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A SURVEY OF THE MENTAL INSTITUTIONS

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STATE OF CALIFORNIA

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UNITED STATES PUBLIC HEALTH SERVICE

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A SURVEY OF THE MENTAL INSTITUTIONS OF THE STATE OF CALIFORNIA

I THE OCCASION

Funds—The State of California—like many other States in the Union—has suffered from inadequacy of provision for its mentally ill citizens who are known to be in need of hospital care and treatment. Building programs have been undertaken with more or less success, but overcrowding soon reappeared. In 1943 a fortunate surplus appeared in the State Treasury and an appropriation was made to prepare building plans so as to increase the capacity of institutions and also to replace some buildings that are perilous fire hazards.

Planning—Under war conditions this money could not be spent immediately, since needed building materials are not available. It was wisely decided that plans should, so far as possible, be made before the end of the war in order that this Department, and particularly the staff of the State Architect, might study the problems unhurried, reach decisions after due consideration, and make building plans free from the defects that often characterize hasty efforts on a large scale.

Invitation—It was desired to compare observations on the experience of other States. Dr. Thomas Parran, Surgeon General of the United States Public Health Service, was asked by the Director of Institutions, Mrs. Dora Shaw Heffner, to assign Dr. Samuel W. Hamilton to study the California institutions with State Architect Anson Boyd, and to comment on the building program. Accordingly Mr. Boyd and Dr. Hamilton visited both mental hospitals and schools for defectives in September and October, 1943, discussing there and in the office at Sacramento the many problems involved. Mrs. Heffner arranged that the superintendents and business managers of the institutions and other State officials would participate in these discussions. A two-day departmental conference including fiscal officers and the fire marshal also was called at Sacramento in October. In February 1944, Miss Mary E. Coreoran, R. N., advisor in psychiatric nursing of the U. S. Public Health Service, studied Napa and Camarillo State Hospitals.

The permanent staff of the Department of Institutions from the deputy director, Mr. Applegate, down did everything possible to make the survey effective. As is customary in good organizations, information and opinion were ready when requested to throw light on every problem.

Sources—The printed reports of the institutions and of the Department are replete with information pertinent to the problems of institutional provision. Other sources of information also have been

consulted. The reports of the United States Bureau of the Census have been drawn upon. The Director's advisory committee of five psychiatrists has been consulted. Other citizens of California have been questioned about various points of importance. Dr. Hamilton had also the advantage of visits to Stockton and Patton in 1937 and 1938 when conditions of employment were more natural, and a detailed study of the activities of the hospitals could be made at leisure.

Previous surveys—The State authorities have not hesitated to ask for skilled study and advice on occasion. Dr. George H. Kirby of New York studied the clinical work of the hospitals years ago and some steps were taken to strengthen it. Dr. Frederick H. Allen of Philadelphia made a very fine survey that was published in 1930. He spent from eight to eleven days in each hospital and several months altogether on the project. Those responsible for the activities of the Department of Institutions may well familiarize themselves with his report, which in scope and insight is a memorable document.

Scope—In discussions with the Director, with other officials, with persons in the Department and in the institutions, and with no small number of patients, many matters outside the provision of space were considered. It was the desire of the Director that this report should deal with such matters and accordingly it does. Those who participated in this study recognize that time was not taken to make an exhaustive review such as Dr. Allen did in 1929, and this fact will be reflected in the limited way in which some topics of very considerable importance are treated. It is believed that light was thrown in these discussions on matters that are of great importance to the patients and great interest to the Department, and that the comments here made will be useful as the policies of the Department mature. Sections IV-VIII will hold less interest for the Division of Architecture.

II HISTORICAL

Stockton—The State of California first made hospital provision for its mentally ill in 1851 at Stockton. Dr. Edward W. Twitchell told his colleagues in San Francisco some years ago that the State commenced the operation of Stockton with 80 beds and 100 patients, and that about the same ratio of overcrowding had continued. At any rate, according to Dr. E. T. Wilkins in 1872, California was the only State that had never rejected a single person who sought admission.

Napa—When in 1870 the gold rush had caused a rapid increase in population, Dr. Wilkins was appointed commissioner in lunacy to visit and report on institutions in this country and Europe. Altogether he saw 149 of them, and the hospital at Napa was the outcome of his studies. Its lovely front entrance bears evidence of the impression made on him and his architect by some of the beautiful structures abroad. It is to be hoped that in any plans for demolition of that building (which has now become a firetrap) a liberal section of the front center will be preserved as the permanently attractive feature of the upper end of the esplanade.

Expansion—Other hospitals were gradually added in both the northern and southern sections of the State, and in 1885 and 1921 the needs of mental defectives were recognized. The names, year of opening and population of the institutions on June 30, 1943, and also the number of admissions in a fiscal year are given in Table I.

Table II and Figures 1 and 2 indicate the extent of the institutional provision for the mentally ill and the mentally defective in this State by decades, comparing it with the population at the time. They also show the gap between the actual provision in California and the provision had it met the present standards of the highest ranking States.

TABLE I

Date of Opening, Resident Patient Population and Number of First Admissions to California State Mental Institutions

Name of Institution	Date of Opening (1)	Resident Population on June 30, 1943 (2)	First Admissions in Year Ending June 30, 1943 (3)
All State Hospitals.....	-----	24,240	5,815
Stockton State Hospital.....	1851*	4,201	1,102
Napa State Hospital.....	1875	3,826	801
Agnews State Hospital.....	1888	3,552	710
Patton State Hospital.....	1893	3,667	913
Mendocino State Hospital.....	1893	2,908	473
Norwalk State Hospital.....	1916	2,257	524
Camarillo State Hospital.....	1936	3,829	1,202
All State Schools.....	-----	4,728	649
Sonoma State Home.....	1885	3,208	398
Pacific Colony.....	1921	1,520	251

* Opened in 1851; authorized as a State hospital in 1853.

Source: Column 1: Statistical Report of the Department of Institutions of the State of California, year ending June 30, 1942, p. 7.
Columns 2 and 3: Data supplied by the Department of Institutions of the State of California.

TABLE II

Resident Population in California State Mental Institutions Compared With Estimated Number Needing Hospitalization, by Decade Years

Year Ending June 30	Total State Population Aged 15 Years and Over (1)	Number Estimated to Need Care in State Mental Hospitals			Total State Population Aged 5 Years and Over (5)	Number Estimated to Need Care in State Schools for Mental Defect and Epilepsy		
		Total (2)	Under Care (3)	Not Provided for (4)		Total (6)	Under Care (7)	Not Provided for (8)
1860	292,083	1,972	417	1,555	337,225	590	---	590
1870	378,659	2,556	1,047	1,509	491,970	861	---	861
1880	600,253	4,052	1,955	2,097	771,268	1,350	---	1,350
1890	876,730	5,931	3,459	2,472	1,101,600	1,928	117	1,811
1900	1,095,222	7,393	5,276	2,117	1,359,116	2,379	Not Available	
1910	1,833,753	12,378	7,137	5,241	2,183,890	3,821	883	2,938
1920	2,611,579	17,628	10,887	6,741	3,151,134	5,515	1,537	3,978
1930	4,382,364	29,581	14,906	14,675	5,271,884	9,226	2,715	6,511
1940	5,540,086	37,396	22,953	14,443	6,453,893	11,294	4,076	7,218
1943	6,059,166	40,899	24,240	16,659	6,985,598	12,225	4,728	7,497

Source: Columns 1 and 5: U. S. Bureau of the Census. Civilian population, March 1, 1943, estimated by the Census Bureau; number aged 5 years and over and number aged 15 years and over projected on the basis of the rate of increase from 1930 to 1940.

Column 2: Based on the assumption that 675 persons per 100,000 of the total population aged 15 and over are liable to hospitalization in a State hospital for mental disease.

Columns 3 and 7: Statistical Report of the Department of Institutions, California, year ending June 30, 1942, pp. 20, 21, 104. Data for 1943 obtained from the Department of Institutions, California.

Column 6: Based on the assumption that 140 persons per 100,000 population aged 5 and over are liable to hospitalization in a State institution for mental defect and 35 persons per 100,000 population aged 5 and over to hospitalization for epilepsy. These standards are based on actual provision in the highest ranking States as reported to the Bureau of the Census for the year 1940. (Table III, p. 11; Table IX, p. 46)

