisting in the treatment and rehabilitation of alcoholics including Alcoholics Anonymous, industry, courts, and the police.

8. That present educational programs on alcoholism for the public and special groups be expanded with particular emphasis on the disease concept, prevention, treatability, and rehabilitation.

9. That education and training programs for professional personnel in the mental health field be rapidly increased and improved and include emphasis on the problem of alcoholism.

10. That there be expansion and further development of research on alcoholism at the State Psychopathic Hospital pertaining to distribution, epidemiology, and evaluation of treatment methods.

11. That health insurance companies expand benefits for mental illness to include treatment for alcoholism.

12. That current statutes governing county funds, public and private hospitals, county homes, and public welfare be amended or modified to permit maximum flexibility in the use of facilities and funds for services to the mentally ill, including alcoholics who are unable to meet the costs for services, regardless of where provided.

13. That Section 321.281 of the Code of Iowa be modified to permit courts discretionary sentencing or commitment to a treatment facility, or probation or parole up to five years.*

14. That there be enactment of state and federal legislation directed toward better control of illegal traffic in addicting or habituating non-narcotic drugs, and that such legislation in no way interfere with the legitimate prescribing of such drugs for patients by licensed professional personnel, or with the proper medical treatment of the unfortunate persons who become addicted.**

15. That non-penal maximum security settings be provided for the withdrawal and treatment of drug addicts when medically indicated.

16. That closed treatment settings for addicts be closely integrated and coordinated with available community rehabilitation services in order to maintain continuity of care.

17. That continued attention be given to the problems caused by addicting and habituating drugs by means of periodic surveys and by appropriate professional and public education. These activities should be performed by the Iowa Mental Health Authority and by the Iowa State Department of Health.

MAJOR RECOMMENDATIONS OF THE COMMITTEE ON MENTALLY ILL AGED

It is recommended:

1. That the special mental health needs of the aged be given full attention in state and local planning for the development, expansion, and location of comprehensive community mental health centers.

2. That adequate service for elderly mentally ill persons be as close to home as possible with minimal disruption of the patient's family and community life.

3. That adequate services for the elderly mentally ill patient include short-term hospital care, long-term hospital care, long-term residential care, foster home care, outpatient services, day care, and home visiting services.

4. That the local service of hospitals, county homes, nursing homes, mental health centers, and other agencies be coordinated to permit effective and appropriate care and treatment of the elderly mentally ill patient through all phases of his illness without interruption.

5. That all non-hospital facilities such as long-term residential care facilities, foster homes, and other homes for the aged be developed and maintained separately from hospital facilities for those patients who do not need further medical or psychiatric clinical treatment.

6. That the State Health Department be provided sufficient appropriational support and personnel to re-examine and expand its services relating to the licensing, inspection, and regulation of homes, in order to promote and insure the adequate care of the aged and convalescent persons in such homes.

7. That county homes be licensed as nursing homes or custodial homes.

8. That medical and psychiatric consultation services be made available to non-medical community agencies and organizations assisting in the care and treatment of the aged mentally ill.

9. That public education programs in the field of mental health be intensified with more responsibility and involvement of local professional people.

10. That the education and training programs for professional personnel in the mental health field be rapidly increased and improved with an emphasis on prevention, treat-

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*The 61st General Assembly passed S.F.529 permitting commitment for treatment of any person convicted of a second, third, or more offense for driving while intoxicated.

**The 61st General Assembly passed S.F.285 pertaining to the illegal possession and sale of prescription drugs.

ability, and rehabilitation of the aged, particularly at the student level.

11. That there be expansion and development of research programs through The University of Iowa and its departments and other universities, colleges, training centers, official state agencies, and voluntary agencies pertaining to the elderly mentally ill.

12. That every effort be made to establish a permanent Commission on Aging. (Passed by the 61st General Assembly.)

APPENDICES

APPENDIX A

STAFFING

In the central office of the Iowa Mental Health Authority, the following persons were employed in comprehensive planning:

Herbert L. Nelson, M.D., a psychiatrist, was the Project Director. He was appointed to the Department of Psychiatry on 7-1-63, the same date Comprehensive Mental Health Planning began. He devoted eighty per cent of his time to comprehensive planning.

Patrick G. Campbell, M.D., a psychiatrist, was the Research Coordinator. He was appointed to the Department of Psychiatry on 3-16-64. About eighty per cent of his work was concerned with comprehensive planning.

Verne R. Kelley, ACSW, a social worker, was Administrative Assistant. His employment with the Iowa Mental Health Authority began 5-1-60. He worked full-time on comprehensive planning from the beginning of the project to the present.

Three full time secretaries were employed during the project:
Mrs. Sally Pease from 9-5-63 to 8-14-64;
Mrs. Evelyn Bollinger from 7-13-64 to present; and
Mrs. Sharon Winegardner from 9-1-64 to 7-16-65.

Although project funds for comprehensive planning could not be used for salaries after 6-30-65, grant-in-aid funds and state appropriations to Psychopathic Hospital have been utilized to retain the present staff.

APPENDIX B
Scientific Division

COMMITTEE ROSTERS

Committee on Adult Offenders

John H. Hege, M.D., Chairman; Superintendent, Mental Health Security Hospital.

Samuel Fahr, L.L.D., Vice-Chairman; Professor, College of Law, The University of Iowa.

R. W. Bobzin, Secretary and Director, Iowa Board of Parole.

William A. Bockoven, M.D., Psychiatrist and Director, Central Iowa Mental Health Center.

Larry Chase, Social Service Department, Iowa State Prison.

Thomas L. Coffey, ACSW, Director of Social Services, Iowa State Prison.

T. E. Hannum, Ph.D., Professor, Department of Psychology, Iowa State University.

Philip R. Hastings, M.D., Psychiatrist and Medical Director, Northeast Iowa Mental Health Center.

Merrill E. Hunt, Director, Division of Vocational Rehabilitation.

Judge B. J. Maxwell, Eighteenth Judicial District Judge.

Richard A. Mueller, ACSW, Psychiatric Social Worker, Mental Health Security Hospital.

Bernard J. Vogelgesang, Consultant, Iowa Citizens Council on Crime and Delinquency.

Larry Gutz, J.D., Consultant for Iowa Mental Health Authority.

Committee on Children

R. H. Riensche, D.D., Chairman; Executive Director, Lutheran Children's Home.

Richard Jenkins, M.D., Vice-Chairman; Professor, Department of Psychiatry, The University of Iowa.

Richard J. Bealka, M.D., Director, Childrens Unit, Independence Mental Health Institute.

Alan L. Christensen, ACSW, Supervisor of Field Services, Division of Corrections, Board of Control of State Institutions.

Mrs. Gordon DeLay, Linn County Mental Health Association.

Kenneth L. Eaton, Consultant, Visual and Physical Handicaps, Department of Public Instruction.

Marilee Fredericks, Ph.D., Chief Psychologist, Des Moines Child Guidance Center.

Wayne Gerken, Division of Special Education, Department of Public Instruction.

Robert E. Hyde, ACSW, Supervisor, Family and Children Specialist, Department of Social Welfare.

Henryk Kosieradzki, M.D., Psychiatrist and Medical Director, Mental Health Center of Marshall, Hardin, and Tama Counties.

George McGee, ACSW, Executive Director, Waterloo Family Service.

Mrs. Donald Neale, Children's Home of Cedar Rapids.

Ralph H. Ojemann, Ph.D., Professor, Institute of Child Development, The University of Iowa.

Mrs. Elizabeth Palmer, Director, Children's Division, Board of Control of State Institutions.

Anthony P. Travisono, Superintendent, Iowa Training School for Boys.

Committee on Mental Retardation in Children and Adults

Mrs. Helen B. Henderson, Chairman; Field Representative, Iowa Association for Retarded Children.

Gerald Solomons, M.D., Vice-Chairman; Assistant Professor, Department of Pediatrics, The University of Iowa.

Mario G. Barillas, Assistant Director for Special Services, Division of Vocational Rehabilitation.

Donald L. Carr, Ph.D., Assistant Professor, Department of Education, The University of Iowa.

Doyle R. Cottrell, Member, Finance Committee, Board of Regents.

Madelene M. Donnelly, M.D., Director, Maternal and Child Health, State Department of Health.

Mrs. R. L. Emerson, Black Hawk County Association for Mentally Retarded Children.

Glen C. Frey, Director, Keokuk Elementary Schools.

John Garfield, Ph.D., Director, Psychological Services, State Services for Crippled Children.

Richard Jenkins, M.D., Professor, Department of Psychiatry, The University of Iowa.

Leonard W. Lavis, ACSW, Superintendent, Glenwood State School.

Alan Mathiason, ACSW, Executive Director, Polk County Association for Retarded Children.

Edward L. Meyen, Project Director, Iowa's Comprehensive Plan to Combat Mental Retardation.

William C. Wildberger, M.D., Superintendent, Woodward State Hospital and School.

Committee on Alcoholism and Drug Addiction

Leo B. Sedlacek, M.D., Chairman; Psychiatrist, Alcoholism Study Commission Member.

John Clancy, M.D., Vice-Chairman; Associate Professor, Department of Psychiatry, The University of Iowa.

Representative Hillman Sersland, Decorah.

Harold Mulford, Ph.D., Research Professor, Department of Psychiatry, The University of Iowa.

Homer Adcock, Iowa Liquor Control Commission.

Karl A. Catlin, M.D., Superintendent, Clarinda Mental Health Institute.

Alex C. Evans, Counselor in Charge, Veterans Administration Center.

L. K. Berryhill, M.D., Psychiatrist, Medical Director, Jasper County Mental Health Center.

Arthur Downing, ACSW, Chairman, Board of Social Welfare.

Richard Vornbrock, ACSW, Chief of Social Service, Psychopathic Hospital.

Sutherland Cook, Cedar Rapids.

Richard Hammer, M.D., Iowa Academy of General Practice.

Charles Churan, Jr., Executive Secretary, Alcoholism Study Commission.

Committee on Mentally Ill Adults

H. C. Merillat, M.D., Chairman; Psychiatrist.

Charles Shagass, M.D., Vice Chairman; Professor, Department of Psychiatry, The University of Iowa.
Mrs. Joseph Rosenfield, Member, Board of Regents.
F. W. Pickworth, Director, Division of Hospital Services, State Department of Health.
Harold Korner, M.D., Psychiatrist, Medical Director, Black Hawk County Mental Health Center.
Donald Cordes, Administrator, Iowa Methodist Hospital, Des Moines.
Willard C. Brinegar, M.D., Superintendent, Cherokee Mental Health Institute.
Jay Hess, ACSW, United Community Service, Cedar Rapids.
Ross Wilbur, ACSW, Director, Division of Family Services, State Department of Social Welfare.
Eugene Kraus, ACSW, Executive Director, Des Moines Family Service.
Arnold Carson, Ph.D., Psychologist, Des Moines Child Guidance Center.
Mrs. Darlene Brown, Polk County Mental Health Association.
Louis Gaffney, Iowa Pharmaceutical Association.

Committee on Mentally Ill Aged

Mrs. Eleanor Carris, Chairman; Director, Des Moines Health Center.
W. W. Morris, Ph.D., Vice-Chairman; Director, Institute of Gerontology, The University of Iowa.
Representative Ray Eveland, Boone County.
R. J. Quackenbush, Executive Secretary, Iowa Nursing Home Association.
Don C. Charles, Ph.D., Professor, Department of Psychology, Iowa State University.
Wayne B. Brown, M.D., Superintendent, Mt. Pleasant Mental Health Institute.
Jack E. Penhollow, M.D., Director, Division of Gerontology and Chronic Diseases, State Department of Health.
Frank Itzin, ACSW, Associate Professor, School of Social Work, The University of Iowa.
William Turner, ACSW, Services for the Aged of Linn County.
Margaret L. Jacobsen, R.N., Executive Director, Iowa Nurses Association.

APPENDIX C
A COMPREHENSIVE MENTAL HEALTH PLAN FOR IOWA

COMMITTEE REPORTS

Report No.	*Committee*	*Final Report*
20	Adult Offenders	May 12, 1965
23	Children	August 4, 1965
24	Mental Retardation	August 4, 1965
25	Alcoholism and Drug Addiction	August 4, 1965
26	Mentally Ill Aged	October 6, 1965
27	Mentally Ill Adults	October 6, 1965

APPENDIX D
A COMPREHENSIVE MENTAL HEALTH PLAN FOR IOWA
Governmental Agencies Division

INVITED PARTICIPANTS

State Level:

Office of the Governor
Iowa Mental Health Authority
Iowa Medical Society
Iowa Psychological Association
Iowa State Hospital Association
Iowa League for Nursing
Iowa Nurses' Association
Practical Nurses' Association
The University of Iowa, Iowa City
Iowa State University of Science and Technology, Ames
Iowa Association for Mental Health
Iowa Association for Retarded Children
Iowa Council of Catholic Charities
Lutheran Welfare Society of Iowa
Iowa Children's Home Society
Iowa State Education Association
Iowa Welfare Association
Iowa Nursing Home Association
Iowa Speech and Hearing Society
Iowa Society of Osteopathic Physicians and Surgeons
Iowa Council on Mental Retardation
Iowa Council of Churches
Iowa Council for Exceptional Children
Iowa Legislative Research Bureau
Iowa Chapter of American Academy of General Practice
Iowa Congress of Parent-Teachers Association
Iowa State Employment Service
State Health Department
- Division of Hospital Services
- Division of Public Health Nursing
- Division of Maternal and Child Welfare

State Department of Public Instruction
- Division of Special Education
- Division of Vocational Rehabilitation

Board of Control of State Institutions
- Division of Mental Health
- Division of Corrections
- Division of Child Welfare

State Department of Social Welfare
Department of Public Safety
Board of Parole
Veterans Administration Hospital, Des Moines
Veterans Administration Hospital, Knoxville
Council of National Association of Social Welfare Chapters
State Commission on Alcoholism
Joint Coordinating and Planning Council for Health, Education, and Welfare
American Friends Service Committee
Goodwill Industries, Inc.
Manpower Training Coordinator
United Community Services

County Level:

Joint Association of County Officers
County Boards of Supervisors
Public Health Nurses
Clerks of District Court Association
Council of Social Agencies
County Welfare Departments
County Home Stewards and Matrons Association
Vocational Rehabilitation
Joint Coordination and Planning Council for Health, Education, and Welfare

Community Level:

Mental Health Centers
Psychiatrists in Private Practice
Community Consultants of the Board of Control of State Institutions

APPENDIX E
Scientific Division

PROJECT REPORTS

Report No.	*Title*	*Date*
1	Index of Iowa Statutes Dealing with Mental Illness and Mental Retardation	September 14, 1964
2	Summary and Index of Iowa Statutes	January 20, 1965

	Concerning Support of the Mentally Ill and Retarded	
3	Synopsis of Iowa Statutes Regarding Commitment, Discharge, Guardianship, and Competency of the Mentally Ill	September 15, 1964
4	Judicial Survey	November 19, 1964
5	Report On Cost Study	November 24, 1964
7	Distribution and Cost of Professional Time in Three Iowa Community Mental Health Centers	December 16, 1964
8	Mental Health Facilities and Personnel in Iowa	December 28, 1964
10	A Survey of Attitudes of Physicians with Patients in After Care Homes	January, 1965
11	A Study of the Total Cost of Treatment for Mental Illness and Sources for its Financing in Iowa	April 19, 1965
13	Essentials of Coordination	March 9, 1965
14	Consequences of Patient Entry Patterns in Three Psychiatric Settings	March 15, 1965
15	Alcohol and Alcoholics in Iowa, 1965	April 7, 1965
18	Mental and Emotional Symptoms in Private Medical Practice	April 19, 1965
21	Community Agreements to Provide Comprehensive Mental Health Services	June 4, 1965
22	Iowa Population Trends and Characteristics	June 1, 1965
26	Socio-Economic factors and the Length of Stay Per Hospitalization of Psychiatric Patients	October 6, 1965

To be completed:

Surveys of Aftercare Homes

Follow-up Studies of Psychiatric Patients

APPENDIX F

Planning and Projections for Iowa Mental Health Institutes

James O. Cromwell, M.D.

