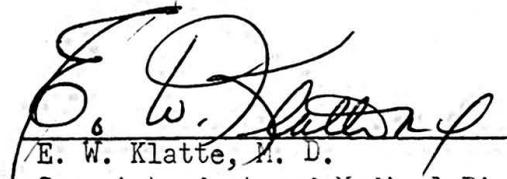
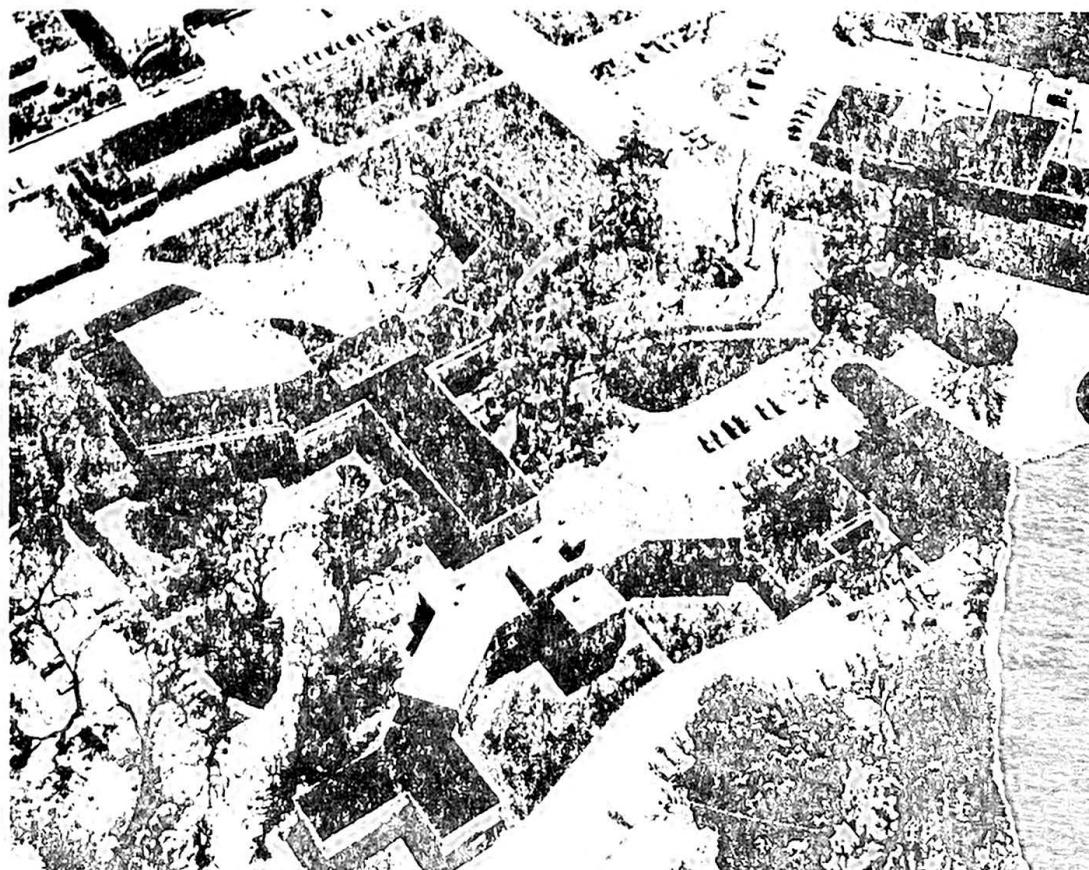


JULY, 1963

STATUS REPORT  
MENDOCINO STATE HOSPITAL  
AUGUST 1962

In late August, 1962, at two all-morning meetings, area chiefs and department heads at Mendocino State Hospital reported to each other on where they were and where they hoped to go. Taken together, the reports give a rough and incomplete sketch of a hospital in motion. Major changes (and some minor ones) since last August have been added in notes at the end of many sections.

  
E. W. Klatte, M. D.  
Superintendent and Medical Director



## AREA I

AREA I includes the admission suite and the four admitting and intensive treatment units in the R and T building. Staffing in the area is relatively rich and many kinds of programs are offered, in an effort to keep hospitalization as brief and effective as possible. Area I also serves as an intensive training area for residents in psychiatry.