Resident Population Compared with Estimated Needs in Decade Years

CALIFORNIA STATE HOSPITALS FOR MENTAL DISEASE

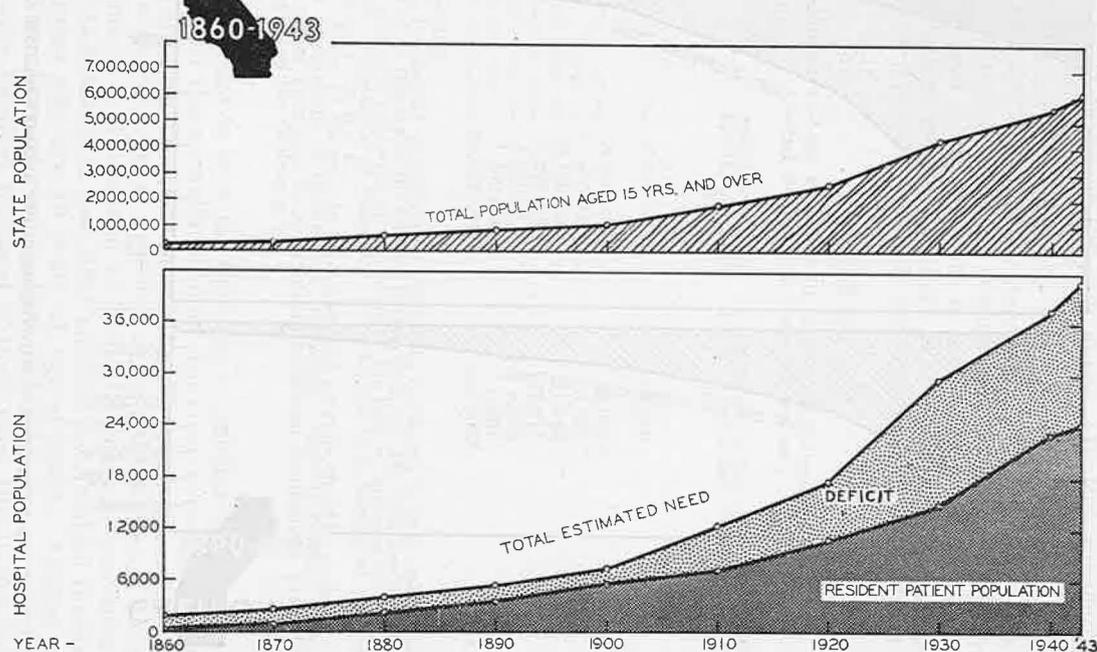
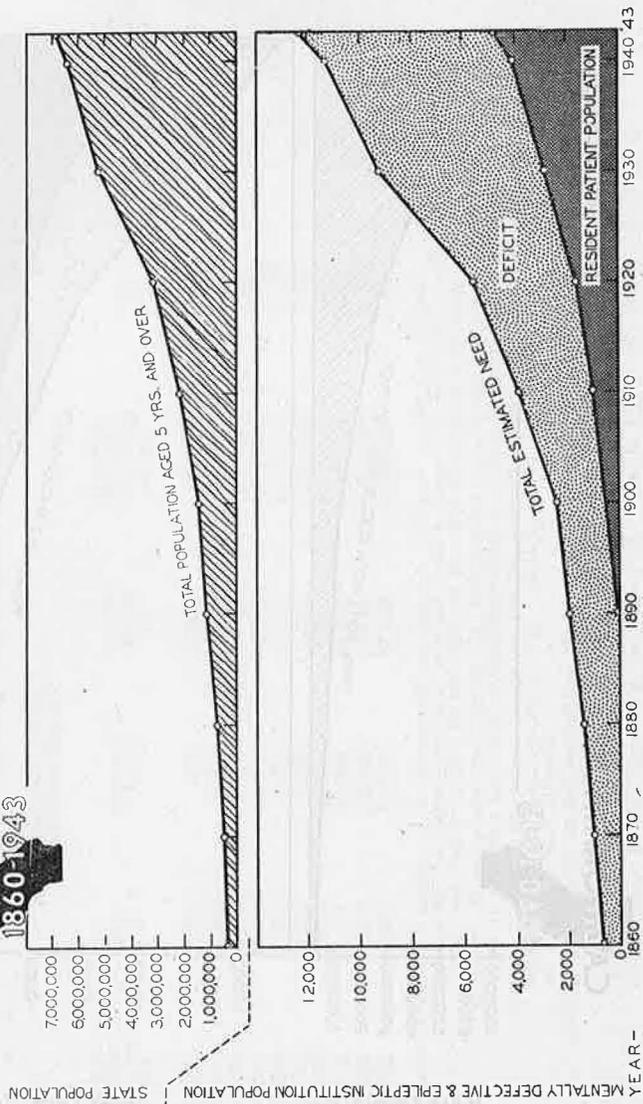


Figure 1

Resident Population Compared with Estimated Needs in Decade Years

CALIFORNIA STATE INSTITUTIONS FOR MENTAL DEFECT



DIVISION OF MENTAL HYGIENE
U.S. PUBLIC HEALTH SERVICE

Figure 2

Comparison—At this point one may compare the institutional provision in California with that of a few other States, large and small. The figures in Table number III indicate that in spite of consistently humane efforts on the part of this State, provision has not caught up with the probable needs of the community. In this connection, it may be said that repeated surveys of mental illness in many communities, by the National Committee for Mental Hygiene and other agencies, have indicated that the incidence of mental disease does not vary especially much. In rural communities it is easier to care at home for a person whose conduct is somewhat peculiar, hence the number hospitalized may be smaller. The progress of urbanization inevitably creates greater demands for hospital accommodations.

TABLE III
State Provision for the Mentally Ill, California Compared With the United States and Selected States

State	Total State Population Aged 15 Years and Over (1)	Patients Resident in State Hospitals at End of Year (2)	Hospitalization Rate per 100,000 Population Aged 15 Years and Over (3)
1943			
California	6,059,166	24,240	400.1
1940			
California	5,540,086	22,953	414.3
Colorado	835,313	3,931	470.6
Illinois	6,189,240	31,046	501.6
Massachusetts	3,376,295	22,871	677.4
Virginia	1,910,941	9,256	484.4
Washington	1,369,669	6,491	473.9
United States	98,697,194	404,293*	409.6*

* Incomplete reporting.

Source: Column 1: Civilian population of California on March 1, 1943, estimated by the U. S. Bureau of the Census (Series P. 3, No. 38) with age distribution 15 and over projected on the basis of the rate of increase from 1930 to 1940. Population of States for 1940 from the U. S. Bureau of the Census (Series P. 10, No. 6).

Columns 2 and 3: Patients in State hospitals on June 30, 1943, obtained from the Department of Institutions, California. Patients in State hospitals at end of year 1940 from, "Patients in Mental Institutions, 1940," U. S. Bureau of the Census, p. 17.

Statisticians like to take for the base in calculating the number of beds needed for the mentally ill in an American community a suitable fraction of that part of the population 15 years old and upward, since very few children are to be found in mental hospitals. Accepting this scheme, it will be noted in Table III that the provision in California State hospitals is now 400.1 patients per hundred thousand of the population who are 15 years of age or older. Against this figure it will be observed that in 1940 Massachusetts provided for 677.4 patients per hundred thousand of these ages, Illinois for 501.6, Virginia, 484.4, Washington, 473.9, Colorado, 470.6, and the United States as a whole an average of 409.6. California ranked seventeenth in State provision for the mentally ill in 1940.

State organization—When there were but few institutions each was governed by an independent board. The growth of population and the increase in the number of institutions in a State results inevitably in the development of centralized authority. In 1897 a State

Commission on Lunacy was set up, consisting of the Governor, the Secretary of State, the Attorney General, the Secretary of the State Board of Health and an appointed officer called the General Superintendent of State Hospitals. The purposes were said to be to provide for uniform government and management, and to prescribe methods of care, custody, and apprehension of persons believed to be insane. This Board reviewed actions by the Boards of Managers and their estimates and exercised supervisory control over the five State hospitals with their 5,000 patients.

Activities of Commission—The first necessary work of the Commission was to formulate a commitment plan, then they moved to get the mentally ill separated from criminals in the jails and other places of lodgment where they were temporarily quartered. A bookkeeping system was set up, information about the expenditures of the institutions was accumulated, better collections were instituted.

The first biennial report of the State Commission spoke confidently of the liberality of the State. The Stockton State Hospital was now maintaining its patients at the rate of thirty-five cents a day, and the Commission considered this not niggardly but efficient. One object of the creation of the Commission was the belief that it might bring about economy, they reported, and Stockton had set an example. They thought that the food cost—a fraction over nine cents a day per patient—should not be reduced, but might be increased, though the patients were already fed abundantly. Only one out of fifty-two asylums in twenty-four States fed its patients as cheaply as the lowest one in California, and only four were as low as the highest one here. There were too many foreigners in the hospitals and too few pay patients. Advance in medical care was proceeding. Suitable cottages were needed for epileptics. There was urgent need of an asylum for the convict insane and the most economical plan would be to erect it at the Folsom State Prison.

Course—This step in the direction of centralizing power was considered economical, and was indeed similar to what many other States did at some time in their history. The salary of the general superintendent was not high enough to bear favorable comparison with that of the hospital superintendents.

Department—In 1921 the Department of Institutions succeeded the old commission. It had a director and a consulting psychiatrist. The psychiatrist's salary was much less than that of the superintendents or the department dentist. A woman physician was appointed inspector at \$25.00 a month; her work was with outpatients. A social worker was appointed. There were familiar problems: Further housing was needed; Pacific Colony did not have enough water; collections were increased.

Occasionally the Director has been a physician with experience in the treatment of mental disorders. Usually however, the governors have preferred a layman to sit in their cabinets. The assistant director is a permanent official, and division heads look after records, collections, statistics, food administration, social service, legal questions

and other matters. Other departments advise on construction, fire protection and farm management.

Responsibility—The Department of Institutions has little to do except foster mental health and treat mental illness. Indeed these duties make a quite sufficiently heavy load. The Department should be ambitious in its program, and should be given a staff adequate to effect its projects.

Need—Human nature being what it is, all large organizations are liable to perpetual error and even to deterioration in some of their functions unless expert inspection is carried on with regularity. The Department of Institutions is now responsible for the welfare of over 29,000 patients of various sorts in ten institutions. The time has come when the Department should have a medical officer directly responsible to the Director, but himself a person of such accomplishments that a considerable number of functions would be routinely delegated to him. He might be designated the medical inspector, chief medical officer, or by any other title that would appeal to the fashion of the moment. His salary and allowances should at least equal those of the superintendents. Some of the ordinary functions of this officer would be the following:

1. Inspection of public and private institutions, including interviewing of patients.
2. Recommendations for licensing private institutions.
3. Establishment of standards of care throughout the institutions of the Department.
4. Oversight of out-patient clinics.
5. Liaison with health officers, medical organizations, hospitals, and other State departments.
6. Assistance to the Director in formulating rules for the Department.

Trustees—Happily, California did not make a mistake that was frequent during the period of centralization in other States—the mistake of abolishing its local boards. On the contrary, each institution has a board of trustees. The law specifies that they shall be five in number, and their terms sometimes overlap. When the law was changed so that their duties were to be “only” advisory, many members who had been accustomed to a measure of authority naturally lost interest, and so many of their successors took their jobs to be meaningless that for the most part the boards are inactive. Recently more interest has again been shown.

Any political unit such as this great State becomes ridiculous when it assumes that citizens of standing are going to be interested in appointments to places of trivial consequence, and the Department would do well even to divest itself of a small portion of its great administrative authority in order to strengthen the position of these boards. Nevertheless, much can be done on the present level. Meetings of the boards should be held monthly at the hospitals instead of quarterly; the minutes of each board should be kept at the hospital and a copy sent to the Department; record of attendance at meetings should be kept by the Department and transmitted to the Governor.

Every governor ought to interest himself to see that persons of influence in the community, known for their benevolence and competence, should be appointed to these boards. All parts of the hospital district should be represented and those members who fail to attend meetings without submitting a reasonable excuse should be replaced. The institution and all its papers should be open to inspection by the board and reports should be rendered to the Department and to the Governor at stated intervals. Many of these points require no amendment to the law.