November, 1964

In November, 1964, the Committee on Mentally Ill Adults requested some information from the Director of the Division of Mental Health, Board of Control, concerning the future directions and plans for Iowa's four Mental Health Institutes. This report was prepared by Dr. James O. Cromwell and represents the philosophy and thinking at that time. The tables on patient statistics have been updated through June, 1965.

Statistics for our "average patient population at the end of the period" come diagonally down at all four Mental Health Institutes. If this trend continues, in five years we will have 350-400 patients at each institute, and less than none in ten years.

The total admissions pursue a diagonal course upward. Projected in the future—in five years each institute would admit 1,100 to 1,300, and in ten years 1,500 to 1,700.

Of course this data is not an accurate index of the future. We have no evidence of a "plateau" yet, but one has to come in time.

The future distribution will be quite like the present. We have fairly accurate data for 1961 to 1964. A larger percentage of patients 15-24 are being admitted, and a smaller percentage over 65. All other age groups remain about the same. (See tables.)

The "admission by diagnosis" reveals little. Possibly there is a significant decrease in the percentage of "manic depressives," although the number remains the same. We cannot break this down into "with mania" and "with depression."

The percentage of senile dementia has decreased by half in four years, but considering senile dementia and cerebral arteriosclerosis together, there is no significant change. The psychoneurotic reaction and personality disorder have increased.

Of those in residence we note a decrease in the percentage of those for the manic depressives, and the schizophrenics; all others increase correspondingly a little in each category.

It would appear that in ten years things will be about as now except that we will have a somewhat smaller percentage of manic depressives and schizophrenics, and a somewhat higher percentage of arteriosclerotics, psychoneurotics, alcoholics, and other personality disorders.

The outpatients appear to be holding steady at 1,400-1,600 each year.

The role of the Board of Control in providing mental health services for the Correctional and Childrens Divisions is more difficult to asssess. Present goals have been tentatively established while several planning groups ponder the problems. Briefly stated, the present plans are:

1. To seek to evaluate, screen, and diagnose all felons, all juvenile offenders, and every child admitted to our care.

2. To seek to provide the professional services required to treat all those who are found to have clearly defined medical or psychiatric needs.

3. To seek to establish a "security hospital" which will be staffed with an adequate security force, plus the medical and psychiatric personnel to provide active treatment for all security cases.

4. To seek to establish ways of providing psychiatric and medical treatment for all cases in Iowa placed on parole or on leave from our institutions who are clearly in need of such medical or psychiatric treatment—and to do this by whatever means we can. Hopefully, to accomplish it by arrangement with private practitioners and/or community clinics. But, if this fails, to provide "stop-gap" direct service until local communities are able and willing to do the job.

5. To coordinate correctional, children's, mental illness and mental retardation services so as to make the most efficient use of professional personnel.

The Board of Control has no specific plans with regard to after-care clinics that can be reduced to number and location. Our plans are to fulfill our obligation and see that after-care is provided. To accomplish this we have "community consultants." They are to work with community agencies and hopefully to get them to provide the after-care. If this cannot be accomplished we plan to "pinch-hit" by providing the needed after-care until the community can do so. We expect to do this largely through the Outpatient Department.

If a community had a large number of patients requiring after-care and did not have an adequate way to provide after-care and requested us to set up an after-care team and charge it back to the county, we would consider doing it, but only until that community could provide the after-care itself. Then we would withdraw our unit, or the community could just take it over. This is what we hoped to do at Des Moines. All other large areas requiring after-care seem to have community clinics now, and most of these clinics are providing after-care. I do not envision us needing to establish any community after-care clinics, and if we did it would be only after the established community clinics serving the area had failed to provide it, and upon the request of the local people who were responsible, with us, to provide such after-care. But this is not likely to happen.

We too are members of the Mental Health Hygiene Committee, and we helped develop the present philosophy of clinic development. We believe that locally controlled clinics or centers are the best way to develop services and plan on doing all we can to aid in promoting their development; so we refer all inquiries

to the Mental Health Authority. But we do intend to see that after-care is provided for persons for whom we have a legal and ethical obligation—one way or another. If a community sends us patients, then refuses to develop a clinic or, on developing one it does not provide after-care, then we will explore other ways of doing it with the community people who are responsible along with us, and follow their suggestions when we are able to do so.

In computing the number of psychiatrists and other professionals needed to do the work of the Board of Control in the future, we are presently being guided by:

One psychiatrist for each thirty cases in residence; plus one additional psychiatrist for each sixty admissions per year; plus one additional psychiatrist for each 150 admissions to Outpatient Department.

My personal opinion is that the state hospitals will always have some cases. I believe they will become more and more hospitals for the active treatment of the difficult or unresponsive patients. Even when the number of psychiatrists is adequate, and the number of private facilities and community centers is adequate, some patients will be referred to the state hospitals after everyone else has failed because something still has to be done. Even so, the state hospitals should attempt to provide only "active treatment."

The patients in residence will "plateau" around 350 or 450 at each Mental Health Institute, I suspect. For planning purposes let us use 400 in ten years.

Admissions now seem to be even more numerous than they were. Eventually, this too, will "plateau"—and may even decline. I should think that we will continue to admit around 600 to 900 after the communities have stopped sending us so many that they could otherwise care for at home if they would just do it.

But, assuming that in ten years each Mental Health Institute does have 400 patients; admits and discharges 800 and has 800 outpatients per year—using our guideline, we would need:

400/30	13 M.D.s
800/60	13 M.D.s
800/150	5 M.D.s
Total required in 10 years	31 M.D.s

If twelve of the thirty-one are "Residents" they would be considered as eight, so it would mean thirty-five payroll positions needed, or 140 "clinical positions" plus eight administrative positions.

The number of clinical psychologists needed is determined by somewhat similar guidelines, viz:

One clinical psychologist for each 100 patients in residence, plus one additional psychologist for each 300 admissions a year, plus one additional psychologist for each 300 new outpatients per year.

The formula for Social Service Workers is:

One S.S.W. for each eighty patients admitted annually, plus one S.S.W. for each sixty patients on convalescent leave, or on "family care."

One S.S. Supervisor to every five caseworkers.

We will need one dentist for every 500-1,000 cases in residence, plus one dental hygienist or dental technician for each 250-500 patients in residence.

Each patient in residence, or seen as an outpatient, will require an average of ten laboratory procedures annually.

One technician will be required for each 7,500 procedures a year.

WHAT WE THINK THE DIVISION OF MENTAL HEALTH, BOARD OF CONTROL, WILL BE IN 1975

1. The total patient personnel ratio of the four Mental Health Institutes will be approximately one employee for each patient. The employee-patient ratio for the two hospital-schools will be approximately 65 employees for each 100 patients, or 1:1.66.

2. The programs of the six Institutions for inpatient services will completely meet the staffing standards of an active treatment, or active treatment and training oriented hospital or hospital-school.

3. The functions and responsibilities of the Division of Mental Health will be essentially what they are now except that the several obscure and controversial responsibilities will have been discussed and agreed upon in such a way that they will no longer be obscure or controversial.

4. For each 100 patients the personnel employed will be classified about as follows:

	Mental Health Institutes	*Hospital-Schools*
M.D.s	8	1
Clinical Psychologists	3	2
Social Service Workers	9	3
ST & OP	7	8
R.N.s	10	3
L.P.N.s	25	17
Attendants	10	10
A. & M.	28	22
	100 employees	66 employees

5. The "extramural" programs of each hospital or hospital-school will be adequately staffed, organized, and the program developed to where the responsibilities of the Division of Mental Health to the communities will be fully implemented through a corps of "community consultants" backed up by community controlled agencies, if possible, and by an outpatient service team as necessary.

6. The extramural responsibilities of the Division of Mental Health will have been clearly agreed upon in relation to several areas, as follows:

a. The selection and the determination of patients for admission to the hospital or hospital-school. This will be directed by professionally trained personnel who are informed as to the capabilities and limitations of the hospitals and of the community facilities. Personnel performing these functions will have exhausted every opportunity to provide the needed services without turning to the state. Having turned to the state, the medically most appropriate plan of management or of providing service will be utilized, whether this means treatment in the community through contract with local professionals and agencies, by outpatient department at the hospital, or admission for inpatient service.

b. The selection and determination of patients for readmission will be handled in a manner similar to that spelled out in (a).

c. The making of arrangements for the provision of adequate after-care and follow-up services will have been accomplished.

d. The numbers and types of community consultants required to bring about the effective liaison and coordination with the community will have been determined, secured, and their role established and accepted.

e. The community consultants' role in concerning themselves with how best to secure the services needed by all persons dependent upon the Division of Mental Health—whether they are new patients, readmissions, county home residents, nursing home or foster home placements on county care, or persons on probation or on parole and in need of mental health services while under the custody of the Divisions of Corrections and Juvenile Institutions,

or new and experimental cooperative approaches will have been worked out.

f. In working out the provision of needed services of persons dependent upon the Division of Mental Health, local community facilities will be utilized to the fullest extent possible. If the local facilities do all that needs to be done there will be no further need of state-directed services. But until that goal is attained, the Division of Mental Health will continue to plan and implement services—ever seeking to do it through more adequate local services under local control, but by direct service when necessary. The direct service will be withdrawn when replaceable by local facilities, or it may become the basis for starting local services.

7. The role of the state hospital in providing training for all categories of personnel needed to man the state and the community mental health facilities will have been clearly established, accepted, and operating successfully.

8. Coordination of the professional training program with the Board of Regents programs for student nurses, social workers, clinical psychologists, several types of "special therapists," and psychiatrists, will have been accomplished. This coordination will involve all echelons of administrative and staff organization, as recommended at the interstate conference in July, 1964.

9. The service programs of the Board of Control, Department of Health, Department of Social Welfare, and Board of Parole will have become the "social laboratory" for the academic social scientists of the Board of Regents, and the fullest possible inter-staff relationship will have been established so as to insure that the Board of Regents personnel exploit the training and research potential of this social laboratory. The personnel of the service organizations of this laboratory will be enabled to receive and give effectively to the scientific and educational activities in the field, and the educational and scientific personnel of the Board of Regents will be enabled to contribute and derive benefits from the practical experience, training, and research opportunities afforded by the "social laboratory."

Board of Control
Division of Mental Health
November, 1964

November 3, 1965

TO: Dr. J. O. Cromwell
Director of Mental Health

FROM: Raymond D. Taylor, Statistician

SUBJECT: POPULATION CHANGES IN THE FOUR MHI FROM 1961 TO 1965.

The data you requested on age at admission for all patients entering the MHI are shown in Table 1. The percentages are based on total admissions each year.

Table 1
Admissions to MHI by Age

	FISCAL YEARS									
	1961		1962		1963		1964		1965	
AGE AT ADMISSION	No.	%	No.	%	No.	%	No.	%	No.	%
Less than 15	50	1.6	89	2.5	85	2.1	61	1.4	76	1.8
15 - 24	347	10.8	412	11.7	547	13.8	555	13.0	573	13.6
25 - 44	1183	36.9	1253	35.7	1364	34.4	1559	36.6	1574	37.5
45 - 64	1024	31.9	1117	31.8	1278	32.2	1402	32.9	1385	33.0
65 and Over	605	18.8	644	18.3	696	17.5	685	16.1	594	14.1
TOTAL ADMISSIONS	3209		3515		3970		4262		4202	

In Table 2 are shown the data for patients admitted by major mental disorder for the four years.

Table 2
Admissions to MHI by Mental Disorder

	FISCAL YEARS									
	1961		1962		1963		1964		1965	
MENTAL DISORDERS	No.	%	No.	%	No.	%	No.	%	No.	%
Acute Brain Syndromes	57	1.8	41	1.2	48	1.2	55	1.3	58	1.4
C.B.S.-Cerebral Arterio.	297	9.3	414	11.8	447	11.3	459	10.8	340	8.1
C.B.S.-Senile Brain Disease	141	4.4	86	2.4	123	3.1	87	2.0	110	2.6
All Other C.B.S.	196	6.1	268	7.6	248	6.2	232	5.4	262	6.2
Manic Depressive Reactions	160	5.0	148	4.2	148	3.7	165	3.9	147	3.5
Schizophrenic Reactions	794	24.7	992	28.2	1032	26.0	1085	25.5	1049	25.0
Other Psychotic Disorders	166	5.2	174	5.0	206	5.2	198	4.6	175	4.2
Psychoneurotic Reactions	248	7.7	251	7.1	340	8.6	397	9.3	371	8.8
Alcoholism	528	16.5	524	14.9	554	14.0	683	16.0	750	17.8
Other Personality Disorders	285	8.9	336	9.6	490	12.3	573	13.4	638	15.2
Trans. Situational Pers. Dist.	68	2.1	97	2.8	110	2.8	95	2.2	104	2.5
Mental Deficiency w/Psych.	69	2.1	115	3.3	121	3.0	125	2.9	137	3.3
All Others	200	6.2	69	2.0	103	2.6	108	2.5	61	1.4
TOTAL ADMISSIONS	3209		3515		3970		4262		4202	

The patients remaining in residence at the end of each fiscal year are shown by major mental disorder in Table 3 below. The percentages are based on total residence.