Some aspects of the admission and early treatment procedures were reviewed last August by Dr. Ralph Kennedy, then Chief of Professional Education and also Chief of Service for Area I. At that time, the admission procedure had been revised to allow direct admission to all of the R and T units, rather than just to RT 1 and RT A; at the same time, direct admission to other units in the hospital was being explored, in order to insure maximum continuity of treatment for all patients.

THE OPERATION OF THE ACUTE TREATMENT  
AREA

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The operation of the acute treatment area can be examined to advantage from three points of view.

- I. The movement of patients through the area.
- II. The movement of patients within a unit in the area.
- III. The organization of the staff to maintain the above two objectives.

I. The Movement of Patients Through the Area

Patients are received in the admission suite from the community under a variety of Welfare and Institution Code and Penal Code commitments, as well as voluntarily. In some instances, hospitalization at Mendocino State Hospital does not seem appropriate, and a referral to a more appropriate resource is attempted. The remainder of the patients are admitted to the appropriate unit according to established criteria.

The units outside the area presently receiving patients directly are Units 14, G, RT-4, 2 and 4. The patients admitted to Units 14 and G are committed under Section 5404 of the Welfare and Institutions Code for alcoholism. Those admitted to RT-4 are first admissions over 65 who are considered to be candidates for the acute intensive geriatric treatment program. The patients admitted to Units 2 and 4 are former patients on the unit whom the unit physician feels would benefit from the maintenance of continuity of treatment in the programs on Units 2 and 4, where the patient had been treated prior to leaving the hospital. The remainder of the patients are admitted to the acute treatment area and are either returned to the community or transferred to the continuous treatment area, following treatment.

One of the major objectives of this pattern of movement is to provide continuity of treatment. Factors that contribute to the continuity are the assignment of mentally ill patients to the medical staff of the acute treatment area for psychiatric evaluation and the admission of patients to all four units in the area. The objectives for the program, as it is presently established, are to:

- (A) Increase the number of patients returned to the community from the area.
- (B) To hold the length of stay in the hospital to the minimum.
- (C) To make hospitalization, including admission, as therapeutic as possible.

II. Patient Movement Through an Acute Treatment Unit

Patients are received on the acute treatment units from the admission suite on the day of admission. An admission note and cursory physical examination are completed by the unit physician and the unit staff begins orientation of the patient to the unit.

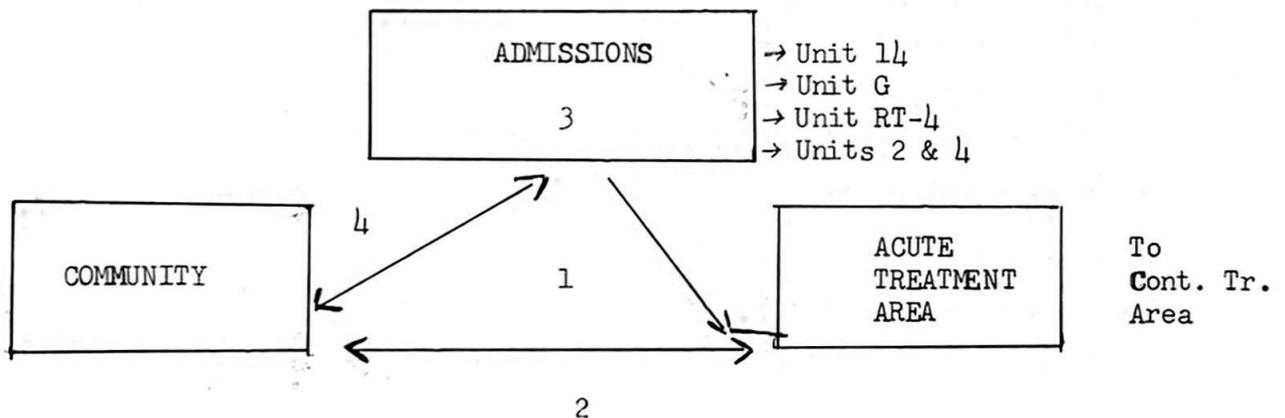
Within 72 hours of admission the patient's psychiatric evaluation and physical examination are completed by the physician to whom the patient is assigned. Within 7 to 10 days, an intake conference is held. At this time, all the information about the patient that has been collected by the staff members is presented, a formulation

The responsibility for the patient movement on the individual units as described is assigned to the staff psychiatrist. All of the units have in addition an administrative physician who serves as unit consultant.