Stronger law—In improving the law it would be well to place on the Board of Trustees responsibility for (1) holding hearings and making reports to the Department in case of charges against any officer; (2) visiting wards, service facilities, farms and other parts of the institutions, and reporting their findings; (3) commenting on policies and practices of the institution. The interest of the Board also would be strengthened if its approval were necessary for the appointment of a superintendent.

Growth of institutions—It has already been pointed out that there has been continuous pressure for the accommodation of more patients in the California institutions, and overcrowding has been almost if not quite as continuous. To a considerable extent floor space has been measured and a proper capacity arrived at on a mathematical base. The figures for the several institutions are reported in Table IV.

TABLE IV

Resident Population, Normal Capacity and Excess Population in California State Mental Institutions

Institution	Resident Population, June 30, 1943	Normal Capacity, February 1944	Excess Population	Overcrowding in Percent of Capacity
Total—Mental Hospitals.....	24,240	20,558	3,682	17.9
Agnews State Hospital.....	3,552	2,714	838	30.9
Camarillo State Hospital.....	3,829	3,933	-104	-2.6
Mendocino State Hospital.....	2,908	2,397	511	21.3
Napa State Hospital.....	3,826	2,962	864	29.2
Norwalk State Hospital.....	2,257	1,885	372	19.7
Patton State Hospital.....	3,667	3,267	400	12.2
Stockton State Hospital.....	4,201	3,400	801	23.6
Total—Institutions for Mental Defectives	4,728	4,038	690	17.1
Pacific Colony	1,520	1,533	-13	-0.8
Sonoma State Home.....	3,208	2,505	703	28.1

Source: Data obtained from the Department of Institutions, California, and Circular Letter No. 952 dated February 15, 1944, issued by the Department of Institutions.

Crowding—Overcrowding breaks down standards of treatment. It interferes with distribution of the patients into proper groups. It renders plumbing and other facilities inadequate, since more patients must be placed in a ward than are suitably accommodated. It complicates feeding, recreation and exercise. Worst of all, it gives the individual patient too little privacy and he tends to get too little attention and to develop a state of mind characterized by frustration and lack of effort to help himself.

Drifting—Faced by the evils of overcrowding, State authorities have at various times taken whatever measures seemed available to meet it. Sometimes, as has been shown, a new hospital has been planned not only to care for the surplus patients but also to improve geographical provision by having an institution nearer to an area that had been less well served. Too often the authorities of California have followed a customary American practice of merely making additions to existing hospitals. When money is scarce or the legislature is reluctant to appropriate it, the easiest course is to increase the size of existing institutions. Hospital authorities acquiesce rather than prolong an era of no beds. Sometimes a virtue is made of the unwillingness of fiscal authorities to find new sites, and we are told that the number in an institution should depend on the amount of land that can be added to an existing plant, or the quantity of the water supply, or the total number of patients unprovided for, or some other minor factor.

Size—If there be virtue in large institutions, the State of California is exploring that virtue. Stockton already numbers over 4,000 patients, and Napa and Camarillo have over 3,800. There is talk of developing some 7,000-bed institutions.

Standard—There should be some relation between the patients in whom the head of the institution can take a personal interest and the size for which the institution is planned. The farther the census goes above 1,500 the less likely is it that the superintendent can have personal knowledge of most of his patients. One finds that thoughtful persons have predicated 1,500, 2,000, or even 2,500 as a suitable limit. In New York it was stated some years ago that above 1,500 it soon becomes necessary to duplicate one and another executive position on the payroll. Few veterans hospitals are above 2,000 beds, though from studies made soon after the other war, it was concluded that the best results were obtained in institutions of not over 1,000 beds. A recent volume out of Russia says that even their chronic patients are housed in institutions of not over 1,500 beds.

Argument—Usually it is said by those who like the big institutions that "it is all a matter of organization." But in large hospitals one usually hears apologies; the organization looked all right on paper but there were not enough physicians, or enough nurses, or enough engineers, or enough of some other group available to fill out the organization that existed on paper; perhaps it will be done next week, next month, next year—or perhaps never.

Psychopaths—The State has already embarked on a plan for making special institutional provision for psychopathic delinquents. The clinical boundaries of this diagnosis are not always clear, but in the mass of cases we understand quite well who are meant by this and similar designations. They are unstable people with poor judgment, law breakers on what appears to be very little provocation, unable at least in their early years—and some of them throughout life—to set due measure of self-control upon their selfish tendencies. Traditionally the cell has been their abode, but society is now differen-

tiating them and indeed making prisons and reformatories more habitable places for other convicts by weeding out these impetuous and unreasonable folk. California has taken the necessary legal steps to commit such persons to the civil State hospitals, where indeed there were always a few of them, and has undertaken to provide a special hospital.

When the new institution for psychopathic delinquents is definitely being planned, a superintendent should be chosen from the ablest psychiatrists available. The State should send him to the Medical Center for Federal Prisoners at Springfield, Missouri, for a month or two of study and then should have him make critical visits to some of the most enlightened and best operated reformatories. California may then be in position to do an outstanding piece of work in this field—work that will serve as a model to other States.

Next steps—It would be futile to attempt to turn the clock back, and reduce existing hospitals to ideal size; hence it is not proposed that the State of California attempt to make a gross removal of patients from its present institutions. It is recommended, however, that separate provision on new sites be made for several groups that are now large enough so that they complicate the operation of existing institutions.

(1) **The Psychopathic Delinquent.** The State should go ahead with its plans to create a special institution for psychopathic delinquents, starting with the male youth. If many of them are scattered through the other hospitals, they will disrupt the management of more than one institution. Being as a rule quite shrewd and certainly quite clear about their movements, they are in position to express their annoyance by persecuting duller and more confused patients, by conspiring to overthrow ward discipline, and by joint action—very infrequent among the actually mentally ill—against those who have been employed to attend to the needs of the patients. Obviously many of the psychopathic delinquents need to be in an institution that provides a high degree of security, and unless their institution is equipped to deal with the most difficult members of its population, it is in no position to provide on a satisfactory basis the contrast of less secure provision for those who, with some help, are able to adjust themselves to hospital life.

No definite figures are available in the experience of other organizations to indicate just how many are likely to be committed under this category, but after considering the experience of Massachusetts, New York, Michigan, Illinois, and the Federal prison system it is concluded that the 500 beds originally planned will be ample for some time to come. Since many of the psychopaths will not be ready for discharge when they are 21, requiring another 5 or 10 or even longer number of years under training, the allotment of beds will come progressively nearer to being filled with the class for whom they are intended. But that number of beds will not under any circumstances be wasted. It must be remembered that human types coalesce along the borderlines, and in many instances a young man who is clearly psychopathic may have to be studied carefully before the clinician will be sure whether he is merely dull or definitely feeble-minded.

No harm will come of a combination of these two groups. As months go on it will become easier to classify them accurately.

(2) **The Mentally Ill of Criminalistic Tendencies.** The unhappy but inevitable tendency of a few mentally ill persons is to develop a state of mind in which there is a persistent desire to injure someone. Others there are who are not moved by this wanton attitude, but who are so blindly centered on the idea of winning their freedom that anyone who stands in the way is in constant peril. One or two persons of this sort may require such close supervision that their care affects the discipline of a whole ward, or even a whole institution. It is altogether too easy—human nature being what it is—for the personnel of an entire hospital to incline to set its standards in accordance with the more repressive policy that may be necessary in that single ward.

There is also a considerable number of patients who enter the mental hospitals following court procedures that have revealed their long-standing criminalistic tendency. Persons who have spent much of their lives among the elements that work against society and try to break down its security should not be mixed indiscriminately with people from good homes, right-minded people whose mental illness has not twisted their fundamental attitudes. The State, therefore, should—and does at Mendocino—make special provision for mentally ill criminals. It should extend that provision to a few patients to be transferred from civil State hospitals because of criminalistic tendencies that have been overlooked at the time the patient was admitted, or that have developed later during the mental illness. But already the accommodations for these patients at Mendocino are inadequate. It is proposed that the present plan be modified. This modification is not urged in the interest of economy, though indeed it will involve a measure of economy, but rather because making a sound clinical classification will relieve patients in the civil State hospitals of unpleasant and objectionable association with criminals, something they never had before they became ill. It is proposed that at the new hospital for psychopathic delinquents there be another unit for 500 of these patients who have been classified as mentally ill criminals and are under care, either at Mendocino or in the State prisons. If the population of the State shall sometime double, and much larger numbers of these unhappy and difficult persons shall accumulate, this hospital can be devoted to one group instead of the two, but one institution is quite sufficient to care for them for some years to come, under present policies.

Cheap Care—For many years some hospital men have believed that mentally ill criminals should be kept in prison. The usual argument is given in the first biennial report of the State Commission in Lunacy, 1898. The ideal system, says the report, would be a separate hospital, but this would involve expense in construction and maintenance; the most economical plan would be the erection of a building at the State prison under the immediate direction of the warden, with medical attention from the prison physician and an intern. Such an arrangement is cheap but not good. It is as faulty as keeping mentally ill patients in a branch of the almshouse because they are poor.

Administration—Another question is as to which department should administer the hospital for mentally ill criminals. There are advantages in placing such an institution within the hospital system, but no harm need be expected if it be in a Department of Corrections.

Women—Others have already proposed that the unit at Mendocino be devoted to the needs of women of criminalistic type, and the plan is quite feasible. If doors to the rooms are left unlocked (or in many instances are removed) this building will be a very desirable residence, since it has so many separate rooms instead of dormitories.

III ACCOMPLISHMENTS AND EXPANSION

Deficit—Provision of beds in California has not kept pace with that in some other States. It may be that in great tracts of agricultural and forest land the need for hospital care is not so urgent as in manufacturing centers, but California has dense communities, the growth of population is rapid, and is expected to be permanent. If the rate of increase during 1930-40 continues only seven years the State will have at least 8,000,000 inhabitants. A State authority predicts that number in 1944. Certainly California should prepare for this prospect and is doing well to make comprehensive plans for those among the population who will be sick as well as for the hordes whose health will be good. The Department has already estimated that it will have over 28,000 mentally ill and 8,000 mental defectives in hand in 1948, an increase of 7,000.