Table 3
Resident Patients in MHI by Mental Disorder

	FISCAL YEARS									
	1961		1962		1963		1964		1965	
MENTAL DISORDERS	No.	%	No.	%	No.	%	No.	%	No.	%
Acute Brain Syndromes	24	0.7	23	0.7	20	0.7	12	0.5	14	0.7
C.B.S.-Cerebral Arterio.	247	7.1	307	9.4	302	10.3	307	12.3	212	10.2
C.B.S.-Senile Brain Disease	159	4.6	124	3.8	114	3.9	90	3.6	91	4.4
All Other C.B.S.	435	12.6	409	12.5	365	12.5	323	13.0	284	13.7
Manic Depressive Reactions	211	6.1	177	5.4	151	5.1	121	4.9	98	4.7
Schizophrenic Reactions	1563	45.2	1492	45.8	1283	43.7	1061	42.5	859	41.3
Other Psychotic Disorders	163	4.7	139	4.3	129	4.4	97	3.9	89	4.3
Psychoneurotic Reactions	72	2.1	70	2.1	79	2.7	96	3.8	77	3.7
Alcoholism	60	1.7	81	2.5	81	2.8	90	3.6	105	5.0
Other Personality Disorders	92	2.7	89	2.7	118	4.0	88	3.5	97	4.7
Trans. Situational Pers. Dist.	20	0.6	25	0.8	30	1.0	29	1.2	28	1.3
Mental Deficiency w/Psych.	233	6.7	228	7.0	185	6.3	157	6.3	121	5.8
All Others	179	5.2	96	3.0	77	2.6	22	0.9	4	0.2
ENDING RESIDENCE	3458		3260		2934		2493		2079	

An abbreviated population movement report for the MHI Out-Patient Clinics covering 1962 through 1965 is presented in Table 4.

Table 4
Population Movement in the MHI Out-Patient Clinics

	1962	1963	1964	1965
New Admissions	1397	1626	1151	900
Readmissions	301	415	454	389
Total Admissions	1698	2041	1605	1289
Terminations	1017	2032	1775	1208
Ending Caseload	1580	1589	1419	1500

APPENDIX G
Committee on Mentally Ill Adults

Report of the Subcommittee on Financing Mental Health Services

A broad look at the treatment program for the care of the mentally ill in the state of Iowa reveals a dramatic shift in the site of this treatment from the large State Mental Health Institutes to the local communities. Through improved staffing, administration, and clinical practice in the State Mental Health Institutes, the census of the institutes has been nearly halved during the past fifteen years. Active intensive treatment is afforded to all but the most resistant patients, and the general characteristics of the patient population have been greatly modified. In at least some of the institutes, over 50 per cent of the admissions are now voluntary and there has been great increase in the volume of patients seeking outpatient care and not requiring admission as inpatients.

The reduction in census results largely from improved methods of treating those patients now admitted. It also results in part from the policy adopted by the State Board of Control twelve or fifteen years ago under which those patients deemed to be beyond further benefit from treatment at the Mental Health Institutes and who are harmless to themselves and to society are returned to the local communities where they are placed in either the county homes or private nursing homes and, in a few instances, their own or foster homes. This one action alone has served to change the site of care for a significant number of the mentally ill patients in Iowa.

Concurrently, there has been notable improvement in the local community facilities for treatment of the mentally ill throughout the state. There are now fifteen mental health clinics, some of which have been in operation for as long as twenty years, and others being in the organization stage. These clinics serve to entice into communities psychiatrists, psychologists, psychiatric social workers, and other personnel necessary for treatment of the mentally ill. There has been a significant increase in the number of psychiatrists in private practice in the state.

These two parallel developments have resulted in other changes: personnel competent to treat the mentally ill are no longer exclusively centralized at The University of Iowa and the four mental health institutes. The "control" of psychiatric treatment, once centralized in the State Board of Control and The University of Iowa, is now as decentralized throughout the state as are the facilities for treatment. Two decades ago the major outlay of money for treatment passed through the channels of the State Board of Control and the State Board of Regents. The largest sums supported the State Mental Health Institutes. Today, a significant portion of the expenditures flow from the outpatient or his insurance company directly to the private psychiatrist, to the local mental health clinics, or to the State Mental Health Institutes. The county boards of supervisors also continue to administer tax funds. These are separated into funds for institutional care; the county poor fund; funds for care of the mentally ill in the county home and, in several counties, there have been three-eighths-mill tax levies for operation of a county mental health center.

The State Department of Social Welfare, through each of its county departments of social welfare, provides financial assistance, medical care, and social services to many mentally ill persons who receive Old Age Assistance, Aid to the Disabled, Aid to the Blind, and Aid to Dependent Children. In "integrated" counties, mental health services may be offered to other persons in the community within the scope of the function of the director of relief. Some mentally ill adults may also receive services within the scope of the Child Welfare Services program when these are appropriate to the well-being of the children and youth in families of such adults. These services are rendered to adults and children in their own homes, in nursing homes, custodial homes, and foster family homes, or may be purchased from specialized children's facilities. The medical care program within the scope of the public assistance categories includes diagnostic examination and drugs, but not psychiatric treatment.

While the financial support for mental health services formerly was centralized in the State Board of Control, the funds themselves actually have come from the property tax of each of the ninety-nine counties. While there has been some use of county funds for support of mental health clinics and support of the mentally ill patients in county homes, we are not seeing a significant shift in the flow of county tax funds from institutional care to support local mental health clinics to a degree which will stimulate the futherance of the decentralization of mental health services into the local communities.

The following goals relative to financing the care of the mentally ill are recommended:

1. Persons who themselves are able to pay for necessary care should be required to pay the charge in full whether the care is rendered in a private office, in a psychiatric unit of a general hospital, in a community mental health clinic, or in a State Mental Health Institute.

2. Blue Cross, Blue Shield, and commercial insurance companies are urged to expand benefits for mental illness and to pay for care in a private office, in general hospitals, in community mental health clinics, and in a State Mental Health Institute.

3. The current method whereby the cost of patient care in State Mental Health Institutes is paid from the institutional care fund of each county should be continued. County auditors should continue to collect these charges from the patients themselves, from the family, or from insurance benefits in the patients' behalf. We believe it would be a serious mistake to provide the financial resources for operation of the state mental health institutes from direct state (vs. county) taxation.

4. The statutes currently requiring strict separation of county-administered funds into an (1) institutional care fund, (2) a county home fund, (3) the Poor fund, and (4) a fund for a community mental health center should be amended to permit the county board of supervisors to pay for care for those unable themselves to pay for care, regardless of legal settlement, whether the care is rendered in the State Mental Health Institute, a community mental health center, the county home, a nursing home, or in a private office. The most appropriate site for the care should be determined on medical criteria by the family and the attending physician. The place of care should be only secondarily based upon the source of funds from which the care will be paid. Provided there is local administration of funds, state and/or federal supplemental moneys are accepted. Federal categorical assistance funds are currently providing care for Public Assistance, A.D.C., Aid to the Blind, etc. and are administered by local welfare departments. State funds are also transmitted to the counties for care of mentally ill patients discharged from the State Mental Health Institutes into the county home, foster homes, or nursing homes. It is appropriate for those mentally ill persons who can be maintained in the community through the utilization of public assistance funds to be provided such care. These programs will be supported by county, state, and federal moneys. The provision of mental health services by public agencies may require both statutory and budgetary adjustments. Iowa statutes should facilitate the maximum utilization of federal funds in meeting mental health costs, and state and local agencies will need to include in their respective budgets funds for the expense of providing mental health services or for the costs of payment for such services when they are purchased

from private resources. The inclusion of care and treatment in appropriate mental health facilities should become a part of the medical costs in the several programs mentioned. Such services should be broadened to include the costs of those professions which are appropriate to the treatment of mentally ill persons.

5. State and federal social security programs have tended to eliminate residents of county homes needing purely domiciliary service, and the people in county homes are primarily sick people who belong in a health facility. The County Home Law enacted in 1842 and last amended in 1909 should be completely rewritten to direct the county board of supervisors to bring the county home into the mainstream of medical care and establish methods of accomplishing this transition. Major construction of additions or replacements of existing county homes in their rural setting should be discouraged. In the thirty-seven counties with county hospitals the patients should become the responsibility of the county hospital, and the tax levying authority of the county board of hospital trustees should be increased. In the remaining counties, new construction should be in close proximity and administratively associated with a general hospital serving the area. The county board of supervisors should be authorized to join with other counties to create a single facility sufficiently large to support the staff needed to provide modern health care and should be authorized to contract with a hospital or related health care facility for the operation of the facility. All county facilities providing care for county patients should have an organized medical staff, including the services of a psychiatrist, which would determine the medical care program of the facility and an appropriate staff of medical and paramedical personnel to carry out the modern health care program.

6. Until such time as the County Home Law is changed and the appropriate transition made, county homes caring for patients discharged from the Mental Health Institutes (and a few admitted directly) should utilize the psychiatrists and other professional personnel of the community health clinic wherever one exists. The cost of such services should be paid from county administered funds on behalf of any persons who are themselves unable to pay.

7. While it is expected that persons able to pay the cost will avail themselves of private psychiatrists, the services of the community mental health centers should be available to all citizens; those able to pay the full cost of care should be required to do so; others should be charged according to their ability to pay; operating expenses of the clinics in excess of charges collected should be paid from locally administered funds.

8. In some counties where resources are limited, we urge several counties to join in common effort to inaugurate and insure the operation of community health centers appropriately located geographically. We commend the action taken by several counties that have already combined their resources to support a community mental health center.

9. Community general hospitals are encouraged to develop units for the care of the mentally ill. The cost of care for the mentally ill should be borne in the same manner as the cost of other care. County boards of supervisors are encouraged to utilize the authority already included in the Code to purchase care from community hospitals for the care of those unable themselves to pay such costs.

APPENDIX H
Committee on Mentally Ill Adults

Report of Subcommittee on Mental Health
Community Mental Health Resources in Addition to Mental Health Centers

Mental Health Planning can be considered on three levels:

1. Helping people who request or desire assistance in developing the fullest utilization of their personal resources.

2. Helping people to deal adequately with stress.

3. Helping people who cannot maintain their emotional equilibrium without hospitalization or hospital facilities.

All community resources at every level provide help toward the fullest development of the individual's potential, whether they come in contact with the individual at the level of personal enrichment, of dealing with stress which produces sufficient anxiety to seek outside help, or helping people maintain emotional equilibrium through hospitalization.

On the second level, specialized practitioners or agencies, such as private psychiatrists, psychologists and social workers, Mental Health Centers, Family Service Agencies, and County Departments of Social Welfare provide services to help people cope more constructively with stress.

In the continuum of service, some persons will require hospitalization under psychiatric supervision, i.e. day or full-time residential facilities.

In order to make the continuum of care effective, there needs to be close coordination between residential and non-residential facilities if they are not under the same administrative organization.

I. Direct Services

A. County Public Welfare Agencies

County departments of social welfare share with voluntary agencies and with specialized agencies the responsibility of providing mental health services to the community. Services are extended to those receiving public assistance and child welfare services, often "hard-to-reach" or "multi-problem" families. Services may be extended to those who were formerly assistance recipients or whose economic situation is sufficiently marginal to cause them to be potential recipients of public assistance. In "integrated"* counties such services are available to anyone in need as a part of the general relief program.

Mental Health services provided by county departments of social welfare include:

1. The early identification of persons with mental health problems.

2. The utilization by referral to local, regional or state resources for the diagnosis and treatment of mental illness.

3. Consultation with and the provision of supportive services to persons and families who are experiencing difficulties in family relationships or in other aspects of their social functioning.

4. The placement and supervision of children and adults in family homes, nursing homes, or custodial homes.

B. Family Service Agencies

Family Service agencies provide a voluntary service for families and individuals who are experiencing difficulties in their family relationships or in other aspects of their social functioning. Its services are available to all regardless of race, income, or religion. It is prepared to give help with a wide range of problems such as unsatisfactory relationships between marriage partners or between parents and children; unsatisfactory development or behavior of children and adolescents; need for help with such matters as household management, work adjustment, vocational training; need for help in planning for the care of ill, handicapped, or aged individuals, or for the care of other family members at the time of illness, mental disturbance, desertion of a parent, and so forth. Casework treatment by a family agency may be described as "family oriented;" it takes into account family interrelationships as well as the needs of

* Defined as a county where general assistance and federal categorical assistance programs are administered by the county welfare departments.

individuals of the family. Service is given on a fee basis, according to a scale established by the agency, and is available without cost for those unable to pay. This broad basis of service makes the family agency the principal one in the community offering casework help with problems of personal and family adjustment.

Mental Health services provided by family service agencies include (1) identifying cases requiring mental health services, (2) providing help at a time of crisis by intervening to meet the immediate emergency, (3) providing direct casework treatment of emotional problems, and (4) referral of cases to other appropriate mental health professions and mental health centers.

C. Travelers Aid Agencies

Travelers Aid Agencies, through their chain of services, provide the same casework and mental health services as the family service agencies but on an inter-city basis for people who use movement in an attempt to handle their emotional problems and are away from their resources at home.

D. Settlement Houses or Community Centers

Settlement houses provide a place to which individuals and families come voluntarily to participate in cultural, physical and recreational activities designed for developing a healthy personality and strengthening family life. Here people also work together to develop and maintain a better neighborhood.

Mental Health Services provided by settlement houses include:

1. Provision of a climate which fosters good mental health, one in which the individual feels freedom of expression, opportunity for experimentation and achievement; a climate which is tolerant of deviant behavior.

2. Sharing of information and interpretation to the neighborhood regarding mental health problems and preventative and treatment resources within the community.

3. Early recognition of behavior symptomatic of mental health problems.

4. Preparation for referral, including supportive services geared toward acceptance.

5. Referral to appropriate agency for service.

6. Provision of ongoing supportive contacts with family members when hospitalization and/or intensive treatment is necessary.