RALPH C. KENNEDY, M.D.

8/20/62

PATIENT MOVEMENT - R&T



OBJECTIVES:

1. Increase number of patients returning to community.
2. Maintain length of stay at minimum.
3. Make entry into hospital as therapeutic as possible
4. Make referrals to appropriate resources when hospitalization is not indicated.

of the patient's difficulties is made, an appropriate plan of treatment is agreed upon and treatment goals established. The treatment program includes a number of modalities:

- (A) Milieu Therapy
  - 1. Unit meetings
  - 2. Social interaction (planned and unplanned)
  - 3. Unit housekeeping
  - 4. Activities' programs
- (B) Somatic Therapies, mainly drug therapy and, in a few cases, electroshock therapy.
- (C) Individual therapy or counseling.
- (D) Industrial therapy.
- (E) Group therapy
- (F) Special programs, such as the school program and the Merry Makers.
- (G) Other therapies.

Evaluations of patient's progress are made on an ongoing basis; when he approaches the agreed upon therapeutic goals, the patient is considered for disposition. At Discharge conferences, the patient's hospital course is reviewed and appropriate recommendations for disposition are made. Subsequently, the recommended disposition is effected.

### III. The Organization of the Staff to Maintain the Above Two Objectives

- A. Nursing Service - The Nursing Service in the area consists of the staff of the four treatment units and the admission team, the Assistant Superintendent of Nursing Services for the area and her supervisory staff.
- B. Psychology - Two psychologists are assigned to the area, each providing service for two of the treatment units.
- C. Social Work - Two psychiatric social workers are similarly assigned; in addition, there is a part-time supervising psychiatric social worker.
- D. Rehabilitation Service - One Assistant Supervisor of Rehabilitation Services is assigned to the area.

The medical staff of the area consists of the Area Chief of Service, two staff psychiatrists, and four residents, one assigned to each unit. Each of the staff psychiatrists is responsible for supervising the unit program, the administration of patient care, and resident training for two units. In addition, one psychiatrist serves as the admitting physician and the other is alternate in this position. The unit programs are formulated by the entire staff of the unit and to a considerable extent are carried on by the Nursing Service staff.

The rehabilitation worker assigned to the area does not have a unit assignment but functions as a resource person for all four units, as well as for the area as a whole.

PATIENT MOVEMENT - ACUTE TREATMENT UNITS

1. Admission to unit
2. Evaluation
3. Intake conference
4. Treatment program
  - (a) Milieu therapy
    1. unit meeting
    2. social interaction
    3. unit housekeeping
    4. activities program
  - (b) Somatic therapies
  - (c) Individual therapy or counseling
  - (d) Industrial therapy
  - (e) Group therapy
  - (f) Special programs and other therapies
5. Disposition conference
6. Disposition

TRAINING STRUCTURE  
MENDOCINO STATE HOSPITAL

AUGUST 1962

RESOURCES	POSITION	RESPONSIBILITY
Inter-facility travel fund )	Superintendent, Nursing Services	Dept. and affiliate
Administrative travel fund )	Personnel Officer	Hospital-wide
Specialized training )	Training Assistant	Hospital-wide
Department training )		
programs )		
Consultant funds )	Psychiatric Nursing Education Director	PTT, et al
Books and Journal fund )	Chief Professional Education	Residency, hospital-wide
Medical Library funds )		including extension
Training Aids )	Supervisor, Rehabilitation Services	Dept., SPA and affiliate
Grant Information )	Supervisor, Social Work	Dept., SPA and affiliate
	Assistant Superintendent, Medical and	Dept.
	Surgical Services	
Research and demonstration )		
projects )		
Project fund information )	Psychologist III	
Travel funds )	Hospital Business Administrator	Dept.
Audio-visual contact )		
Supplies and equipment )		

## AREA I

### Since last August

Procedural problems in the direct admission of alcoholics to Units 14 and G have been resolved, so that direct admission of this group of patients to units where they will be treated is now the rule. Also, patients returning from indefinite leave within the year are now going to home units. This has resulted in some change in the population of Area I.