Comparison—Were California to make as liberal provisions for its mentally ill as does Massachusetts it would have an additional 60 per cent of accommodations. If general conditions come to approximate those in the Bay State there will be need of over 40,000 beds. Present provision will be inadequate to the extent of some 15,000 beds, and if the normal capacity of the present institutions were considered rather than the overcrowded condition now existing the deficit would be even higher.

Compensation—Obviously the State of California ought to provide for its sick citizens the best treatment known. Fortunately the best treatment is not always the most costly, particularly if one takes the long view, for with the best treatment more patients are restored to the community. It is an exaggeration to say that the best hospital is the one that sends the largest number of its patients back to the community, but one may say truly that it is a poor hospital that fails to restore a very large number to their homes.

Increase—The incidence of mental illness seems not to be increasing among young people, though the total number of young persons with mental illness becomes greater as the total population rises. The number of middle-aged and old persons increases more rapidly than the general population, and they are more liable to mental disorders than are the young. The expectancy of human life in the United States has almost doubled in the last sixty years, and we do not know

where the increase will stop. Since middle-aged and elderly people are much more numerous than they were sixty years ago, and since they are much more liable to mental illness than are young people, it is easy to see why mental institutions all over the country have become inadequate in size to take care of the many elderly patients who need to come to them.

Criticism—There are those who declaim about this burden and assert that the younger members of families in which an elderly person has developed mental illness are somehow at fault for not keeping the old person at home. But for years we have been improving the treatment afforded in our hospitals and have been urging the community to get its patients to us early in their illness instead of clinging to them until the last possible moment. It would be absurd to throw all this sound reasoning overboard and now try to get families to keep their patients at home as long as possible. This is neither sound medicine nor sound social sense, nor is there objective evidence that family feeling and spirit of self-sacrifice among the young is less than it used to be. Since the dawn of time such complaints have been made by the older generation against the younger, and there is no demonstration that the complaint is any truer now than it was four thousand years ago.

Cheap care—In some quarters thought has been given to schemes for taking care of the old people cheaper than is now done in the mental hospitals. Since mental hospitals are forced to operate at costs much below those of any other kind of hospital, such efforts will be futile unless they result in a standard of care still poorer than is now accepted. Anyone who sees what is done and what is not done for the aged patients in the California State hospitals can justly come to but one conclusion—that great economy is already practiced, economy that at times borders on parsimony. Large numbers of them are brought together to be looked after by a small personnel in simple quarters. It is easy to see that they often do not get the same share of per capita expenditure that is accorded to younger and more vigorous patients. This could be proved by an elaborate book-keeping system that would compile the costs of the hospital, ward by ward, but the expense of such elaborate accounting would not be justified by proving what is already obvious. Indeed, much better results could be obtained with many of these aged patients if a larger personnel made possible more individual attention. We may conclude that there will be need for some years of increasing hospital provision in California.

Epileptics—Considerable numbers of persons with convulsive disorders come to light in connection with every draft. Epilepsy was a high cause for rejection in the draft of the Civil War. It has also been a high cause in the two wars engaged in by the present generation. The disorder in many instances is not disabling and important posts are not infrequently held by persons affected, if their convulsions occur infrequently and at times when spectators are not about.

Not all such patients can care for themselves, and there are advantages, dietetic and psychological, in separating patients with convul-

sive disorders from others whenever their number becomes large enough so that proper classification can be made. The problems of mental defect are present in many cases, but a few students are able to do advanced work; therefore the school curriculum is ordinarily more extensive in such an institution than in a school for defectives. The institution also must have provision for a few patients who are much disturbed on any particular day; in this regard it is like a mental hospital.

The experience of Minnesota and Massachusetts would indicate that about 36 beds per 100,000 of total population, aged 5 years and over, is a liberal provision. If California shall plan to do as well it would mean that there should now be about 2,500 beds for its present population.

Institution—It is recommended that the State take steps to establish an institution for its epileptic patients. This institution should provide work and schooling and nursing care: Work for as many patients as can possibly be engaged; schooling for the young, whether they be bright or dull children; nursing for those who cannot care for themselves, because they are crippled either in body or in mind or in both. This should be a village (cottage) type of institution, arranged for the comfort and peace of mind of small groups of patients.

Until obstetric and other medical procedures become so effective that birth injuries and inflammation of the brain in infancy are rare, we shall continue to have a considerable number of patients with convulsive disorders who will need at least a period of hospital care. Some of them deteriorate so severely that no medical treatment now available and no surgical procedures can restore them to activity. Every now and then, however, some new procedure comes to light which sends back some more of them to usefulness. One may mention brain surgery in a few cases, and drugs called phenobarbital and dilantin (new within 30 years), and other measures. These inroads on the group of convulsive disorders are small, but each serves to give us hope that still greater advances will be made.

Proximity—The institution for epileptic persons should be in the neighborhood of a medical school in order that the brain surgeon and the neurologist may not be far away, and their services may be easily obtained. Since the population of the State tends to increase more rapidly in the South, it is recommended that this institution be within easy reach of the medical schools at Los Angeles and Loma Linda.

Needs of the Southland—It is high time also to pick the site for a new general mental hospital in the southern part of the State. The population here climbs rapidly, and among those who come to enjoy the comfort and benefit of the mild climate are many persons who are all too liable to mental disorder.

It is clear that a new institution is needed in this section of the State, preferably in the San Diego region. Whether it be placed there or near the central part of the State, its first unit should provide for patients who have mental illness complicated by pulmonary tuberculosis.

Tuberculosis—It happens that this special group, mental patients with pulmonary tuberculosis, now needs special provision, and quickly. Under a tentative arrangement, they were all to be taken to Patton. Patton, however, is plenty large enough now, without the addition of several hundred tuberculous patients. The building in which its tuberculosis cases are housed is a good building, but in some regards not too convenient for the nursing care of this group. On the basis of figures obtained already by the survey of some of the institutions, now in progress, supplemented by the reports of surveys in other States, it seems clear that almost 500 patients will be found with tuberculosis, either early or late. Authorities both in California and elsewhere are insistent that the best results are obtained if these patients with tuberculous lesions of the lungs are not transferred to other wards as soon as an arrest has been obtained, for when mixed in with other patients they are all too likely to suffer a relapse and become a danger to the health of those about them. Accordingly the provision of beds for tuberculous patients should cover not only those who are in the most actively infective stage but all those with lesions that bring them under treatment. The fraction for the first few years will be 4½ to 5 per cent in the hospitals and up to 2 per cent in the schools for defectives. Accordingly, in the institutions of Southern California there are now about 450 mentally ill and about 30 mentally deficient patients with pulmonary lesions. After a few years this number may be decreased as a result of the faithful campaign of diagnosis and segregation that is being started. Such a service will be attractive to one or two physicians who have had the best of training in the treatment of pulmonary tuberculosis, and who will have charge under the medical superintendent. This institution should ultimately have housing for 1,000 patients of other types, predominantly the aged cases who are now coming to our hospitals in considerable numbers. Obviously the one-story structures in which California and Illinois have specialized for some years, and which are found in smaller numbers in some of the older States, should be the standard of construction in this institution.

Central California—The population in the central portion of the State, formerly thin, is now more numerous. People should not have to travel two or three hundred miles in either direction when a member of a family in central California develops a mental illness. The State should take steps to obtain a suitable site, and after the institutions already mentioned are well on their way in construction, this section too should have its own provision.

Maintenance—Although the good things that California does for its mentally ill require considerable expenditure, nevertheless that expenditure is less per resident patient than the average for the United States as a whole (see Table IVa and Figure 2a). California is fortunate in its climate, and the amount spent for fuel, light and water is low. Provisions also are low, and the beautiful farms contribute to save in this item. Salaries and wages require a larger outlay than they do in most of the States. California's hospital personnel is inadequate in size, but it has been the policy of the State to make the individual salaries attractive, at least in ordinary times.

TABLE IVa

Annual Per Capita Maintenance Expenditures in State Mental Hospitals, California Compared With Selected States, 1940

State	Average Daily Resident Population	Annual Per Capita Expenditures								
		Total Amount	Salaries and Wages		Provisions		Fuel, Light and Water		Other	
			Amount	Amount	Percent	Amount	Percent	Amount	Percent	Amount
California	22,853	\$290.58	\$194.01	66.8	\$41.70	14.3	\$14.15	4.9	\$40.72	14.0
Connecticut	7,149	355.71	200.89	56.5	66.86	18.8	26.28	7.4	61.68	17.3
Massachusetts	21,725	424.93	244.39	57.5	72.99	17.2	39.17	9.2	68.38	16.1
Michigan	16,044	481.62	295.26	61.3	86.16	17.9	32.58	6.8	67.62	14.0
New Jersey	10,716	395.01	238.27	60.3	61.98	15.7	31.81	8.1	62.95	15.9
United States	398,419	300.63	167.06	55.6	62.24	20.7	23.67	7.9	47.66	15.8

Source: "Patients in Mental Institutions, 1940," U. S. Bureau of the Census (P. 63).