7. Serves as a bridge from the Mental Health Institute back to community living.

A closely integrated working relationship between psychiatric services and settlement houses could establish a mental health outpost at the neighborhood level which would more adequately reach individuals who are reluctant to move to the wider community for needed mental health services.

More and more neighborhood-based casework services in the settlement houses are being seen and provided as a necessary complement to meeting the needs of people mentioned above.

Participating agencies designated above should render services on a regional basis following natural demographic and geographical areas and take into account the adaptation of particular services to local needs.

II. Recommended standards for participating agencies (mental health clinics and centers, county public welfare agencies, family service agencies and all other agencies or centers which are or become incorporated into the Comprehensive Mental Health Plan for Iowa.)

1. Equivalent standards of professional qualification should be established according to job functions for participating agencies.

2. Adequate salaries should be paid to attract competent personnel in each of the participating agencies in accordance with their professional qualifications and job function.

3. Directors of participating agencies should be professionally qualified in the services offered by their agencies, whether it be in social work, psychiatry, or psychology.

4. Participating agencies should provide for ongoing evaluation of treatment effectiveness.

5. Participating agencies should provide for the continuous evaluation of intake policies in relation to community needs and other resources available.

Financing, Budget, Insurance

The costs of mental health services are a shared responsibility to be borne first by the individual or family receiving such services and then by private and public resources. Such costs should be related to the ability of the individual to pay and the resources of his family, but in no instance should the individual in need of care be denied services because of his inability to pay or because of his status in the community.

Resources of voluntary agencies may supplement those of the individual when mental health services are a part of the program of such agencies.

Costs beyond those the individual can pay should be borne by those public agencies responsible for providing services or for purchasing needed services from private facilities. Such resources include the county poor fund, the soldiers', sailors', and marines' relief fund, public assistance funds, child welfare services funds, and the institutional fund.

Coordination of Mental Health Services

Coordination of Mental Health Services needs to be considered on two levels, an operational level and a planning level.

Lack of coordination on either level will result in lack of continuity of services to the patient or client, resulting in poorer treatment than is otherwise available, costly duplication of services, and larger gaps in service to the community in the mental health area.

The types of professional groups and agencies providing mental health services are varied. In addition to psychiatrists, social workers, and psychologists, professions such as pediatricians, psychiatric nurses, vocational counselors, and lawyers all provide mental health services in varying degrees. However, at the operational level, coordination should be carried out through the vehicle of the agency, institution or clinic. For the purpose of specificity, agencies providing the mental health services are classified as medical, non-medical, or social service. Examples in the same order are a state mental hospital, a community mental health clinic, and a family service agency.

Basic through the coordination on the operational level are the following:

1. An awareness on the part of each agency, institution, or clinic that they play only a part in the total mental health services to the community, both indirect and direct.

2. A thorough knowledge of one's own service—what the agency is equipped to do better than anyone else and what services a patient or client can better be provided by another service.

3. Implicit in the last statement is a knowledge of mental health services offered by other types of agencies, institutions, or clinics, regardless of their medical, neo-medical, or social service orientations.

4. Acceptance of the contributions of each profession and service to the total complex of mental health services in the community.

If these ingredients are present, coordination on the operational level will work smoothly with little, if any additional structure needed.

On the planning level, an organization which is accepted by all mental health services is needed to bring together all of the services to meet the gaps and priorities of implementation. An organization of this type should be independent of administration by medical, neo-medical, or social service institutions. It should be developed to function in such a manner that it would

allow for planning around gaps in service and priorities of implementation, according to where these needs can best be served rather than through an affiliation with a particular kind of agency or institution.

This planning will vary from community to community and size of area (county vs. state), and will have to take into consideration the organizations already in existence for planning, such as community welfare councils and the level of development of the community services. On the community level, the responsibility may rest with the mental health center, or if no other resources exist, this may fall to the county welfare department. Ideally, administration of such a planning body should be independent of agency affiliation, although its place of operation is usually located in a social service building, mental health center, or hospital for convenience. To be effective, all groups in the community who participate in planning must accept the designated organization and provide it with the respect and cooperation necessary to do the job. This same planning body can be very useful to the community by using its resources to foster the basic ingredients necessary for coordination on the operational level.

APPENDIX I
COMMITTEE ON MENTALLY ILL CHILDREN
Desirable Pattern of Services for Children in Iowa

Report of Subcommittee on Emotionally Disturbed and Dependent Children
June 5, 1964

A desirable pattern of services for children in Iowa will recognize, initially, that responsibility for the care, nurture, and social training of children rests primarily with their parents. A public responsibility has been recognized and accepted for the education of children, but their care, particularly in the early years, is the private responsibility of their parents. The community becomes involved only as the parents seek assistance in meeting their responsibilities or as they fall so short of meeting them that the intervention of community authorities is called for.

The following kinds of assistance should be available to and for children in Iowa when they are needed:

1. Financial assistance in the event of financial need. For example, lack of a breadwinner in the home through the death, illness, incapacitation, or desertion of the father makes financial assistance necessary.

2. Social work services. In times of family crisis, the understanding assistance of a social worker can be of enormous importance in aiding parents to the point at which they are able to marshall their own resources effectively to meet the needs of their children. Financial assistance given over a period of time without social work contacts carries a special risk that it may foster chronic dependency. Social work contacts may be of crucial value in helping parents to understand the problems of their children and to meet the needs of their children.

3. Homemaker services to provide for care of children in their own home when this is appropriate. If the mother is incapacitated or otherwise unable to provide for their care, homemaker services should be available.

4. Foster home care. Since not all homes can be rehabilitated and since not all children have responsible parents, there must be facilities for foster care of children. This involves foster family care, particularly for younger children. There is some need also for group homes, particularly for older children. Adequate foster home care sometimes requires the availability of a receiving home, or institution for short-term care of children before they are placed.

5. Receiving home. The receiving home may be combined with the institution for longer-term care of dependent children or may be separate from it.

6. Outpatient psychiatric services. When the problem presented by a child is serious or confusing to the responsible adults or when the problem does not respond to their efforts to resolve it, the clinical services of a mental health center should be available. Such a center provides diagnostic services and outpatient treatment services. Since these latter services particularly are necessarily limited in their availability and their effectiveness by the problem of geographical distance, there is a need for spotting such services widely over the state.

7. Inpatient psychiatric services. There is a need for special inpatient psychiatric facilities for children for both diagnosis and for treatment. These should be available at various places in the state so that weekly visits by and from the family will be feasible.

8. Day hospital facilities. Where possible, day hospital facilities for children are advisable in population centers. They facilitate the resolution of family problems.

9. Residential group care and treatment center. It should be recognized that some children, particularly adolescents, cannot accept a foster home, and that some children are not accepted by a foster home. There are a good many older children who are likely to do better in an institutional setting than in a foster home. In providing institutional care for dependent children, account should be taken of the fact that easy-to-place children are easily placed in foster homes while hard-to-place children with problems tend to accumulate in the institution. The institution for dependent children must have treatment facilities such as social work and psychological services, and also psychiatric services, at least on a consultative basis, if it is to fulfill its function. This is particularly important for the undomesticated child who needs a period of taming and training before a foster home is likely to accept him. While there will be some potential overlap between the function of a group-care facility for dependent children on the one hand, and a true residential treatment center (as psychiatric inpatient service) on the other hand, there is an active need for both.

The need for cooperation and coordination between and among these various services should be obvious. For example, diagnostic and treatment services supplied by mental health centers need to be available for dependent children under the care of social agencies. Emotionally disturbed children, after a period of hospital treatment may not be able to return to their own homes, and a foster home placement may be essential. This requires the participation of a child-placing agency. Those who do return to their own homes may urgently need outpatient treatment in the home community after discharge from the hospital.

APPENDIX J
COMMITTEE ON MENTAL RETARDATION
Diagnostic Planning and Treatment Center for the Mentally Retarded
(Ideal Community of Approximately 100,000 population)

Location

Where easily accessible (probably the main town). Ideally, a diagnostic center for the mentally retarded should be related to a broader program of medical services. Where there is a pediatric service, a child psychiatry service or a child guidance clinic, and services to handicapped children, it would be desirable that the diagnostic service for mentally retarded children be attached to these. Such a pediatric service would, of course, not take care of adults, and some provision should also be made for services to mentally retarded adults. Where there is no broad

pediatric service, but there is a community mental health center which serves both children and adults, it would be logical to relate the diagnostic center for the mentally retarded to this service and to have it serve both children and adults.

Purpose

The purpose is to provide aid to the mentally retarded individual and his family through evaluation and diagnostic service, early identification of the mentally retarded, and follow-up services directly or by referral. This will in some instances involve recognition of a familial disorder in which mental deficiency is preventable in future children in the family. In all instances it will involve a study of the subject's health, his limitations and his assets, to the end that he and his family may be aided toward bringing about the best adjustment of which he is capable.

Staff

Physician—preferably with pediatric, neurological and/or psychiatric training.

Clinical Psychologist	Speech and Hearing Clinician
Public Health Nurse	Vocational Rehabilitation Counselor
Social Worker	
Secretarial and Clerical Staff	Administrative Director

Consulting Staff

Pediatrician	Otolaryngologist	Neurologist
Internist	Ophthalmologist	Orthopedist
Psychiatrist	Others as indicated	

Intake Policy

Age: There should be provision for services for both children and adults, whether in a combined service or separate services.

Referral: Any responsible person, including a parent, should be able to request an evaluation.

Cost: No one should be denied this service because of inability to pay.

Parents' Participation: Whenever possible, parents or guardians should participate in clinic visits.

Clinical Laboratory Facilities

Arrangements should be made for both routine and selective use of appropriate laboratory facilities.

Release Forms

Parents or guardians should be asked to sign "release of information" forms to obtain hospital records, school, psychological, and other agency reports as indicated, and to make reports as appropriate.

Coordination Services

The Center should designate one member of its staff, presumably a social worker, to be responsible for intake, including telephone requests for service or information, and for seeking the coordination of community services for the mentally retarded individual and his family. In the intake phase, the coordinator should (a) secure reports from the referring person or agency, (b) determine with the staff the need and urgency for clinic evaluation, (c) refer to the appropriate agency if unsuitable for service at the Center, and (d) schedule a screening review if appropriate. Once an examination date is scheduled for the patient, appropriate personnel from community agencies would be notified and invited to participate in the case conference. In the case conference, the results of the examination would be discussed, a diagnostic summary prepared, and a treatment plan devised with the active cooperation of the participating community agencies. Following the examination, the results of the study should be interpreted to the parents, who would be encouraged to ask questions and to discuss their concerns. The objective of the interpretation is realistic planning for, and when possible, directly with, the retardates. It is important that the patient's personal physician receive a full report of the diagnostic evaluation. Whenever possible, the personal physician should be considered as a part of the team in the over-all planning of the patient's program.

Planning such programs will be greatly facilitated by the existence of this "fixed point" within the community for providing direct service and coordination of services for the retarded. Not only should representatives of community agencies be invited to attend case conferences, but every effort should be made by the Center to hold regular conferences aimed at improving existing services, establishing desirable new programs, and helping to define the respective roles played by community agencies in meeting the total needs of the retarded individual and his family.

Other Services

Management: Counseling service in the "management" of the retardate needs to be provided. This may be on an individual or group basis with counseling from physician, psychologist, social worker, special educator, or public health nurse, depending on the specific needs of the family.

Special Education: Although educable and trainable classes should be the responsibility of the public schools, classes for those potentially eligible for public school placement might be provided in the Center.

Pre-school facilities should be available in the community to retarded children. Such classes should provide readiness activities for satisfactory adjustment in special classes, or the day-care program.

Vocational Rehabilitation: Although the service would be available in the community, there will be the need for a full-time vocational rehabilitation counselor for the Center itself. Preparation for vocational guidance could then be instituted before the legal age for eligibility for rehabilitation services.

Sheltered Workshop: A sheltered workshop for individuals with different disabilities is necessary in the ideal community. There may be advantages to locating it within the Center. The counselor of vocational rehabilitation would then participate in its management.

Day-Care Program: Children not accepted in special education and patients with severe and multiple handicaps, with behavior problems, or with family circumstances necessitating care outside of the home, should be able to receive "care and protection," in suitable cases, within the community. Depending on facilities, the Center might be considered as the location for such a program.

Residential Care: The community should be responsible for providing temporary care for the retarded. This could include foster home care and a small residential unit.

Homemaker and "Baby Sitting" Services: The value of these services in the field of mental retardation has been proved. They should be available as a service provided by the Center or by the parent groups using the Center as headquarters.

Special Recreation Activities: So far as possible, the mentally retarded should be encouraged to participate in community recreation programs. Special activities for the retarded should also be provided by these programs. Special recreation needs may be met also at the Center.

Parent Groups: Facilities should be available for parents and other organizations to meet and participate in the affairs of the Center.

Research

Although the primary function of the Center is to provide service, some clinical research may be carried out with advantage. Service is improved and motivation is enhanced as personnel of higher caliber can be recruited.

APPENDIX K
COMMITTEE ON MENTAL RETARDATION
Pattern of Community Services for the Mentally Retarded

Underlying Principles

1. The mentally retarded person, just as any human being, has human dignity and inherent human rights. Therefore, insofar as is feasible, the basic health, education, and welfare needs of the mentally retarded should be provided for out of the main stream of the community's health, education, and welfare program.

2. An effective program of service for the mentally retarded is dependent upon the existence of an adequate basic community health, education, and welfare program for all its citizens.

3. Existing community health, education, and welfare services are highly applicable to the problem of mental retardation. These basic community services should be made fully available to the retardates. When necessary, modifications of existing programs can be tailored to meet the unique needs.

4. Specialized services for the retarded are necessary to supplement basic health, education, and welfare programs. However, these special programs for the retarded must be viewed as supportive and supplemental.

5. Every "community" and the health, education, and welfare agencies therein must have a formalized structure upon which a sound pattern of coordinated planning and action can be based.

Structure for Local Community Program Coordination, Planning, Consultation and Service for the Retarded

I. Permanent Committee on Mental Retardation—Each "community"[1] of 100,000 or more should develop a permanent committee on mental retardation. Whenever feasible, this committee should be part of the ongoing program of a centralized planning organization serving that community.

   A. The permanent committee on mental retardation would provide the community an authorized focal point for over-all community program planning, coordination, and public interpretation. Its primary responsibility would be to continually evaluate program needs in relationship to service available and to make recommendations to the community and its agencies as to ways and means to more nearly fulfill service demands. It would also serve as an agent in helping to recognize and resolve problems which develop between related agencies in the provision of day by day service.