Some experimenting is being done with direct admissions to special units, i.e.: newly admitted women patients from Mendocino County to RT-B; adolescent males to RT-2.

A number of special programs for an increasing number of patients under 20 have been developed, including an adolescent group, with Dr. Mayfield and Miss Woodward as co-therapists; the Youth Socialization Program, organized by Dr. Lipscomb, and further expansion of the school program, including a full-time teacher at the hospital and some experience in sending our patients to high school in town.

In May, Dr. Ralph Kennedy accepted the job of Northern Regional Director, State-Local Mental Health Services: for May and June, Dr. Sheldon Grinnell served as acting Chief of Area I and also as acting Chief of Professional Education. On July 1, Dr. Joseph O'Neill assumes these duties.

## AREA II

AREA II includes medical, surgical and related services for the entire hospital, a coeducational unit for intensive treatment of newly admitted geriatric cases, and five continuing treatment units for geriatric patients. The felt needs of the area were reviewed by Dr. Homer B. Matthews, Assistant Superintendent, Medical and Surgical Services, and Chief of Services for Area II at the meeting last August.

August 1962

CURRENT STATUS REPORT FOR AREA II

1. HOSPITAL-WIDE SERVICES

A. Laboratory

At present, the laboratory has adequate personnel and equipment for the generally used laboratory tests and a few uncommon tests. Autopsies now include microscopic examination which is being done in hospital laboratory. Surgical specimens are still sent to Dr. Aagaard's office. A small volume of laboratory tests are sent out to private laboratories; so far the number of requests has not exceeded budgeted funds.

Quality control, as recommended by the American Society of Clinical Pathologists, has been instituted and will be a continuing process.

Equipment needs can be predicted and have been submitted in budget requests. The need for replacement of the Centrifuge is certain. The need for an electronic cell counter remains doubtful.

Laboratory personnel have discussed among themselves their training needs. Martin Hull has arranged to take a chemistry course at Santa Rosa Junior College, occupying two and a half days a week. He would like to have transportation costs provided by the State but will take the course regardless. Mrs. Bruton is interested in learning new procedures. For example, electrophoresis. Were any new laboratory procedure to be introduced, technicians would need to be trained in some laboratory where the tests are already being properly carried out.

B. X-ray

X-ray appears to be adequately staffed for the normal working day; there has been some problem with vacation relief. The radiologist has been coming 4 mornings a week and has been able to keep up with the workload.

Mrs. Wages is receiving On The Job Training in x-ray techniques with a view to becoming a registered x-ray technician. She has already met the State Personnel Board requirements but has not yet met the requirements for registration.

There are many equipment needs in x-ray; these have been submitted in the form of budget requests. This year, we will purchase a replacement portable x-ray machine. Dr. Nicholson has suggested that equipment for rapid film changing in angiography should be available in the community. He is seeking to finance the cost of equipment privately, expecting that the purchaser would be reimbursed in part by the use of this equipment in our hospital on a contract basis. In other words, we would pay a fee for rental of the equipment.

C. Pharmacy

(1) Tranquilizing drugs.

Mellaril has become more popular and may consequently be in short supply for the second quarter. Quarterly orders for tranquilizers are now to be based on actual usage during the previous three months. Appropriate usage records have been kept since March of 1962 and it is unlikely that major shortages will occur. In the first seven months of 1962, 379,662 doses of tranquilizing drugs were issued.

- (2) General drugs appear to be provided for adequately.
- (3) We are budgeted for one and one-tenth pharmacist positions. Hospitals with 2500 or larger bed capacity are allowed two pharmacists. It would seem that we would be entitled to more than one-tenth of a position for relief. In other words, could we not justify requesting 22/25ths of two pharmacists, or one and eight-tenths positions?
- (4) An average of 5 prescriptions per day are being filled for patients on indefinite leave, including the supply given at time of departure.
- (5) There are no felt needs for training for the pharmacist but Nursing Education may be interested in the pharmacist's observation that PTT's now in the hospital seem to have less training in pharmacy matters than previously. In other words, the drug requisitions made out by PTT's betray lack of understanding of what the drugs requested are for. Trainees working in drug rooms have informed the pharmacist that they have little supervision in preparing requisitions and consequently do not know which drugs are hypnotics, narcotics, tranquilizers or general purpose.