Annual Per Capita Maintenance Expenditures
CALIFORNIA AND SELECTED STATES 1940

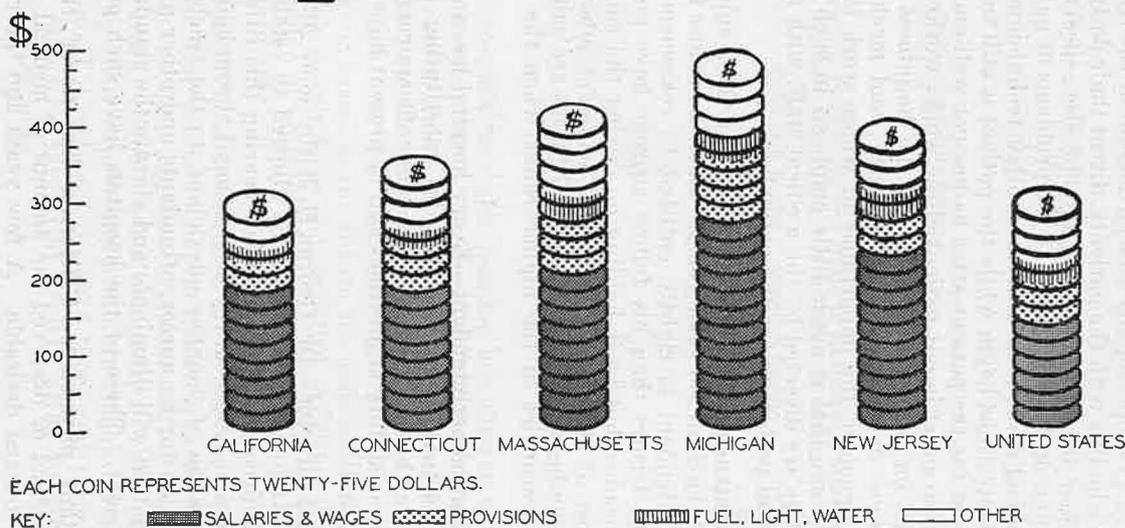


Figure 2 a

IV MEDICAL STAFFS AND THEIR WORK

Composition—A mental hospital organization consists of physicians who study the problems of their patients, lay out lines of treatment and carry on personally a large amount of the treatment; nursing personnel who live with the patients, direct their daily activities, come to know them better than almost anyone else; special therapists who apply sundry skilled techniques to the problems of patients designated by the medical staff; laboratory and other technicians; social workers whose ministrations begin while the patient is still in the hospital but who do most for the patient after he has got well enough to go home, and who also assist in out-patient clinic work; workers in the dietetic department on whose skillful labors the happiness of both patient and employee depends in large measure; and mechanical and agricultural personnel, the importance of whose work is so obvious in a mechanical age that it needs little emphasis in such a report as this. All activities are directed by the medical staff, with a view to getting the most and best done for the patients.

Superintendent—Each hospital has a medical superintendent who has served the State for some years. Indeed, in more than one instance the superintendent is rightly entitled to retirement and a greater measure of leisure than his fellow citizens have permitted him for several decades, but he is holding on during the continuation of the war because of physician shortage. Competent subordinates on duty either in the hospitals or in the armed forces are said to be available to fill all vacancies in the higher ranks when the staffs are again complete.

Assistant superintendent—Every hospital has an assistant superintendent, actual or acting. Besides substituting for the superintendent when he is off the grounds, these officers carry a considerable load of responsibility at all times and at present have to carry clinical services as well.

Clinical director—Dr. George H. Kirby some 20 years ago recommended that institutions should be allowed to establish the position of clinical director. The physician bearing this title usually devotes his time to a constant survey of treatment throughout the institution, to the direction of younger physicians, to the teaching programs of the institution for its nurses, attendants and other groups, and to all procedures that will illuminate and elevate the standards of diagnosis and treatment. Three of the hospitals have such positions.

Assistant physicians—California has never thought that its patients needed or deserved the amount of medical attention that is generally deemed desirable. A few years ago the ratio of one physician to 300 patients was set officially and has not yet been met. This compares unfavorably with many of the best hospitals. In Tables V and Va and Figure 3 relevant data are presented.

TABLE V

Number of Authorized Physicians and Ratio to Patients in California State Mental Hospitals 1943

Hospital	Average Daily Resident Patient Population	Authorized* Number of Physicians**	Patient Load per Authorized* Physician**
California—			
All State Hospitals-----	23,961	85	281.9
Agnews State Hospital-----	3,507	12	292.3
Camarillo State Hospital-----	3,736	15	249.1
Mendocino State Hospital-----	2,880	8	360.0
Napa State Hospital-----	3,782	13	290.9
Norwalk State Hospital-----	2,181	8	272.6
Patton State Hospital-----	3,671	13	282.4
Stockton State Hospital-----	4,204	16	262.8

* Includes filled positions plus full-time vacancies reported on June 30, 1943.

** Includes interns, excludes superintendents.

Source: Data supplied by the State mental hospitals listed, 1943.

TABLE Va

Number of Authorized Physicians and Ratio to Patients in State Mental Hospitals, California Compared With Selected States, 1940

State	Average Daily Resident Patient Population	Authorized* Number of Physicians**	Patient Load per Authorized* Physician**
California***-----	22,853	76	300.7
Illinois-----	30,654	125	245.2
Massachusetts-----	21,725	119	182.6
Michigan-----	16,044	74	216.8
New Jersey-----	10,716	67	159.9
Washington-----	6,430	27	238.1

* Includes filled positions plus full-time vacancies.

** Includes interns, excludes superintendents.

*** Similar data for 1943 appears in Table V.

Source: "Patients in Mental Institutions, 1940," U. S. Bureau of the Census (p. 59) and unpublished data obtained from the U. S. Bureau of the Census.

Training—California's favorable position has allowed it to annex occasionally to its medical staff a physician well trained in some other region. Postgraduate training in psychiatry has not until recently been offered on the Pacific Coast. Happily the juxtaposition of the Langley Porter Clinic and the University of California School of Medicine will make it easier in the future for assistant physicians in the California State hospitals to get so-called refresher courses in which their knowledge of both the theory and practice of psychiatry will be brought up-to-date.

Senior physician—These staffs lack the grade of senior physician. Every mental hospital should expect to have a group of younger physicians who come to learn and to accumulate a bit of capital, then to pass on to other work. Each needs also a group of older physicians who after acquiring their experience prefer to remain in this type of work. It is a good investment to make them and their families comfortable since otherwise they tend to drift away to States that appreciate their abilities more.

Present situation—The influence of the war is felt here as in all parts of the country. Physicians, in some instances experienced and very active physicians, are away in military service. The essential part of their work has been spread among the remaining physicians

Patient Load per Assistant Physician Authorized

CALIFORNIA AND SELECTED STATES 1940

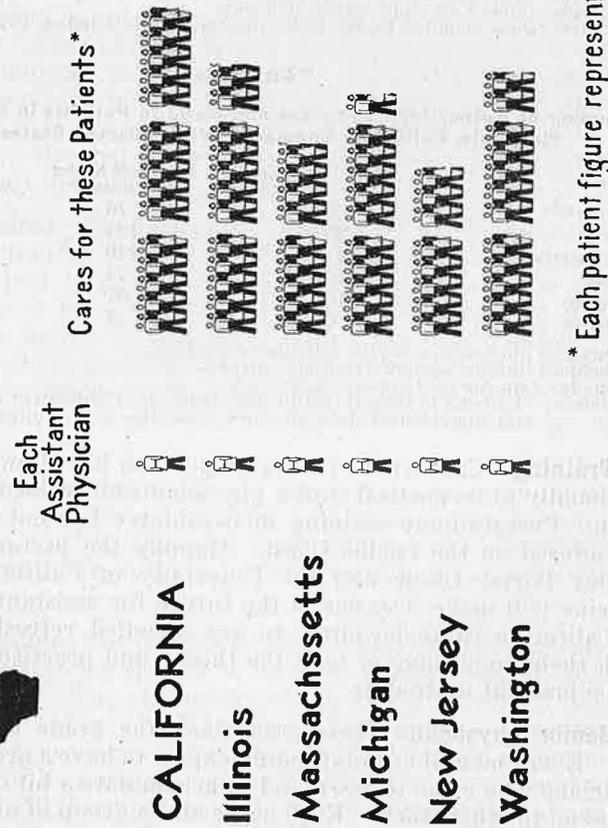


Figure 3

DIVISION OF MENTAL HYGIENE
U.S. PUBLIC HEALTH SERVICE

* Each patient figure represents 10 patients.

as far as possible. One need not lament this situation, for it is only part of the country-wide effort to assure the military forces of suitable medical attention, and most of the present deficiencies in the hospitals can be called the contribution that the mentally ill are making to the war effort. In comparing the work of California with other States one can not make a statistical allowance for such things since the ratio of patients to physicians changes from day to day. Accordingly any statistical comparisons are made on the basis of payroll jobs rather than on the number of positions filled at the time of this survey.

Research—Whether there are many persons with research minds in the medical organization was not discovered. Certainly at the present time it would take a strong internal drive to enable a man to do any original or independent study. In ordinary times productive problems should always be under consideration.

Pathology—Generally speaking, the best mental hospitals have a pathologist on their staff. If a full-time functionary can not be obtained, it is important to legalize arrangements for the part-time service of some competent pathologist from the neighborhood.

Medical libraries—The medical library of every one of these institutions will bear strengthening; some are unnecessarily weak.

Laboratory—Every hospital has an adequate clinical laboratory and some neuropathological work is either now on or projected.

Autopsies—In some hospitals consistent effort has been made to obtain the opportunity to examine the tissues of patients who have not survived their illness. Only by such studies can medical men keep their activities on a high level.

Offices—Many physicians in the California hospitals have their offices on their services. Too many offices are still grouped together in the administration buildings. This arrangement makes it somewhat easier for the superintendent to find the physician, and much harder for the patient to find him. Adequate examining rooms are generally provided, but not on every service.

Quarters—In all hospitals some cottages are available for married physicians. The number of such houses is not yet adequate.

Medical meetings—Where inquiry was made it was found that county medical societies meet at some of the hospitals. It must be noted that these meetings are usually for the few counties that happen to contain public institutions. There has been no organized effort to take to other counties the results of the experience and experiments of the mental institutions. Occasional addresses are made to lay organizations. This too has never been systematized, but should be when the staffs are again built up.

Psychotherapy—Patients come to mental hospitals because their most complex functions—thinking and feeling—are disturbed. There is too much inclination in mental hospitals to concentrate attention on various adjunct therapies and leave the core of the trouble to natural

healing. At present there is considerable excuse for the lack of individual psychotherapy, but one learns that it has never been much studied here. While many mental illnesses can not be touched by discussion with the physician, a very large number can be. Such discussions are now carried on in a desultory instead of an organized way.

Dentistry—Dental service has been furnished in good measure though not on the recommended standard of a dentist for each thousand patients. War conditions have cut down the amount of work done.

Psychology—Especially in studying the young, but also in many other connections, the work of the experienced psychologist is very helpful. The hospitals may well be provided with competent men in this field to lift some of the burden of examination from the shoulders of the physicians.

Newly admitted—Transportation of the mentally sick in California is done by the sheriff, usually with a revolver in his holster, thus stigmatizing the patients as proteges of the court on a level with convicts. Hospitals have reception services, often connected with the wards for the physically ill so that the patients come into an atmosphere of sickness and surgical operation. They are usually received by supervisors, questioned, bathed and put to bed. A physician sees the new patient on the same day, but ordinarily is not the one to admit him, and he makes no note on his first findings.