   B. Representatives on this committee should include:
      1. Liaison representatives of all community health, education, and welfare organizations which have an identifiable direct-service program for mental retardation.
      2. Mental retardation specialists from the Mental Retardation Center.
      3. Interested and representative citizens at large.
      4. Board members of health, education, and welfare agencies.
      5. Public Officials.
      6. Board members of the community's Social Planning Council.

II. Mental Retardation Center—Each "community" of 100,000 or more persons should have a Mental Retardation Center.[2] In addition to providing the necessary specialized direct services the Center would also serve a leadership role in community and agency program development, inter-agency cooperation, and coordination and public interpretation and education.

   A. The Mental Retardation Center should have available to it the following professional persons who would serve as a multi-discipline advisory, planning, consultation, and service team:[1]
      1. A mental retardation specialist with training and experience in community organization and planning.
      2. Mental retardation specialist with training and experience in medicine.
      3. Mental retardation specialist with training and experiience in psychology supervision and consultation.
      4. Mental retardation specialist with training and experience in nursing supervision and consultation.
      5. Mental retardation specialist with training and experience in social work supervision and consultation.
      6. Mental retardation specialist with training and experience in special education supervision and consultation.
      7. A mental retardation specialist with training and experience in vocational rehabilitation supervision and consultation.

   B. The mental retardation specialists attached to the Center would, in addition to performing direct services as required, also:
      1. Represent their area of specialty on the community's permanent Committee on Mental Retardation.
      2. Maintain a close working relationship with the health, education, and welfare agencies' appointed liaison persons for the purpose of:
         a. Interpreting the role and function of the Mental Retardation Center.
         b. Understanding and interpreting the role and function of each of the health, education, and welfare agencies in behalf of the retarded to the Mental Retardation Center, to other agencies, and to the community.
         c. Clarifying operational procedure and policy between the Center, the agency, and other community agencies.
         d. Providing consultation and planning services as requested by the agencies.
      3. Provide leadership and take an active part in community education and interpretation activities.

III. Community Health, Education and Welfare Agencies—Each health, education, and welfare agency in the community has a responsibility to provide service to the mentally retarded as a part of its ongoing service program to other citizens in so far as this is feasible. They should also attempt to adapt their programs where it is reasonable to do so to meet some of the unique needs of the retarded.

   A. In addition to serving the retarded within these existing programs, each health, education, and welfare agency serving a community of 100,000 or more persons which has an identifiable direct-service program serving the mentally retarded should appoint one of its professional staff members directly involved in the mentally retarded service as the agency's official representative (liaison person) on mental retardation.

   B. The liaison persons from the communities' health, education, and welfare agencies would:

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[1] The term "community" as used in this material may refer to a metropolitan area, a large county, or to a number of cities, towns, or counties which may gather together for cooperative planning and service.

[2] The Mental Retardation Center may be a separate unit; however, preferably it would be a unit within a broader health center, mental health center, or health, education, and welfare center.

[1] In any given community the number of different mental retardation specialists and number of different professional disciplines represented may be increased or decreased as local community circumstances warrant.

1. Represent their agency on the community's permanent Committee on Mental Retardation.
2. Relate directly to the Mental Retardation Center's mental retardation specialists.
3. Serve in a leadership capacity to his agency in its efforts to refine and strengthen its service to the retarded and in its efforts to coordinate and cooperate with related agencies in behalf of the retarded.

APPENDIX L
COMMITTEE ON MENTAL RETARDATION
Community Residential Facilities Redefined

Assignment

During the July 23, 1964, meeting of the Committee on Mental Retardation, Comprehensive Mental Health Plan for Iowa, I was asked to prepare a statement on "Community Residential Facilities." It was the intention of the Committee that this statement take into consideration the number and type of residential beds required to meet adequately the needs of a community of 100,000.

On the National Scene

The President's Panel report NATIONAL ACTION TO COMBAT MENTAL RETARDATION discloses that "on any given day there are over 213,000 mentally retarded persons housed in residential institutions; they are 4 per cent of the estimated 5.4 million mentally retarded persons in the United States." The report further indicates that "residential facilities are currently required for at least another 50,000 children and adults now not served."

The mission to the Netherlands sponsored by the Panel made the following recommendations which are particularly germane to the future of residential care in Iowa:

1. "Impetus should be given in the United States to the development of a wider range of diversified residential arrangements for those retarded persons who, for whatever reason, cannot live with their own or foster families; i.e., small units designed in program and structure to meet different needs."

2. "Emphasis should be directed to the development of group homes in urban and suburban areas for small homogeneous groups of retarded persons who can use the various community opportunities for work, recreation, and education, and to the design, construction, staffing, and use of living units for six to ten children within larger institutions."

In Iowa

A cursory review of available statistics for Iowa discloses that the estimate of 4 per cent of the retarded nationally are in residential care seems to be quite accurate when projected upon the Iowa situation. Four per cent of Iowa's estimated 84,000 mentally retarded would represent 3,360 persons. The average daily residential population in our two state institutions during the time period 1955-1960 discloses that approximately 3,400 patients were being cared for daily within these two facilities.

Iowa has witnessed a rather dramatic decrease in its state institutional population for the retarded since 1960. The average daily residential population in 1963 dropped to 2,510. By June 30, 1964, this figure reached 2,333. The actual residential population on June 30, 1964, for the two institutions was 2,141.

Despite the rapid decrease in residential care offered at Glenwood and Woodward in recent years, the validity of the national estimate referred to earlier seems to be upheld in analyzing the Iowa situation a bit further. While the residential population reached 2,141 on June 30, 1964, we also find 1,411 patients in a leave status from the state institutions at this same time. The great majority of these patients were on leave to county homes, nursing homes, custodial homes, and foster family homes, that is, on leave to other types of residential care. We also know that there are many mentally retarded persons who are being cared for in these facilities who either were previously discharged from the institution or were placed in the facilities through other channels and therefore not accounted for in our state institutional statistics.

Number of Residential Beds Required

All of the above attest to the fact that as Iowa and its communities give consideration to a comprehensive plan for the mentally retarded it must plan to provide appropriate residential care for approximately 4 per cent to 6 per cent of the mentally retarded. In as much as facts already available clearly establish that 4 per cent of our retarded population are already in some type of residential facility, not including foster family care, it would seem advisable to select the figure 6 per cent as a guide in planning. This figure is suggested because experience has long proven that demands for appropriate services and facilities increase just as soon as the using public become aware of the fact that sound, acceptable service is available. Therefore, it is recommended that Iowa plan for a minimum of 5,000 residential beds. The model community of 100,000 that this committee has been giving consideration to would need to think in terms of having 180 residential beds available to it.

Classification of Facilities

Historically, residential care for the mentally retarded has been viewed synonymously with state institutional care. This is true in as much as placement in state institutions was considered the most appropriate form of care outside of the family home. This fact is no longer true. It is suggested therefore that residential care for the mentally retarded be defined simply as 24-hour-a-day care outside of the home of the natural parent or relative. Using this definition, the state institution can then be recognized as providing a form of residential care. At the same time, however, recognition is also given to such facilities as nursing homes, county homes, custodial homes, half-way houses, foster homes, boarding homes, and various other types of group facilities.

A review of the literature discloses that literally hundreds of articles have been written describing the uniqueness and appropriateness for the retarded of various forms of nursing home care, foster home care, and half-way house facilities. However, despite the great number of articles and reports written, one can be most impressed with a lack of uniformity of definition and the vague almost veiled descriptions of the facilities used. It is most clear that there does not exist any single precise description or classification of the variety of residential facilities which should be made available to the retarded.

It is proposed that those involved in developing comprehensive plans in Iowa give consideration to the following five broad classifications of residential care. It is felt that these five categories, by and large, circumscribe twenty-four-hour-a-day care required by Iowa's mentally retarded citizens.

1. Nursing Homes provide, in addition to room and board, good physical care, skilled nursing care, and related medical services which require professional training, judgment, and technical knowledge. Care in these facilities is based upon a diagnosed medical condition which dictates medical and nursing related services as a primary aspect of total care and treatment required. (Only the licensed nursing home or hospitals in Iowa would be considered as possibly meeting the requirements of this definition.)

2. Good Care Homes provide, in addition to room, board, and good physical care, assistance with self-help skills within an environment tailored to meet the social, emotional, recreational, and religious needs of patients on a long-term basis. These facilities are characterized by the benevolent, kind, understanding, and accepting atmosphere which prevails. (County homes, custodial homes and some nursing homes as they now exist would be considered in this category.)

3. Group Homes provide, in addition to room, board, and good physical care, the protective and supportive aspects of group

living along with the more intimate atmosphere of family life including an opportunity for normal community experiences. (Half-way houses, quarter houses, agency-owned group homes, foster family group homes.)

4. Foster Family Homes provide maximum opportunity for normal family and community life, stimulation and motivation for development of maximum capacity of the individual within the framework of parent, child, and sibling relationships. (All classifications of foster homes and boarding homes, special foster homes, etc., serving four or less persons would fit this definition.)

5. Specialized Treatment and Training Facilities provide, in addition to room and board on a long- or short-term basis, and good physical care, professionally directed diagnosis, evaluation, and treatment services. The major characteristics of these facilities are their multi-disciplinary goal-directed programs of medicine, nursing, education, and training supported by extensive auxiliary services. The provision of twenty-four-hour-a-day care is secondary to the specialized programs provided. (Hospital schools, inpatient diagnostic clinics, and some research and education centers would be included.)

Ratio of Facilities Needed in Each Classification

Determination of the recommended ratio of facilities in each of the classifications as defined above is needed to provide the state and its communities with some broad guide lines in determining relative priority of need. Unfortunately there is only the most limited experience factor to guide us in the early phases of this program development. Some of the facilities defined have only most recently been used, and these only to a limited degree for the retarded in Iowa. Therefore, it is somewhat difficult to determine what the actual impact will be as they are made available and developed in increasing quantity and quality. The availability, or lack of availability of any one of the classified facilities has direct bearing on the quantity and nature of service required by the other facility.

At the persent time it seems we can only estimate from the experiences we have had in recent years in our state institutions and in our existing nursing homes, county homes, custodial homes, and foster care facilities what the ideal goals might be. Under these conditions it seems quite appropriate that we call upon the best judgment that is available from those who have had experience with the various classifications of residential care to establish some tentative long-range goals. Experience in the operation of additional and new facilities will in time give us a broader basis for modification of the ratio. With these thoughts in mind, the following ratio is recommended for consideration as a starting point.

Facility	*Recommended Percentage*	*Available To State*	*Available To Community of 100,000*
Nursing Homes	20	1,000	36
Good Care Homes	35	1,750	63
Group Homes	15	750	27
Foster Family Homes	10	500	18
Specialized Treatment & Training Facilities	20	1,000	36

Respectfully submitted,
Leonard W. Lavis
September 24, 1964

APPENDIX M
COMMITTEE ON MENTAL RETARDATION
Social Service Role of the Community Project for Mentally Retarded

The over-all and broadly defined social service responsibility of a community for its mentally handicapped members must attempt provision of an almost overwhelming scope of programming, for individuals of all ages and varying degrees of handicapping.

Historically, programs for the mentally deficient in the United States have nearly traversed a complete cycle, from the attitude of isolation or exclusion of the retarded from those social institutions serving the more normal population, to a recognition that the condition is deserving of the most modern treatment methods applied to other disease conditions. Inherent to this changing attitude is a greater acceptance and realistic understanding by the general population of causative factors in mental retardation and the realization that the vast majority of affected individuals are more effectively treated in or near their home and community.

We can no longer speak of the retarded as being inherently delinquent or immoral, or capable of diluting the general intelligence level of our population through an ascribed abundance of procreative abilities. Nor can we in truth regard them all as helpless and hopelessly dependent creatures, incapable of positive social adaption, and unable to make useful, though perhaps modest, productive contributions to the community.

At this point it is appropriate to stop and consider what happens to the family that has a retarded child in its midst. The appropriateness of this consideration comes in understanding that mental retardation is no respector of persons or classes and that any family in a community may at sometime be faced with the need to plan for a mentally retarded member.

The birth of a defective infant transforms a joyously awaited experience into one of catastrophe and profound psychological threat. Grief, mourning, and planning for the future must be lived through simultaneously, and can be overwhelming in their impact.

Parents search within themselves for non-existent answers to "Why has this happend to me?" "How did it happen?" "What have I done?" Previously worked-out feelings of self-doubt and inadequacy may be reactivated as they view the damaged child as an extension of themselves. Marital disruption can occur if the child is seen as a symbol of underlying failure of the marriage. Conscious or unconscious death wishes toward the child intensify the anxiety.

This is not to imply that there must be a pathological reaction. Sorrow and a sense of crisis are natural responses to a tragic experience. During such periods, however, the balance in personality integration usually goes through a phase of disorganization. In helping a family at this point of turmoil the professional person faces both an especially difficult challenge and a unique opportunity. During an important life crisis pathogenic sequences can originate or become aggravated, but there can also be a sudden acceleration of personality maturation. The necessity for treatment as soon as possible to help the family move toward healthy solutions becomes crucial. (This is presented to document the necessity of the community recognizing the serious consequences mental retardation may have upon its members.)

The social service staff should have the major responsibility for helping the community and its resources mobilize (coordinate) a comprehensive service program for the retarded. This will require working closely with community leadership to create an atmosphere of interest and determination. These efforts will need to be directed toward the professional helping services as well as lay persons. Characteristically, the professional group has been hesitant to provide leadership in serving the retardate, a situation that needs to be recognized.

Programming for the retarded should be directed toward utilization of as many existing resources as possible, before new services are sought. Expertness in community organization should be utilized in expanding and making comprehensive programs such as maternal and well-baby clinics, public health nursing, child welfare, public welfare, and mental health clinics available to the retardate and his family. These services will be represented

by both public and private sponsorship, and should be coordinated in their efforts through a "community council."

The social work staff of the retardation project will have responsibility for maintaining a high level of interest and competency of services rendered by their supporting agencies, doing so by means of consultation and performing liaison tasks.

In the newly organized mental retardation project, the role of social work will be a significant one, and there should be a permanent social work staff to assist in organizing and implementing the program.

Social workers will play an active part in the ascertainment process by social history-taking, which will help determine whether the condition has been present from an early age—a basic criteria for the differential diagnosis of mental defect and mental illness.