#### D. Podiatry

Our podiatrist continues to see all new admissions to the hospital and to provide services to resident patients, the majority of his time being spent with resident patients. He visits selected units one to two afternoons a month. During his service here, the podiatrist has assessed and identified a particular problem of major proportions hospital-wide; namely, poorly fitting, inappropriate shoes. He has estimated that several hundred resident patients are currently wearing grossly undesirable footwear. He has seen several cases where foot lesions are directly attributed to shoes. In one case, a patient whose correct size was 12 was wearing size 8 shoes. Stockings have also been noted to shrink enough so that they become damaging to feet. As initial corrective measures for this situation, the following recommendations are made:

- (1) Use of a Brannock device in the hospital shoe shop for obtaining shoe sizes.
- (2) Issue light leather slippers known as Romeos to sedentary patients, especially the men on Unit 7 who are now wearing heavy work shoes but are not working.
- (3) Use of socks which will remain large enough after laundry.
- (4) Use of the podiatrist in an educational program to improve foot care.

Within the podiatry clinic, there is a distinct felt need for more working space and a new podiatry chair.

The podiatrist carries out an on-going training program for himself consisting of a yearly post-graduate course at the time of the Western Podiatry Congress in May of each year and a monthly visit for one day to the California College of Podiatry where he attends the clinic. He would like to request a State car for transportation to these events and also consideration of State payment of tuition and living expenses when he attends the post-graduate course.

E. Dental Clinic

The general level of dental care is judged to be good. The dental clinic operation is smoothly running. Noteworthy features for the purposes of this report are as follows:

- (1) The office is crowded, especially in the laboratory section. Should the opportunity arise, it would be desirable to think in terms of providing a larger and better equipped dental laboratory.
- (2) The hospital now has no oral hygienist. Two oral hygienists could be expected to do all necessary cleaning of teeth on a periodic basis throughout the hospital. One hygienist could handle the worse cases.
- (3) Post-graduate courses for dentists are offered regularly; both dentists would be interested in attending, especially if the budget were to allow for the cost of tuition and/or maintenance.

F. Clinic

Need for more space and equipment continues.

G. E.E.G.

Transferred to Area I several months ago.

H. Physical Therapy

The physical therapy operation is conducted now exclusively in the central clinic. We have two physical therapists, both of whom will be retiring in the near future. Our present plans are to wait until the present therapists have retired and at that time to rebuild a department which will be able to provide ward programs as well as central programs.

2. AREA SERVICES

A. Physician Staff

Physician coverage in the Area is currently unsatisfactory but the addition of a surgeon and a ward physician appear to be forthcoming. Two problem areas indirectly related to physicians are believed to be noteworthy.

- (1) We have identified a need for agreement on policies relating to alcoholic patients. The question of determining what units are to be used for housing and the extent of medical services such as elective surgery procedures is being handled on an individual basis and is cause of recurrent concern.
- (2) A device for paging physicians appears highly desirable since considerable time is required to locate a given physician for fairly minor matters.

B. Clerical Staff

- (1) We see the Area office and the central offices as being adequately staffed for clerical personnel except for relief.
- (2) We recommend the use of unit clerks both in the R&T units and on the continuous treatment units.

C. Nursing Service

No major changes are contemplated at the present time in the R&T units. However, a plan has been developed which would affect continued treatment units, particularly Units One and B.

(1) Objectives.

- a. To have one large unit made into a coeducational infirmary.
- b. To have one large unit made into a coeducational psychiatric unit based on family style groups upon which an application for a Title V Grant can be readily superimposed.

(2) Procedure.