Acutely ill—Every hospital has a service and generally a good service for the pick of the physically ill. Any graduate nurses on the staff are assigned to this service, but perhaps do not have charge of the wards and merely do bedside nursing for designated patients. Operating rooms appear to be adequate.

Chronic disease—Those suffering from subacute and chronic physical disorders are not quite so fortunate as those with acute illnesses. To be sure, the attendants chosen to look after these wards are among the most experienced. The largest number of patients who die pass their last days in wards that are not supervised by graduate nurses.

Surgery—It has been the practice in California to have some member of the resident staff do most of the surgery. This is a pleasant arrangement for the staff member, but as a system it has defects. Even one of the largest hospitals may not have enough surgical work so that the man in charge can maintain the best techniques in his own work or that of his surgical nurse. Moreover, the staffs are too small anyway to detach a man from the treatment of the mental illnesses of the patient, and to require him to devote most of his thought to surgical procedures seems like a dislocation of good organization.

Tuberculosis—A systematic survey of the hospital population for the discovery of early pulmonary tuberculosis is now under way. A physician with experience in this field has been appointed to the staff of the Patton State Hospital, and a like appointment will shortly be made at Napa. It is expected that these tuberculosis physicians will

advise with other hospitals in the south and north of the State respectively in order that a thorough canvass of the situation shall be made. Then it is intended to assemble the patients in one institution at each end of the State and afford them the best treatment possible.

In the present situation a new building intended for tuberculous patients at Napa is occupied by the Navy, and the tuberculosis building at Patton is full and can not receive more patients from the other hospitals.

The disturbed—Overcrowding tends to increase disturbance and overcrowding exists in several institutions. In order to prevent dangerous clashes between antagonistic persons a repressive policy comes to be established in a ward. Fortunately the climate is an ally of the physician in this State and makes it easy to get patients out-of-doors during most seasons. It is obvious, however, that at the present time too many disturbed patients are out-of-doors too little. This is no one's fault, but is due to the stringency in the ward service. Unhappily it is also obvious that too little activity is encouraged when the patients do get out-of-doors. Departments of physical training were not widely developed, and their workers mostly have been taken away for the armed services.

Restraint—No figures as to restraint were obtained on this visit. One gets the impression that as compared with other American institutions the excessive use of these measures is not great. One also feels confident that a vigorous campaign would reduce the amount of restraint now employed.

Mentally ill criminals—A special building of 300 beds is in use for mentally ill persons under criminal commitment at the Mendocino State Hospital. There are attractive features about this building. It surrounds a courtyard and for the most part is but one story in height. On the other hand the court is too small and lacks grass and trees. Everything about the building is very strong, but it is spacious and has many plumbing fixtures. The only sitting room is the assembly hall, full of benches. The only exercise on stormy days is running a polisher in the corridor. Little care is given to the patients. One section of the house is a cell block, and it is thought that there are enough persons of desperate inclination to justify the presence of this structure.

Alcoholism and drug addiction—The State formerly had a special institution for drug addicts. Few are under care, in the State hospitals. The alcoholics are scattered among the institutions. This arrangement is far from satisfactory, and an active program for alcoholics is yet to be developed.

This is indeed a responsible position and should be invested with suitable dignity and remuneration.

V NURSING AND SPECIAL THERAPIES

Ward personnel—Whether a hospital does fine work or only mediocre work depends on the character and training of those who are in constant association with the patients. So many of them are needed that persons of diverse endowment and background can be well employed, provided technical supervision is of high standard.

Psychiatric nurses—Curiously, the California institutions seem to have been loth to give the nurse the place in their organization that has been attained elsewhere. It has been believed and frankly stated that so many graduate nurses are ill equipped to display the intelligent sympathy necessary in guiding the lives of mental patients, that they are detrimental rather than helpful in the hospital organization. Besides, to hire trained people costs money. Nevertheless, when Dr. Cowles in 1882 formed his plans for training ward employees at McLean Hospital he introduced standards that can not profitably be disregarded. There is already a large number of nurses well equipped to give the patients in our mental institutions not only the kind of oversight to which they are accustomed but also a high degree of help in readjusting to the demands of life that have proved too much for their emotional soundness. It is to be hoped that nursing will be accorded in California's institutions the place that it commands in other good mental hospitals. Indeed if the hospitals had had stronger nursing organizations, physicians right now would be relieved of some non-medical duties.

Because of this general attitude of aversion no position of charge nurse has been set up. This should be instituted.

Surgical nurses—Every hospital plans to have its operating room under the direction of graduate nurses, which is, of course, quite right. These nurses also give physical care to patients who have had operations and to a part of those who have severe physical ailments. But they may carry no responsibility for the general management of the surgical patient—only for his arm or leg. Apparently the wards in which the largest number of fatal illnesses terminate are seldom in charge of nurses. Such a situation seems strange in a hospital. What nursing is done seems to be on a good level.

In a few spots, nurses are in charge of wards and appear to handle the mental problems of their patients quite adequately—as indeed would be expected.

Comparison—Table VI and Figure 4 show the ratio of patients to graduate nurses employed in State hospitals for mental disease, by States, at the end of the year 1940. Only two other States, Tennessee and Arkansas reported a heavier patient load per graduate nurse than California.

Charge attendants—The largest number of those who are responsible for directing the daily affairs of the patients are the attendants who have served long enough to be promoted to the grade of charge.

TABLE VI

State	Average Daily Resident Patient Population	Number of Graduate Nurses	Ratio of Patients to Graduate Nurses
United States -----	399,554	4,252	94.0
New England			
Maine -----	2,637	30	87.9
New Hampshire -----	2,226	49	45.4
Vermont -----	1,044	16	65.3
Massachusetts -----	22,075	491	45.0
Rhode Island -----	2,838	40	71.0
Connecticut -----	7,149	73	97.9
Middle Atlantic			
New York -----	73,114	1,509	48.5
New Jersey -----	10,716	168	63.8
Pennsylvania -----	21,946	382	57.5
East North Central			
Ohio -----	19,215	149	129.0
Indiana -----	8,612	16	538.3
Illinois -----	30,843	231	133.5
Michigan -----	16,044	146	109.9
Wisconsin -----	1,846	29	63.7
West North Central			
Minnesota -----	10,072	139	72.5
Iowa -----	6,468	36	179.7
Missouri -----	8,852	41	215.9
North Dakota -----	1,919	11	174.5
South Dakota -----	1,605	7	229.3
Nebraska -----	4,096	39	105.0
Kansas -----	4,917	50	98.3
South Atlantic			
Delaware -----	1,189	17	69.9
Maryland -----	6,753	19	355.4
District of Columbia -----	6,187	114	54.3
Virginia -----	9,148	44	207.9
West Virginia -----	3,922	27	145.3
North Carolina -----	6,846	30	228.2
South Carolina -----	4,480	50	89.6
Georgia -----	7,132	37	192.8
Florida -----	4,611	23	200.5
East South Central			
Kentucky -----	6,360	8	795.0
Tennessee -----	5,534	4	1383.5
Alabama -----	5,663	15	377.5
Mississippi -----	770	2	385.0
West South Central			
Arkansas -----	4,407	2	2203.5
Louisiana -----	6,490	12	540.8
Oklahoma -----	7,039	6	1173.2
Texas -----	13,395	40	334.9

TABLE VIa
Number of Authorized Ward Personnel and Ratio to Patients in California State Mental Hospitals, 1943

Hospital	Average Daily Resident Patient Population	Total	Number of Authorized* Positions		Other Nurses and Attendants		Patient Load per Authorized* Graduate Nurse or Attendant
			Graduate Nurses		Number	Percent	
			Number	Percent			
California—All State Hospitals	23,961	2,343	38	1.6	2,305	98.4	10.2
Agnews State Hospital	3,507	338	7	2.1	331	97.9	10.4
Camarillo State Hospital	3,736	353	7	2.0	346	98.0	10.6
Mendocino State Hospital	2,880	257	2	0.8	255	99.2	11.2
Napa State Hospital	3,782	359	5	1.4	354	98.6	10.5
Norwalk State Hospital	2,181	268	3	1.1	265	98.9	8.1
Patton State Hospital	3,671	364	3	0.8	361	99.2	10.1
Stockton State Hospital	4,204	404	11	2.7	393	97.3	10.4

* Includes filled positions plus full-time vacancies reported on June 30, 1943.
 Source: Data supplied by the State mental hospitals listed and the Department of Institutions.

TABLE VIb
Number of Authorized Ward Personnel and Ratio to Patients in State Mental Hospitals, California Compared With Selected States, 1940

State	Average Daily Resident Patient Population	Total	Number of Authorized* Positions		Other Nurses and Attendants		Patient Load per Authorized* Graduate Nurse or Attendant
			Graduate Nurses		Number	Percent	
			Number	Percent			
California**	22,853	2,219	21	0.9	2,198	99.1	10.3
Connecticut	7,149	1,074	96	8.9	978	91.1	6.7
Massachusetts	22,075	3,240	513	15.8	2,727	84.2	6.8
Michigan	16,044	2,291	153	6.7	2,138	93.3	7.0
New Jersey	10,716	1,341	168	12.5	1,173	87.5	8.0
New York	73,114	10,973	1,509	13.8	9,464	86.2	6.7

* Includes filled positions plus full-time vacancies reported.
 ** Similar data for 1943 appears in Table VI.
 Source: "Patients in Mental Institutions, 1940," U. S. Bureau of the Census (P. 60) and unpublished data obtained from the U. S. Bureau of the Census.

Patient Load per Nurse or Attendant Authorized

CALIFORNIA AND SELECTED STATES 1940



* Each figure represents 1 patient.

Figure 5

Appearance—Women attendants are well groomed and make a good appearance. The men show more variation in this matter.

Occupational therapy—Considerable is heard about occupational therapy, but more about its deficits than its accomplishments. Some persons of considerable skill are employed in this field. There is reason to believe that under normal conditions much more vigorous campaigns can be carried on. As soon as the use of the therapy centers has been brought to a maximum, many of the wards should be invaded. No hospital can be expected to have a large enough number of skilled therapists to direct all the craftwork that should be done in an institution from morning till night, and a large part of it should be under the direction of the ward personnel; where organization is carried out by persons of the right temper a large number of the women's wards will at all times include persons who are doing some kind of handwork. Men are less accustomed to carry their work into their homes, but much more of the sort can be done in men's wards than is realized in some quarters.