They will also be concerned with evaluating the client's social background and his functioning within it, and the assessment of these factors in determining the treatment plan. For instance, if the project staff recommends maintaining the client in the community, as against institutional placement, the caseworker would maintain supporting contacts with the family. This support, in the form of supervision, would be provided by home visits to the retardate and his family at regular intervals, when the caseworker would discuss and try to help with any special problems being created by the retarded member. In certain circumstances, a retarded child or adult might be put under legal guardianship to ensure fuller control.

The first social service available for retarded children should be provided within the maternity and child welfare service for all pre-school children. In this setting every baby would be visited by a public health nurse within the first months of life and subsequent follow-up be provided either by the mother's taking the child to the local clinic at regular intervals, or if this is not feasible, by further visits to the home. A baby with obvious medical problems or who is noticeably behind in development might be referred to the special clinic for retarded children, which might or might not be operating within the normal clinic services. Here he would be examined by a doctor trained in assessing mental sub-normalities and thereafter be seen at regular intervals until school age. The public health nurse will continue to give family guidance on general health problems and management and, when there are pressing social and emotional problems within the family, the social worker of the special clinic for retarded children may be called in to give casework help.

In addition to this service of surveillance provided by the doctor, nurse, and possibly by the social worker, the retarded child may benefit from a pre-school nursery program tailored to meet his special needs, if circumstances so indicate. For example, a child from an underpriviledged home may need experience and play stimulation to prepare him for the next stage of training or education, or in a tense family situation with a hyperactive child who is a management problem this facility may be used to relieve family pressure and tensions. During the pre-school period parents will be given the opportunity to discuss future plans for the child, depending on whether he is potentially educable, trainable, or so severely retarded that only custodial care is feasible. For this third type of child a special care unit should be available in the community for daytime care of severely handicapped children, which permits them to remain at home—at least during childhood—without being an unrelieved burden on their parents. Also, short-term care to relieve family pressures should be developed in local hospitals and private homes for the moderately and severely retarded.

An orientation to these facilities should be initially given to the family in helping create a perspective of relative optimism about their future, which may contribute to their acceptance of the child, even when he is severely handicapped.

At about age five the retarded child will be referred by the project social worker to the school system for psychological testing, and determination of placement within that system.

If the child is found not to be eligible for either the educable or trainable school programs, the project social worker would help prepare the family for placement in an activity-training center program, or possibly institutional placement. Subsequently he will keep in touch on a supportive advisory basis, the intensity of contact depending on how well the family has adjusted to having a retarded child or how stable other aspects of the environment may be. There should be a close link between parents and the activity-training center staff, and the project social worker may act as a liaison to alert them of any inter-family problems. Parents usually need a good deal of help when they first learn of their child's disability and its social implications and at subsequent crisis points in the child's development, such as exclusion from regular school, the onset of adolescence when sex presents potential difficulties, and especially at the end of the school period when inability to gain employment confirms their fear of chronic dependence and brings home to the family that they will have a dependent adult on their hands the rest of their lives. If help is readily available at these points of vulnerability, most parents can manage quite well in the intervening periods.

As the retarded client chronologically matures, the social worker continues long-term supervision of the retarded adult by occasional visits that permit him to assess changes within the family that may affect the client's situation in the community. With aging parents, one of his tasks will be to evaluate the declining strength of the home, to determine whether there are other relatives willing to assume responsibility later on, and if not, to prepare the parents to consider placement.

Depending on the resources of a given community, the project staff may need to evaluate the extensiveness of its "social services" responsibility and through community organization methods help develop a local continuum of services for its handicapped residents.

At the time of this writing it seems inappropriate and impracticable to identify the Mental Retardation Project as having primary concern for the emotionally disturbed client, because of the need for a specialized service being available for all mentally handicapped, on a "from life to death" scope. If the program is structured as suggested earlier in the paper, all the retarded will be under constant supervision and any of the appropriate services will be initiated when the need becomes necessary.

It is my position that the mental retardation project has a broad "social service" responsibility, which should encompass all the necessary services the retarded individual requires in making the best possible social adjustment in the community.

In order to accomplish this he may, at various stages in development, require help from the following specialists: medical, nursing, casework, physical therapy, psychology, education, vocational rehabilitation, sheltered workshop, and custodial care. To plan these just for the emotionally disturbed retardate is impossible.

In planning a continuum of service for the retarded, the complexity of the programs involved is imposing and may present serious problems in providing continuity and assuring on-going communication. Traditionally, social work has assumed the role of implementing society's social conscience and has received relative acceptance in its efforts in this capacity. The professionally trained social worker has skills and knowledge relating to human problems that overlap the other helping professions. This knowledge is carefully structured so as not to suggest ability to usurp the special skills of other professions, but rather to assist their clients in fully utilizing the services of other necessary professions. An important part of the social worker's training is to develop skills in helping his client accurately assess his prob-

lems, and then help him plan the appropriate means for resolution of the problem.

Casework, one of the skills of social work, has developed as a legitimate and acceptable means of helping individuals utilize and mobilize their existing resources as a means of problem solving. This is a supportive type of therapy that is practiced by persons with other professional training as well.

We accept the theory that mentally retarded persons share most of the problems more normal people experience, and that currently accepted treatment practices should be applied with that understanding. If this statement is accepted, the application of social work skills are indicated. A stronger indication for the place of social work in this special project comes from the knowledge that a high level of community organization will be necessary, and recognition that the majority of community agencies are either administered by social workers, or rely upon their social work staff. Therefore, from a practical standpoint, social workers will be in an advantageous position to assure communication that will be necessary at all levels.

Within the project social work staff there should be recognition of specialized skills, such as community organization, administration, group work, and casework. All the social workers should be graduate trained, with previous experience related to their position.

Alan Mathiason, ACSW
Executive Director
Polk Co. Ass'n for Retarded Children
August 21, 1964

APPENDIX N
COMMITTEE ON MENTAL RETARDATION
Vocational Rehabilitation and the Emotionally Disturbed and Mentally Retarded

Within the conceptual framework of the ideal community, the largest proportion of educable, mentally retarded adolescents would be able to move directly from school to work with a minimum of problems. This assumes that special education and the State Employment Service Agencies are expanded and improved to the point that their staffs can make effective use of the knowledge now available in their respective fields.

A smaller proportion of the educable retarded would need additional highly specialized services beyond the scope of those currently available through the above-mentioned programs. These services include physical restoration, such as hearing aids and other prosthetic devices, and psychiatric treatment. They may include additional specific vocational training to provide selected individuals for such particular occupational careers as automotive mechanics, body and fender men, bakers' helpers, assistance with placement into suitable employment, and follow-up to assure the appropriateness of the specific job for the individual. These services would be available when and as needed through the Division of Vocational Rehabilitation. This assumes that the Division is adequately staffed and financed to be in a position to provide these services.

Beyond this, another major contribution of the Division of Vocational Rehabilitation would be in the development of a sheltered workshop. The availability of such an additional resource would enable the Division to provide services to substantial numbers of the trainable, the multiple problem, and other severely disabled retarded individuals who could benefit from the range of services available through vocational rehabilitation.

The sheltered workshop would not be a facility exclusively for the use of the emotionally disturbed, mentally retarded individual, but would serve many other severely disabled individuals. The workshop would need to be staffed using an interdisciplinary approach, including at least appropriate medical supervision, psychological services, vocational counseling services, social services, industrial contracts supervisor, and others. The workshop would need to give consideration not only to those severely disabled individuals who would make use of the facility as a transitional phase of their ultimate rehabilitation into a competitive work setting, but would also give consideration and make provision for those individiuals who at best might have only limited productive abilities and who might be expected to be considered terminal workshop employees.

It is hoped that appropriate attention will be given to the need for the workshop concept to be given sufficient priority to assure the likelihood of it being implemented by the appropriate agencies at an early date.

Mario G. Barillas
February 2, 1965

APPENDIX O
COMMITTEE ON MENTAL RETARDATION
Report on Special Education

Introduction

Delineation of the influence of special education programs and services on the mental health needs of retarded children requires an exploration of the total impact of special education on the education program. Such an exploration will necessitate agreement on certain assumptions relative to the adequacy of the special and general curricula as a part of the over-all comprehensive education program.

To facilitate the formulation of an appropriate frame of reference concerning the implications of special education as a concept of educational programming, this paper will focus in brief on three areas of concern, namely: (1) A general discussion of special education as an integral part of the total school program. (2) The statement of assumptions considered by the writers to be operational in the "ideal community." Agreement on the stated assumptions provides for a closer review of the relationship of special education programs and/or services directly related to the mental health needs of retarded pre-school and school-age children. (3) The recommendation of guidelines germane to programs or services of special education influencing or capable of influencing the emotional and social adjustment of the mentally retarded individual.

Scope of Special Education

Special education for purposes of this report is defined as that part of general education designed to meet the needs of those children who, because of physical or mental limitations, are unable to avail themselves of, or profit significantly from, regular classroom instruction. Special education programs for exceptional children involve differences in many forms. Curricula frequently need to be modified, and trained specialists need to be hired to meet the needs of exceptional children. Classrooms and facilities in some instances must be specially designed or substantially modified in accordance with educational specifications reflecting the needs of the respective area of exceptionality.

The percentage of children requiring special education services and programs is estimated to range from approximately 12.4 per cent of the total school population, as reported in the 49th yearbook of the National Society for the Study of Education, to 15.6 per cent from a more recent survey. Chapter 281 of the Iowa School Law provides for the development of special education services and the expenditure of funds to serve the following areas of exceptionality: physically handicapped, mentally retarded, blind and partially seeing, deaf and hard of hearing, speech handicapped, and the emotionally disturbed. Provision is not included for programs serving the gifted.

The multiplicity of handicaps resulting in learning problems dictates to educators responsibility for developing awareness of of such conditions and an understanding of the needed appropriate services and programs. The following chart reflects an estimate of incidence by handicapped conditions.

Incidence of Handicapped Conditions
by Type and School Placement

Classification	Possible School Placement	Approximate Number and Percent in School Age Population	Estimated Number in Iowa Based on '63-64 Enrollment	100,000 General Pop. School Pop.
PHYSICALLY HANDICAPPED AND SPECIAL HEALTH PROBLEMS	Special class for physically handicapped children in elementary or secondary school, home or hospital instruction, regular class if condition is mild, electrical school-to-home instruction, hospital instruction	1 or 2 in each 100 or 1.5%	9,750	1,500
EDUCABLE MENTALLY RETARDED	Special class in elementary and/or secondary school	2 in each 100 or 2.0%	13,000	2,000
TRAINABLE MENTALLY RETARDED	Special class in elementary and/or secondary school	1 in each 100 or .33%	2,145	330
PARTIALLY SEEING	Public school with special help. Iowa Braille and Sight Saving School	1 in each 500 or .2%	1,800	200
BLIND (BRAILLE STUDENT)	Public school with special help. Iowa Braille and Sight Saving School	1 in 3,000 to 4,000 or 0.3%	195	300
DEAF	Iowa School for the Deaf, residential school, class for deaf in elementary or secondary school	1 in each 2,000 or .1%	650	100
HEARING HANDICAPPED	Special class in elementary or secondary school, lip-reading and auditory training while in regular class	2 in each 100 or 2.0%	13,000	2,000
SPEECH HANDICAPPED	Regular or special class with provision for speech therapy	5 or more in each 100 or 6.0%	39,000	6,000
EMOTIONALLY DISTURBED	Regular class--special teacher, special class for emotionally disturbed, residential school	3 to 5 in each 100 or 3.0%	19,500	3,000

Accommodation of the exceptional child's needs through special education programs and services necessitates the development of an administrative structure. Inherent in the structure should be the provision of consultative and supervisory assistance to the direct-service personnel.

The pupil-teacher ratio and caseload of certain special education personnel is dependent on many variables. The need for special personnel such as speech therapists, psychologists, hearing clinicians, and itinerant teachers must be appraised according to the demands of a given district or cooperation of districts. In planning special education programs, the following guidelines are offered.

Hearing clinician	one per 6,000 enrollment
Itinerant teacher	one per 10,000 enrollment
Psychologist	one per 4,000 enrollment
Speech therapist	one per 3,000 enrollment

Estimated Classes Needed: An estimate of classes needed can be obtained by dividing the pupil-teacher ratios into the estimated number of children in need of special class placement in any given district.

Trainable mentally retarded	(10) per (1) teacher
Educable mentally retarded	(15) per (1) teacher
Physically handicapped	(15) per (1) teacher
Blind	(8) per (1) teacher
Partially seeing	(12) per (1) teacher
Deaf	(8) per (1) teacher
Hard of Hearing	(8) per (1) teacher

The education of exceptional children through the concept of special education previously set forth in this paper supports special education as an integral part of the total education program. It should be noted that programs and services of special education are prescribed for exceptional children as a result of decisions by professional persons in the interest of the individual and the total educational program. Participation in special education

should result in facilitation of the individual's performance in the total school program and the attainment of his or her capabilities as an adult.

Assumptions

To facilitate the writers' review of the role of special education relative to meeting the mental health needs of the mentally retarded, the following assumptions are assumed to be operational in the "ideal community" and programs.

1. The public school system within the "ideal community" has a comprehensive special education program, including services for all areas of exceptional children.

2. Within the public school system, a complete sequential scope of services necessary for serving the mentally retarded are also available.

3. The components of essential and related services typically provided within the community are available in this "ideal community."

4. If special education needs of individuals are not met, the result will probably be an interference with the emotional and social adjustment of the individual child.

Recommendations

Regardless of the educational provision made for the mentally retarded through the public schools, it must be acknowledged that a major portion of their early life will be spent within the environment of a school setting. Through extracurricular activities and the extending influence of the academic program, the school also exerts a strong influence on the lives of the retardates outside the physical setting of the school. Recognizing this influence on the development of the mentally retarded individual, coupled with the knowledge that the influence occurs during the formative years of life, the school must assume considerable responsibility for meetitng the mental health needs of the mentally retarded.

Historically the role of the public schools has been to serve children between the ages of five and twenty-one. This has restricted its effectiveness as an active agent influencing the individual's adjustment and development during the preschool years when the retardate can potentially make considerable growth. The following recommendations are intended to accent the responsibility of the school to the emotional and social adjustment of the mentally retarded.