Table VII shows the number of occupational therapist positions authorized and the number of patients assigned to occupational therapy. Unhappily for statistical purposes some assignments to occupational therapy are formal rather than adjusted to the therapeutic possibilities of those techniques.

Hydrotherapy—Sedative hydrotherapy—the use of the prolonged bath for excitement, restlessness and insomnia—is relatively little used in these hospitals at the present time. Where it is used it is appreciated. Stimulative hydrotherapy, which depends on skilled operators rather than ward personnel for its maintenance, is largely in abeyance.

The hospitals report, as noted in Table VIII, the number of hydrotherapists authorized at the close of the latest fiscal year together with the number of patients receiving hydrotherapeutic treatment on a selected day.

Physical training—Something has been done with physical training in all the hospitals. Since physical training aides are of the build and in the time of life most useful in war and industry, what work there was is badly impaired. It is to be hoped that after the war every hospital will have a strong department of physical training. This is the field in which most male patients and no small number of women make their earliest response when skillful campaigns are carried on to lessen idleness.

Libraries—Some libraries were seen during these visits. They are usefully run, though some activities would be increased by librarians trained in a school of hospital librarians. This work is being carried on usefully in spite of war conditions and can be made much more aggressive when more normal conditions return.

Music—In several places music is well employed as a recreation. Its more earnest and individual use has not yet been developed, since special personnel has not been engaged.

TABLE VII
Authorized Number of Occupational Therapist Positions and Patients Assigned to Occupational Therapy on a Selected Day

Hospital	Authorized* Occupational Therapist Positions	Average Daily Patient Population	Patients Assigned to Occupational Therapy on a Specified Day		Female	Percent of Total Patient Population Receiving Occu- pational Therapy
			Total	Male		
Agnews State Hospital	2**	3,507	1,775	859	916	50.6
Camarillo State Hospital	5	3,736	358	42	316	9.6
Mendocino State Hospital	1	2,880	1,267	949	318	44.0
Napa State Hospital	5***	3,782	1,300	706	594	34.4
Norwalk State Hospital	3****	2,181	71	41	30	3.3
Patton State Hospital	1	3,671			30	0.0
Stockton State Hospital	3	4,204	1,699	1,155	544	40.4

* Includes filled positions plus full-time vacancies reported on June 30, 1943.

** Includes one aide.

*** Includes four vacancies.

**** Includes one vacancy.

Source: Data supplied by the State hospitals listed, 1943.

TABLE VIII
Authorized Number of Hydrotherapist Positions and Patients Assigned to Hydrotherapy on a Selected Day

Hospital	Authorized* Hydrotherapist Positions	Average Daily Patient Population	Patients Assigned to Hydrotherapy		Female	Percent of Total Patient Population Receiving Hydrotherapy
			Total	Male		
Agnews State Hospital	4	3,507	48	22	26	1.4
Camarillo State Hospital	2**	3,736	15	15	0	0.4
Mendocino State Hospital	2	2,880	27	19	8	0.9
Napa State Hospital	4	3,782	54	3	51	1.4
Norwalk State Hospital	2	2,181	14***	1***	13***	0.6
Patton State Hospital	2	3,671	30	15	15	0.8
Stockton State Hospital	2	4,204	100	50	50	2.4

* Includes filled positions plus full-time vacancies reported on June 30, 1943.

** Includes one vacancy.

*** Estimated figure based on the total number of treatments reported for the year.

Source: Data supplied by the State hospitals listed, 1943.

Diversion—Responsibility for running recreational programs is carried by various persons to whom it is assigned in the various institutions. Appropriated funds appear to be sufficient to furnish amusement. There is need to develop small-group recreation.

Data on care—Day clothing is usually adequate, but a great number of men have little or nothing to which to change. Garments are assigned to them only to wear between washings and their appearance is unattractive though their persons may be scrupulously clean. Women look better, for their dresses are ironed.

Night wear is furnished somewhat freely to women and skimpily to men.

These hospitals are not yet all supplied with so-called beauty parlors for the women patients, a feature of institution life generally accepted throughout the country.

Ward decoration is not consistently developed.

Bedding appears to be quite adequate. Not much is needed in California in September and October. Any scarcity of sheets, pillowcases and towels is thought to be due to inadequacy in the laundry rather than to lack of proper purchase.

Ventilation is hardly a problem at this time of year. One of the fine things about the prevailing architecture in the California institutions is that the one-story buildings can have high ceilings in the dormitories.

Care of patients—At least one bath a week is given everywhere. Many patients bathe more frequently. All new patients are weighed. In general, later weights are taken monthly. This makes an easy-going schedule and since generally the weights are kept in the ward and are not a continuous record, it would not be difficult to overlook losses of weight.

VI FOOD: ITS PRODUCTION, PREPARATION AND DISTRIBUTION

Farms—The farms of many of the California institutions might well arouse envy in any part of the country. Although considerable of the land owned by the institutions is rated as not especially fertile, nevertheless almost every farm seems to have plentiful acreage on which to grow a wealth of vegetables as well as hay and grain. In this climate irrigation is depended on to produce growth. This system added to the mild winter climate makes it possible to raise certain vegetables even through winter.

Herds—Among cattle, the Holstein breed prevails. Some herds, such as that of Mendocino, are known far and wide. A cow called "Mendocino Hester" produced over 31,000 pounds of milk in a year and another holds four world records for butter fat. Some herds are composed principally of high-producing grade cattle. There is a difference of opinion as to which type of herd in the long run is most economical. Even where high butter fat records have occurred, breeding is performed with a view to high production of fluid milk, which

is the wisest course. One should not forget that a herd in which the hospital personnel takes pride can also be capitalized among patients and their relatives as something to be seen and admired.

Swine are raised in large numbers. Kitchen and table waste is a considerable item in their feeding, and as this is reduced more grain must be raised or purchased.

Flocks—Poultry is raised on a considerable scale. Eggs are the object of this production and the amount of chicken served to the patients is for the most part restricted to what White Leghorns can yield.

Supervision—The Department has a position known as food administrator. It was vacant for some time but is now filled. The problems of the administrator are many and her work is strenuous. Some kitchen equipment is outmoded. Some vegetables produced are not harvested at the best time. Cooking always can stand improvement. Problems of distribution of food to the patients still await vigorous handling.

Dietitians—The common idea of a hospital includes the presence of graduate dietitians. It is probable that the people of California would support a movement to place trained persons in charge of dietetic departments in all their institutions. There is evidently a considerable number of competent cooks in these institutions, as can be seen from the inspection of food. Nevertheless, it is not to be expected that an institution of 1500, 3000, or even more will function on the highest possible level without a high type of skilled direction at the head.

The food—Observation shows that the patients in all of these institutions appear to have sufficient food, well cooked and for the most part attractive as it comes from the kitchen. Balance is not always maintained.

Service—By far the largest number of patients is served at table. Food is usually parceled out well before anyone takes a seat. Second helpings of some items are said to be available everywhere. The individual usually has no choice even of the amount of each item of food that will be given him, and considerable amounts are left over. It is difficult to systematize such matters since a great deal of the food distribution is carried on by patients and the principles followed are simple, traditional and occasionally crude. Supervision of dining rooms varies in quality. Attendants are unequally efficient, supervisors are few and dining rooms are many.

Tableware—Not only is there room for improvement of the service, but the kind of dishes and the amount of cutlery supplied should some day be thoroughly reviewed. Where cutlery is not supplied and where knives and forks are forbidden the usual defensive clichés are offered in justification. Other hospitals supply to similar patients more cutlery and more knives and forks without excessive breakage and without anybody ever being stabbed. One small dining room was seen in which each patient had two receptacles for fluids so that

he could have, for instance, water and coffee, or milk and coffee at the same meal; this practice may well be extended.

Meal hours—The time between supper and breakfast tends to be excessive. This comes about because of the distribution of employees in the three-shift system. No service was found in which any patient was allowed a snack at nightfall.

Diet kitchens—There is usually a diet kitchen on the surgical service and some of them have special cooks. Dietary therapy is but little practiced, as might be expected where dietitians do not exist and nurses are few. Such work should be much better developed in the next few years.

Dishwashing—Dishes usually are washed in sinks. No studies have been made of bacterial count on these dishes. In some places dishwashing machinery is available.

VII COMMUNITY RELATIONS

Voluntary—Voluntary patients may be received in any of these hospitals and to some extent that type of admission is encouraged. Just now, when physicians have less time to spend with their patients, it is not feasible to give so much time to allaying the doubts and fears of the indecisive patient who is uncertain whether to come in.

Commitment—The California law is so drawn that most patients before entering a mental hospital have to appear in court. Some large municipal hospitals have a courtroom which is made to look as informal as possible. In other places less agreeable arrangements may prevail. As has been noted elsewhere there is no provision under which the hospital would send experienced personnel to bring in patients who have been committed; the deputy sheriff therefore acts as nurse and transportation officer.

Care pending admission—Peace officers are for the most part responsible for the alleged mentally ill pending commitment. Such patients may remain at home or may be lodged in jail.

It is to be hoped that this arrangement will be changed and the health officer will be made responsible for procedures to determine the mental state of those who must be committed to the hospital and also for the care of all such patients while the question is under consideration. Still better is a procedure for admission of a patient on the request of the health officer.

Visiting—It is stated in all the hospitals that visits to patients are encouraged rather than otherwise. This tends to create a friendly feeling on the part of the community and has a distinct relation to the number of patients that ultimately are removed from the hospital.

Out-patient clinics—Out-patient clinics have not been widely developed, though a good start was made before 1930. Camarillo, for instance, reports as many as three that are held at stated intervals

for the benefit of patients out on parole. The department has expected to develop this work much more broadly under the leadership of the Division of Extramural Care.

Social service—The hospitals make use of a considerable number of social workers, some of whom have had the best of training. In some institutions an inordinate part of the time of the workers is consumed in getting histories. Ordinarily, however, a considerable amount of visiting of the homes of patients is carried on. Assistance and supervision of patients who have returned to their homes is of prime importance, and is vital to the success of any effort to keep the improved patient at home.