1. Special Class Curriculum: The uniqueness of special education is not the placement of a child in a separate class, rather it is the curriculum implemented in this particular program. The curriculum for the mentally retarded should be designed according to the ability of the pupils involved and oriented to the application of practical skills which hold the most utility for mentally retarded adults. In view of the limited guidelines for the development of methodology and the structuring of curriculum, much of the responsibility for assuring the provision of appropriate experiences falls to the special-class teacher, thus accenting the need for competent teachers with the appropriate philosophy and methods.

2. Separate Facilities: Recognizing the need for grouping children according to ability for instruction and in view of the small incidence of mental retardation, school districts, at times, have established separate facilities in which children are served from several districts. The centralized facility resolves the problem of grouping; however, it tends to attract attention to the differences reflected by these children. A basic purpose of special education, and particularly special class placement for the mentally retarded, is to improve the instructional program for these children. However, their emotional and social adjustment must also be considered. When we are concerning ourselves with the educable child, we must recognize that in most areas of development these children parallel the normal individual and desire this association. It is, in general, recommended that the special class or classes in a given district be a part of the regular attendance center for the appropriate age grouping and that the special class program be considered an integral part of the total school program. This concept should be carried over into the relationship of the special class teacher with the total faculty.

3. Pupil-Teacher Relationship: Retarded Children in Iowa typically are not placed in special classes until they are eight or nine years of age and, consequently, have spent two or three years in the regular class. As a result of regular class placement and the resulting experience in an environment in which they are not able to cope with the many demands placed on them, they enter the special class with many frustrations related to school. This dictates to the teacher the responsibility for preparing a climate in the classroom which will allow the child to develop the necessary social and emotional adjustment. Closely related to his feelings toward school may be a negative reaction to many teaching techniques that have been tried with him unsuccessfully because of the inability of the regular classroom teacher to devote the necessary time to this particular child with severe learning problems. This again requires much on the part of the special-class teacher to either modify these techniques, choose alternate approaches, or try to present the same technique in a way appealing to the child. The pupil-teacher relationship is extremely important with all children, but particularly so in the situation in which a child is taken from one type of program in the educational setting and placed in a different type of program.

4. Secondary Programs for the Mentally Retarded: Currently in Iowa, approximately nine school districts offer a special education program for the mentally retarded at the secondary level. A common practice elsewhere in the state of Iowa is at age sixteen to return the child to the regular curriculum; the result of such action is the child frequently drops out of school. This obviously should not be the case. It is also reported that the high school counselor is not generally involved in counseling with pupils in special classes for the mentally retarded. It seems in view of the extensive coverage of guidance counselors in Iowa's public schools and in view of the short supply of school psychologists who are more typically involved in working with the mentally retarded that the counselor holds a major potential service for this group of our school population. It is recommended that the extension of counseling services to mentally retarded youth be explored and that arrangements be made to assist the guidance counselors in developing an appropriate frame of reference for working with such young people.

5. School Social Workers: In 1962 the approval requirements and reimbursement procedures of the Division of Special Education were revised to allow for the approval of school social workers in the special education program. This would provide a means of facilitating liaison between the home and the school. It is also considered a major step toward improving special education services which influence the mental health of mentally retarded children. Where school social workers have been employed, the effectiveness of school psychologists has also improved in terms of a social worker applying his skills in making available more adequate case histories on children seen by the school psychologist. It is assumed that the follow-up activities related to assisting parents in adjusting to the learning and behavioral problems experienced by their child are greatly enhanced by the services of a trained school social worker. It should also be noted that the social worker, by training and experience, becomes an effective person in sustaining liaison activities with the family and allied agencies within the community.

6. Health Services: The services of a school nurse are important to the health care of all pupils, particularly the mentally

retarded. By working with parents of retarded children in an advisory capacity on health problems, the nurse can provide additional benefits to the child. The resource of a school nurse is of assistance in establishing appropriate relationships with members of the medical discipline. Not to be overlooked is the role of the school nurse in terms of general health education for the mentally retarded. It is recommended that schools have available within their system a school nurse and that the school nurse have a good orientation to the implications of special education services.

7. Adult Education: Adult education for "normal" individuals has been considered a part of the total education program in Iowa for some time. As adults, retarded individuals have need for learning new skills and for developing more efficient methods of home management and child care; thus, it seems reasonable that such a program could be provided through a framework of adult education in a procedure similar to that provided for the general population. It must be recognized, however, that the approach to instruction and the materials used may need to be altered according to the needs of the group involved. It is recommended that the provision of adult education courses for this group of our population be studied.

Preschool Program

The committee has previously gone on record as favoring early screening, diagnosis, and placement of mentally retarded children in special preschool programs. The possibility of establishing such preschool programs, within the framework of the community school system, is a realistic possibility in Iowa. The last General Assembly passed "enabling legislation" making it legal to develop programs for exceptional children at the preschool age level. Further, if such local programs meet standards provided by the State Department of Public Instruction, the community school system is eligible for partial reinbursement of the costs of such a program.

In our ideal community of "100,000 population," the preschool program could be made available to develop mentally retarded children in the three- to five-year-old age range. The suggestion that the program be designed primarily for the educable (I.Q. 50-80) retarded child arises from the fact that at this C.A. level the trainable retarded child does not ordinarily possess a mental age sufficiently high to allow him to profit from the preschool type of experience.

We are faced with several alternatives in the development of provisions for early diagnosis and placement in a preschool program.

The first alternative would be that of *screening* every three- to five-year-old in the community in order to identify possible cases of retarded development. This screening would probably consist of "short-form" psychological and medical tests which would be followed by a more comprehensive medical, psychiatric, psychological, speech and hearing assessment if indicated by the results of the screening. It is clear that this type of screening program would require a great deal of time and a very large professional staff.

The second alternative would be that of concentrating our screening efforts on groups and areas within the community which have historically contributed heavily to the developmentally retarded population in that community. Further, under this arrangement, the screening efforts would be concentrated upon preschool children referred by private physicians, Department of Social Welfare, the various health agencies, and by parents. We might also wish to initiate a routine screening procedure for preschool age siblings of children already diagnosed as mentally retarded. With this approach to screening, we would hope to identify not only the retarded youngsters in the more middle-class families, but also the cultural-familial type of retardate from the lower socio-economic group. There is a considerable body of evidence to suggest that 50 to 80 per cent of the educable retarded youngsters who remain in the community and who are in special classes are from this lower socio-economic group.

In selecting psychological techniques for screening purposes, we will have to contend with the relatively low reliability of many of our instruments used at this early age level. The selection of appropriate techniques would require not only careful consideration but, in all probability, some research effort.

With regard to the question of facilities for the preschool group, it would probably be ideal if preschool centers were to be established on a neighborhood basis in those areas where the incidence of developmental retardation is high. The question of whether preschool groups should be housed in community school buildings is open to debate.

A comprehensive preschool program should be seen as having two primary objectives. Both of these objectives are clearly related to the mental health status of the children involved. First, of course, the preschool program would attempt to provide for the youngsters in terms of their limited abilities and potential for development. Secondly, the program has considerable preventive value as indicated by the results of research such as the Pine School study. Thus, it may be possible to alter the depressed course of psychological development of some types of retarded children and their families while the youngsters are of preschool age.

Certainly a preschool program would provide a fine means for an interdisciplinary approach to the problems of young retarded children. This would be especially true if intensive efforts were to be made by various community agencies in working with the entire family. The coordination of this inter-disciplinary approach could, in part, be a function of the community's mental retardation clinic. Within this framework the various community agencies involved would voluntarily provide the services needed while the clinic would contribute both a share of the needed services and the means and mechanics for communication and coordination.

The School and the Community Mental Retardation Clinic

In the interest of the closest possible coordination of efforts between the community clinic and the special education program, it is endorsed that an educational consultant be attached to the clinic staff on a full-time basis. This consultant could function as a member of the clinic diagnostic team and could also be primarily responsible for liaison work with the school system. Certainly a clear and consistent pattern for communicating the clinic findings and recommendations to the schools must be established.

The School and the Community Recreation Facilities for the Mentally Retarded

From the point of view of developing an adequate social adjustment, considerable attention should be given to the development of appropriate recreational interests and outlets for the mentally retarded child and adult. The development of such interests cannot be left to chance but must be specifically planned for if the retarded individual is to be integrated into the community. It appears that the area of recreation, especially in public facilities, is one in which mentally retarded individuals are often excluded as a function of their lack of skills, lack of opportunity for learning skills, or lack of information about facilities.

Cooperation between school and community programs in developing recreational skills and outlets are very much needed if the retarded individual is to achieve an adequate social adjustment.

Donald L. Carr, Ph.D.
Edward Meyen, M.A.
October 23, 1964

APPENDIX P
CODE OF IOWA 1966
Chapter 225B
Iowa Mental Health Authority

225.B1 Authority named. The Iowa Mental Health Authority for the purposes of directing the benefits of Public Law 487, 79th Congress of the United States and amendments thereto, shall be named by the state board of regents with the advice of the dean of the college of medicine of the university of Iowa and the committee on mental hygiene hereinafter created.

225.B2 Committee on mental hygiene. A committee on mental hygiene is hereby created to consist of the director of the psychopathic hospital at Iowa City, the director of mental health of the state board of control, the commissioner of the state department of health, the dean of the college of medicine at the university of Iowa, a member of the state board of regents appointed by the board, a member of the state board of control appointed by the board, a member of the state board of social welfare appointed by the board, a member of the state board of public instruction, appointed by the board, and eight (8) members to be appointed by the governor. The appointive members by the governor shall be one from the membership of the subcommittee on nervous and mental disease of the Iowa medical society, one from the membership of the Iowa psychiatric society, two from the membership of the boards of directors of the Iowa community mental health centers, one from the membership of the Iowa association for mental health, one from the membership of the Iowa psychological association, one from the membership of the Iowa society of osteopathic physicians and surgeons and one from the membership of the Iowa association for retarded children. The appointive members, by the governor and the various boards, shall serve for terms of three years beginning July 4 of the year of appointment; however, of the initial appointees by the governor, the terms shall be three for terms of three years, three for terms of two years, and two for terms of one year. Vacancies shall be filled for the unexpired term in the same manner as original appointment.

225.B3 Meetings. The committee shall hold an organizational meeting on the first Monday in July each year at the psychopathic hospital in Iowa City at which meeting a chairman and other officers shall be chosen. Other meetings shall be determined by the committee but shall be at least once in each four-month period. The committee shall keep minutes of its meetings and both its meetings and its minutes shall be open to the public.

225.B4 Supervision. All authorized funds of the mental health authority shall be disbursed under the supervision of the state board of regents and programs of the Iowa mental health authority shall be administered according to policies established by the committee on mental hygiene.

225.B5 Office of administration. The administrative office of the Iowa mental health authority shall be located at the college of medicine at the university of Iowa. A duplicate file of official correspondence, statistical information and minutes of the committee on mental hygiene shall be maintained in the office of the director of mental health of the state board of control at the capitol.

225.B6 Expenses of committee members. Members of the committee on mental hygiene shall serve without compensation but shall receive reimbursement for expenses to attend meetings of the mental hygiene committee from funds allocated under Public Law 487.

225.B7 Policies and programs reviewed. When specifically requested to do so by persons legally responsible, the mental hygiene committee shall review policies and program relating to mental health of the requesting governmental agency, and shall suggest ways of coordinating the programs with those of the mental health authority, relating to research, training, and the demonstration of new techniques.

APPENDIX Q
IOWA MENTAL HEALTH AUTHORITY
COMPREHENSIVE MENTAL HEALTH PLAN FOR IOWA
Report of Expenditures and Encumbrances

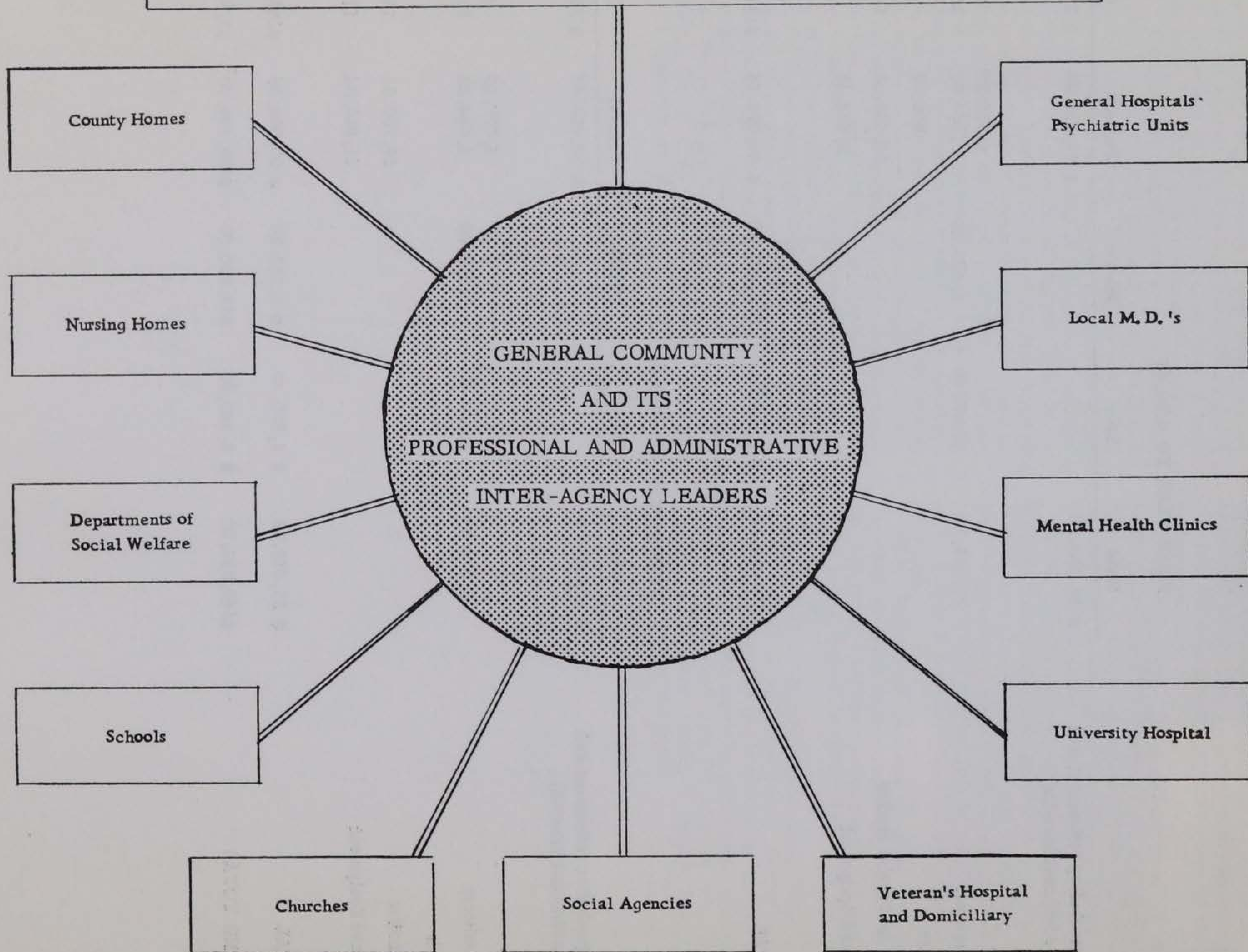
FIRST YEAR TO 6/30/64

	State	Local	Private	Federal	Total
Salaries (including retirement and additional benefits)	$ 58,190.00			$ 12,735.22	$ 70,925.22
Travel					
Staff				1,569.27	1,569.27
Committees	17,128.72	1,469.60	5,626.80	1,364.03	25,589.15
Consultants				200.00	200.00
Contracts for Special Studies				24,461.19	24,461.19
Supplies and Equipment				9,674.43	9,674.43
Other					
TOTAL	$ 75,318.72	$ 1,469.60	$ 5,626.80	$ 50,004.14	$132,419.26

SECOND YEAR TO 6/30/65

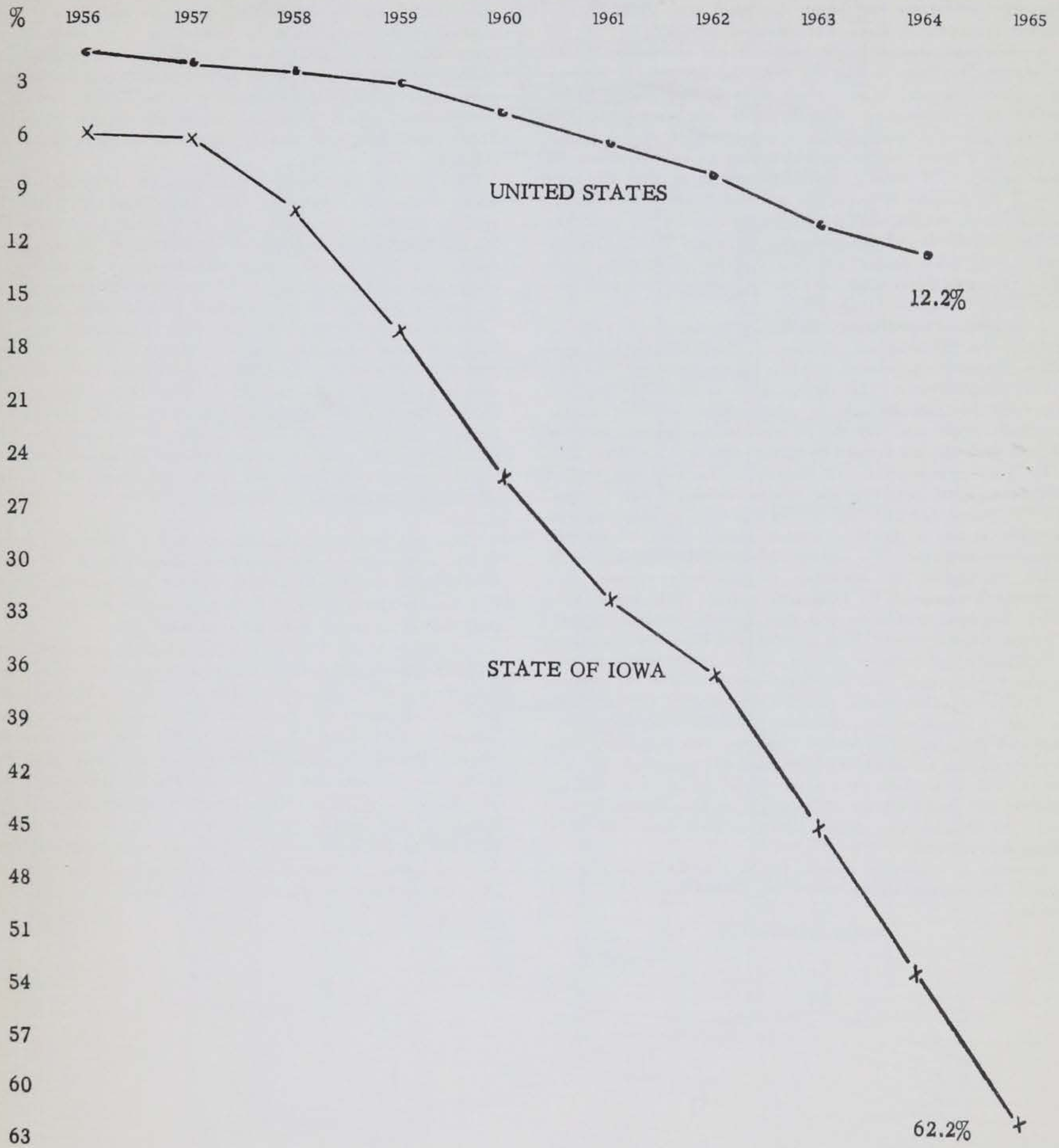
	State	Local	Private	Federal	Total
Salaries (including retirement and additional benefits)	$ 62,040.00			$ 16,656.67	$ 78,696.67
Travel					
Staff				4,077.69	4,077.69
Committees	23,579.28	1,870.40	8,353.20	1,644.22	35,447.10
Consultants					
Special Studies				16,700.34	16,700.34
Supplies and Equipment				11,019.94	11,019.94
Other					
TOTAL	$ 85,619.28	$ 1,870.40	$ 8,353.20	$ 50,098.86	$145,941.74
GRAND TOTAL	$160,938.00	$ 3,340.00	$13,980.00	$100,103.00	$278,361.00

APPENDIX R
LINES OF COMMUNICATION BETWEEN MENTAL HEALTH INSTITUTES AND COMMUNITY FACILITIES



(The double lines indicate lines of communication with community facilites, not lines of authority.)

APPENDIX S
PERCENTAGE DECREASE IN PATIENT POPULATION
State Hospitals — from 1955



APPENDIX T
THE IOWA COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER CONSTRUCTION PROGRAM

The United States Congress has authorized 150 million dollars in federal aid to the states for the construction of comprehensive community mental health centers over a period of three fiscal years, 1965 through 1967. A total of thirty-five million dollars was appropriated for use during the fiscal year 1965. Of this amount appropriated, Iowa was allocated $516,033.

A community mental health center is not necessarily a new or separate building. It may be only the addition of a wing to a general hospital or to a clinic or to another mental health facility in a community. Basically, and more important, the community mental health center is a program of mental health services in a given community which may be located in one or more facilities and under a coordinated system of care. The purpose of the program is to provide a varied range of coordinated mental health services within a geographic area for the treatment of the mentally ill and the prevention of mental illness. Through such a program a patient will find the type of care he needs when he needs it, as close to home as possible, and with the least disruption of his family life.

A complete comprehensive community mental health program includes the following ten services: 1) Inpatient Service. This offers treatment to patients needing twenty-four-hour care. 2) Partial Hospitalization. This service offers at least day care and treatment for patients able to return home evenings and/or weekends. Night care may also be provided for patients who are able to work but are in need of further care or are without suitable home arrangements. 3) Outpatient Service. This service offers treatment programs for adults, children, and families. 4) Emergency Service. This twenty-four-hour service must be available in one of the three services named above. 5) Consultation and Education. The community mental health center staff offers consultation and education to community agencies and professional personnel. 6) Diagnostic Service. This service provides diagnostic evaluation and may include recommendations. 7) Rehabilitative Service. This includes both social and vocational rehabilitation and includes services such as prevocational testing, guidance counseling, and sometimes job placement. 8) Precare and Aftercare. This service provides screening of patients prior to hospital admission plus outpatient care and home visiting before and after hospitalization. 9) Training. This program should provide training for all types of mental health personnel. 10) Research and Evaluation. A mental health center may set up methods for evaluating the effectiveness of its program. It may carry out research into mental illness or cooperate with other agencies in research.

In order to qualify for federal funds, a center must provide at least the essential services which are the first five of the above services.

Each community mental health center will have its own characteristics reflecting the communities' needs and resources. The essential service elements need not be under a single roof. The centers will vary in size, some will be free-standing, but services may be adjacent to each other or in units conveniently located within a given community.

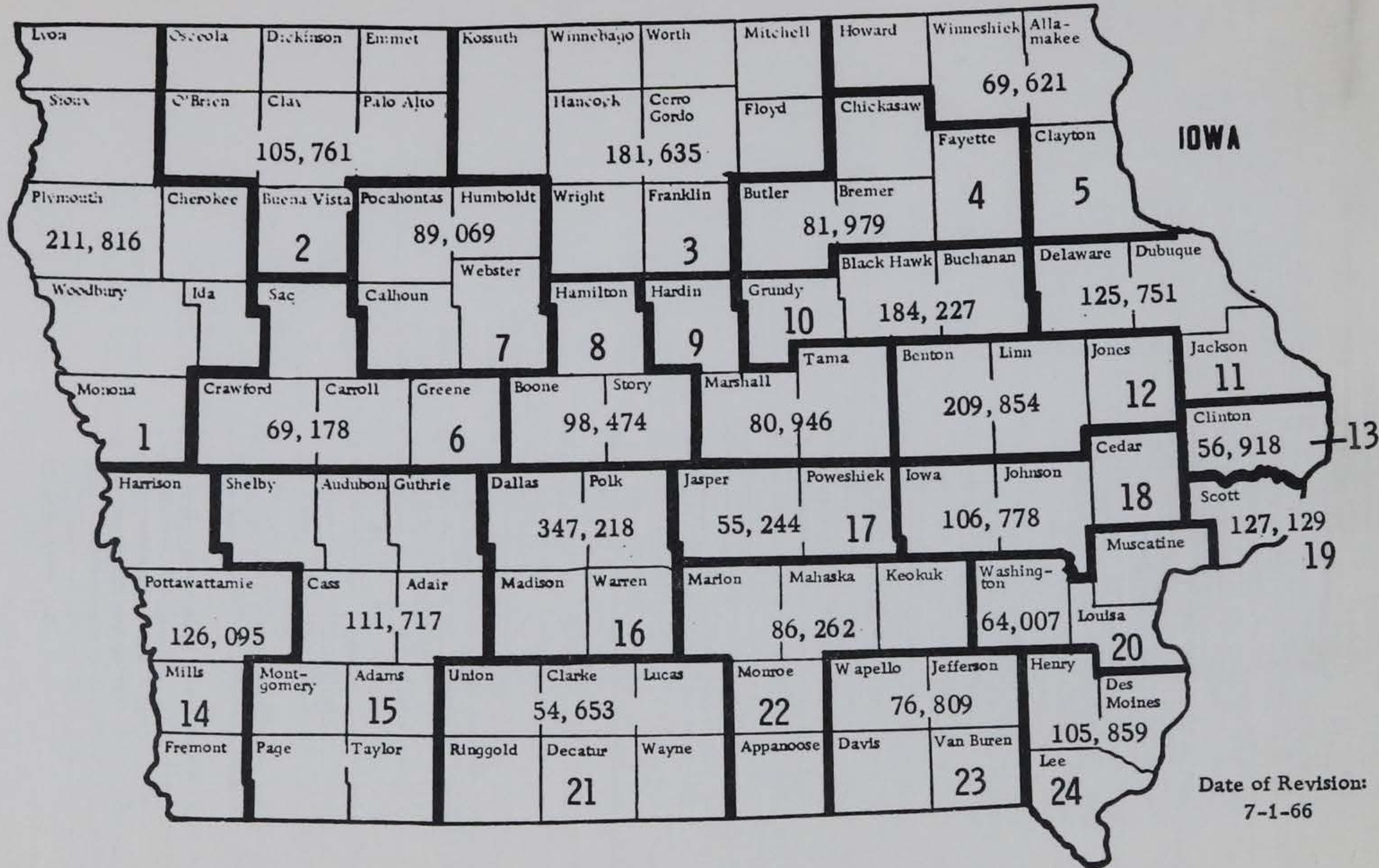
The financing of a community mental health center program is primarily the responsibility of the local community. To receive federal aid for construction, adequate staffing and maintenance of the center must be assured for a minimum of two years. While the services are to be available to all citizens, some of the cost may be covered by individual fees and health insurance. Recent changes and advances in mental health coverage for labor unions and in state and community support of mental health services indicate that new patterns of financing are developing.

Each state is developing a state plan for community mental health centers. In Iowa the State Department of Health has recently published the preliminary draft of the Iowa State Plan for the Construction of Facilities for Community Mental Health Centers. It is based on a state-wide inventory of existing facilities and a survey of needs. It has delineated areas for the purpose of priority and has indicated probable sites for centers (see the attached map). The state plan is consistent with and based on Iowa's long-range over-all planning of comprehensive mental health services. Any public or private non-profit organization in Iowa may apply through the Iowa State Department of Health, Division of Hospital Services, for federal assistance in meeting construction costs. The sponsors of a community mental health center can be a combination of agencies working together to meet the needs and finance the service for an area. The application must be consistent with the state plan for centers.

There are five basic requirements that a community mental health center must provide in order to obtain federal aid: 1) the five essential services; 2) services that are coordinated; 3) services that are accessible; 4) care that has continuity; and 5) planning that is consistent with state planning.

Community effort is a vital part of the process of establishing a community mental health center with federal aid. Community leaders, community agencies, public or private, voluntary agencies, and all interested citizens can help bring to their area the modern center system of mental health care. The interested citizens, groups, or agencies may contact the Iowa State Department of Health, the Iowa Mental Health Authority, or the Director of the Regional Office of the U.S. Department of Health, Education, and Welfare for information about the mental health programs in Iowa. In this way they can learn of the progress Iowa is making in mental health planning and programs, and they can contribute to planning in their area.

PROPOSED AREAS AND ESTIMATED POPULATIONS*
FOR MENTAL HEALTH CENTERS, PUBLIC HEALTH CENTERS, AND MENTAL RETARDATION CENTERS



*Based on U. S. Department of Commerce Projection of 2, 827, 000 Persons in Iowa in 1971.

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