Family care—A notable piece of work has been done in the last four years, not only in increasing the number of patients on visit in their homes but also by placing patients out at State expense. At one time the census of the institutions actually dropped. This work has now run into difficulties. Boarding costs tend to rise, competent social workers are less easy to find and the depletion of medical staffs makes it harder to watch closely the rate of improvement of thousands of patients in the hospitals and estimate promptly when each one may properly be placed out. The work however goes ahead as circumstances permit.

Extramural care—A Division of Extramural Care has been set up in the Department and the Superintendent of the Camarillo State Hospital is acting as its head. At present the division is experimenting to find the best methods of performing the necessary book work involved in the complicated matter of helping patients who have been in institutions and who are now well enough to return to the community.

Public addresses—A considerable number of physicians have been called on at different times to talk to college classes, schools, service clubs and other organizations about the work of the hospitals. It is thought that this work has been done very well. When the medical staffs are again built up probably this function can be expanded even further.

Teaching—Clinical material has been presented to county medical societies on many occasions. A few medical students have worked at some of the hospitals at times. Very little teaching of nurses—either pupil nurses or graduate nurses—has been attempted, and this deficit is most unfortunate. Students of law, students of theology, students of sociology and students of psychology have been given clinics in several of the institutions.

Sterilization—California has felt much pride in its program of sterilization. Varying goals have been set for this program, the most practical being that in each case where dependent progeny is cut off, the public funds are saved for more important work. It is claimed that the public on the whole is friendly to this procedure and that the reputation of the hospitals and schools is enhanced by it rather than otherwise. It is not everywhere accepted.

Reimbursement—Considerable attention is given to collecting from families all or part of the cost of the maintenance of their sick members in institutions. It is stated that the work of these collection officers is done tactfully, but it is also noted that when delays occur in reaching the relatives and setting up a rate of reimbursement unfortunate antagonisms have been aroused.

Repatriation—The Department has a competent group of officers who establish the previous residence of its patients and make suitable arrangements for the return of outside residents to their own communities. No change in this work need be contemplated except that it eventually be included in the division of inspection. The attractions of California as regards climate, abundance of food, and general charm of place and population will continue to bring throngs from other parts of the country. Among them is an appreciable number who develop mental ailments, and such patients have been returned to their domiciles by the carload and even by the trainload. In this connection, it is recalled that some physicians and others who have escorted such patients to their States of residence have asked for opportunity to visit some hospital before returning. This is commendable, and should not be left entirely to individual initiative. The matter should be sufficiently systematized so that all physicians and the most experienced employees will make definite visits to eastern and central institutions as part of their trips. A comment on each visit—not a long report—should be sent in a letter to the Director.

VIII THE TRAINING AND CUSTODY OF THE MENTALLY DEFICIENT

Care—An appreciable fraction of any population that is known as feeble-minded or mentally defective has claimed some space in institutions ever since mental hospitals began to exist. Special institutions for them were developed somewhat later. California opened the Sonoma State Home in 1885 and the Pacific Colony in 1921.

Types—These individuals may roughly be divided into two groups: (1) Those who are relatively helpless and not capable of much development. In general it is reported throughout the country that larger numbers of such persons are brought to the institutions than formerly and that this tendency makes it difficult to save space for the second group. (2) A large number whose native capacities are limited but who by properly directed training can be brought to a higher level of social existence than would be possible if they were left in their own families. A great many of these children after a few years of training become useful adults in the community.

Social problem—It should be remembered that the largest number of mental defectives do not go to State institutions. They happen to be born into good families and get their training at home and in special classes in the public schools—or even in the regular classes. Many families are not bright enough and not prosperous enough to give proper training to a defective child and these are the ones whose children come to the institutions in largest numbers. They present, therefore, not only a problem of intellectual training but also a problem of social development.

Comparison—The provision for mental defectives in California may be compared with that of a few other States. The statistician likes to give us as a base for this comparison the population aged 5 and over, since few inmates of these institutions are younger. Table IX accordingly shows the beds available and the ratio per 100,000 of the total State population aged 5 and over. This provision places California twenty-eighth among the forty-four reporting States in the liberality of its provisions.

Waiting lists—Since no State attempts to take immediately every defective child for whom admission is sought, there is customarily a waiting list. This is said to amount to several hundred for the two California institutions. Since the movement of population is not always rapid, lists may not be exactly current; that is, some of the patients who were listed six months ago may no longer be in need of this help, because of death, or removal from the State, or—rarely—because the family has fallen on better times and is now in position to provide for its own.

Schooling—A careful study of the educational practices of these two institutions was not attempted in the short time given to the survey. It was noted that Sonoma has positions for 11 teachers; Pacific Colony 3.

Training—Good things may be said for the training program in both institutions. It was indicated, however, that with a larger personnel much more can be accomplished.

Epileptics—Both institutions have a considerable number of epileptics. They would total about 600.

TABLE IX

State Provision for the Mentally Defective, California Compared With the United States and Selected States

State	Total State Population Aged 5 Years and Over (1)	Mentally Defective* Patients Resident in Institutions at End of Year (2)	Hospitalization Rate per 100,000 Population Aged 5 Years and Over (3)
1943			
California -----	6,985,598	4,016	57.5
1940			
California -----	6,453,893	3,462	53.6
Illinois -----	7,350,279	7,664	104.3
Massachusetts -----	4,035,024	5,136**	127.3**
Michigan -----	4,824,722	4,803	99.5
Minnesota -----	2,562,243	2,679	104.6
Washington -----	1,614,273	1,180	73.1
United States -----	121,127,751	83,386**	68.8**

* Patients classed as epileptic by the institutions not included.

** Incomplete reporting.

Source: Column 1: Civilian population of California on March 1, 1943, estimated by the U. S. Bureau of the Census (Series P. 3, No. 38), with age distribution 5 and over projected on the basis of the rate of increase from 1930 to 1940. Population of States for 1940 from the U. S. Bureau of the Census (Series P. 10, No. 6).

Column 2: Data for 1943 supplied by the Department of Institutions, California; data for 1940 from "Patients in Mental Institutions, 1940," U. S. Bureau of the Census (P. 121).

IX RECOMMENDATIONS

Construction

1. Sites should be obtained for new institutions in the very near future. The interest of trustees of existing institutions might well be enlisted in obtaining preliminary information.

2. The total hospital provision should be increased to a quantity more commensurate with the need of the community as shown in statistical studies.

3. No increase should be made in the size of present institutions except as such an increase is incidental to the provision of a building for a special group of patients not at present properly provided for.

4. The recent policy of specializing on one-story buildings should be continued, especially in view of the increase of elderly people in hospital populations.

5. The entrance of the main building at Napa may well be preserved in reconstruction as a fine relic of the Gothic ecclesiastical type of institution architecture.

6. A hospital should be erected for some of the most difficult patients. Its first two units should have 500 beds each, one for psychopathic and defective delinquents, the other for mentally ill persons of criminalistic history or behavior.

7. A hospital and school for epileptic patients should be erected. A thousand beds should be provided.

8. A hospital should be provided for Central California. The first unit should contain 500 beds for mentally ill persons with pulmonary tuberculosis, and all such cases from the southern group of institutions should be transferred to it.

9. Necessary reconstruction and replacement should be done to abolish the fire risks that now exist, especially at Mendocino, Napa and Stockton. In the new buildings at Napa, ample provision should be made to care for the tuberculosis cases of Northern California.

10. The Langley Porter Clinic should have more land and an addition to its building.

11. The State should proceed to acquire a site for the psychiatric clinic in Los Angeles to whose development it is committed.

Administration

12. The gratitude of the State is due to institution officers and employees who stretch their hours and their efforts to cover the deficits of this difficult period. That gratitude should be both vocal and practical.

13. Highly competent psychiatric advice should be quickly available to the Director of the Department. The present commendable practice of calling in the superintendents should be supplemented by having a medical inspector in the Department.

14. The Boards of Trustees should be expected to meet oftener to study the activities and needs of the institutions and should file stated reports with the Director.

15. The commitment laws should be revised to free patients from the burden and stigma of court appearance and transportation by peace officers.

16. The training and education of mental defectives should be still further advanced when suitable personnel is available.

17. Medical officers of these institutions and experienced employees, particularly in supervisory positions, should be encouraged to study the practice of good hospitals in other parts of the country.

18. Each institution should have at least one dietitian.

Medical Staffs

19. The ratio of physicians to patients in the California hospitals should be brought much closer to the standard recommended by the American Psychiatric Association, namely 1 to 200 resident patients with an additional physician for each 100 admissions.

20. Courses for assistant physicians should and undoubtedly will be given in the Langley Porter Clinic.

21. Every institution that lacks a clinical director should consider setting up that position, so that upon demobilization it may be filled well and promptly.

22. The position of senior assistant physician should be created and placed sufficiently high in the scale of remuneration so that its occupants could live in reasonable comfort during a long hospital career.

23. When dentists are again available, the recommended ratio of 1 to each 1,000 patients should be approximated.

24. Pathological work in the institutions should be maintained on a high plane.

25. Accommodations for resident physicians as well as for the various types of employees though not luxurious should be suitably comfortable.

26. The offices of physicians should be on their services.

27. Medical libraries should be put in order and made adequate to the standards of knowledge that will be expected of the physicians.

28. The work of the hospitals should be reported from time to time to interested citizens and particularly through scientific communication to the several county medical societies of each hospital district.

Nursing

29. Nurse training for any of the several groups that may be available should be introduced into several of these hospitals.

30. The services of graduate nurses should be usual rather than exceptional in these institutions.

31. The position of charge nurse should be created in the civil service.

32. The ratio of ward employees to patients should be established at about 1 to 6.5.

Treatment

33. The present commendable effort to identify and segregate all patients with pulmonary tuberculosis should be continued. In new construction suitable units should be developed, at Napa in the northern part of the State and in a new hospital in the southern part of the State.

34. The service of competent psychologists should be made available in these institutions.

35. Hospital staffs should be brought to a level where individual psychotherapy could be the rule of practice.

36. The special therapies should be further developed after the war, especially occupational therapy, physical training, music and bibliotherapy.

37. A better standard of clothing should be established, particularly for men patients.

38. The personal hygiene of women patients should be placed on a high level.

39. Now that the planning and preparation of food are receiving more expert attention, steps should be taken to abolish all crudeness and to make its service enticing.

*To all those whose courteous attentions made this survey possible,
thanks are extended.*

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