- a. Twenty-five physically fit men would be transferred from Unit 3 to Area IV.
- b. Twenty-five men would be transferred from Unit One to Unit 3.
- c. Ten women requiring convalescent and infirmary medical care would be transferred from RT-3, RT-C and RT-D to Unit One. Fifteen women requiring concentrated nursing care would be transferred from Unit A to Unit One.
- d. Fifteen women would be transferred from Unit B to Unit A.
- e. Fifteen men selected for psychiatric intensive treatment would be transferred to Unit B.
- f. Twenty-five vacancies would be thus produced in Area II, distributed so as to have supply of empty beds in the R&T units including RT-4 to allow fluidity of patient movement as medical and surgical illnesses occur and as new geriatric admissions are received.

(3) Personnel Needs.

Unit One would require actual staffing at the ratio of 1:4.5.  
Unit B would require actual staffing at the ratio of 1:4.5.  
Unit A, C and 3 would be staffed as well as possible after the needs of the R&T units and the above mentioned units had been met.

(4) Training Needs.

- a. Unit One - Nursing personnel assigned to this infirmary unit will require financial support for attendance at specialized training courses in the care of diabetes and acute and convalescent bedside nursing.
- b. Unit B - In order to develop intensive psychiatric nursing with small family style groups, a training program should be developed utilizing a professional consultant of the stature of Hildegard Peplau to conduct a two-weeks course in group dynamics and in personnel relationships. As an alternative, nursing service personnel could be sent for specialized training at teaching institutes.

(5) Equipment Needs

- a. Several hydraulic patient lifts will be needed. We are budgeted for only one during 1962-63.
- b. Handrails will be needed on all geriatric units, particularly in the hallways, bathrooms. These have not been budgeted to our knowledge.
- c. Side rails for high beds must be replaced and funds for this purpose have been budgeted.
- d. Wheelchairs need continual replacement and we understand that approximately six are being purchased each quarter.
- e. Other medical and surgical equipment will be needed; budget requests for several thousand dollars in excess of what is likely to be approved have been submitted.

HOMER B. MATTHEWS, M.D.  
Assistant Superintendent,  
Medical & Surgical Services

August 20, 1962

HOSPITAL-WIDE SERVICES

Laboratory

The centrifuge is now in the budget and will be obtained; a budget request for an electronic cell counter will be included for 64-65.

At present, several vacancies in the laboratory are anticipated.

X-ray

Since Mrs. Wages has met the requirements for a registered x-ray technician, vacation relief is no longer a concern.

Mr. Cowan has invented a rapid film changing device for use in angiography; this has been demonstrated to visiting consultants from U.C. The device has been received with enthusiasm, and Mr. Cowan has received requests to supply it. Thus not only are our own needs satisfied but also, potentially, the needs of others.

Pharmacy

By developing better methods of anticipating drug needs and making more accurate predictions, we have had fewer shortages. The needed relief for the pharmacist has been obtained.

About 50 prescriptions a week are being prepared for patients on indefinite leave; a report on this is being written for Dr. O'Neill.

Need for a closer control of methedrine has come to our attention.

Podiatry

The podiatrist reports that the Brannock device is now being used in shoe fitting, with some real improvement in fit as a result. The equipment needs of the podiatry clinic have been included in the budget.

Dental Clinic

Minor space changes have been made in the dental clinic. The Department has published a dental needs survey for all hospitals; some of the information duplicates information prepared here. The use of oral hygienists for scaling and examination is being recommended by the department.

Clinic

The clinic has been moved to the old shock suite; the shock suite has moved downstairs, and the former clinic now provides class space for nursing education.

Physical Therapy

A third physical therapist has been employed and this department has thus increased its services.

## AREA SERVICES

### Physicians Staff

Many policies relating to alcoholic patients have now been agreed upon.

During the past 10 months, our surgeon has made various improvements in aseptic technique aimed at the prevention of wound infection (we have a very low rate of trouble in this area). Entrance to the surgical suite is restricted; the admission of patients to the unit is contingent upon the absence of infection, and the pre-operative stay on the surgical unit now extends over several days to allow for the appearance of any latent infection.

### Geriatric Programs

July 15 is now the target date for a number of contemplated changes in the arrangement of Area II. At this time, the following assignments are planned:

- Unit A -- pre-leave unit, coeducational
- Unit B -- Women's continued treatment
- Unit C -- Men's continued treatment
- Unit 1 -- Coeducational infirmary
- Unit 3 -- Coeducational habit training

Special features will include a part-time rehabilitation therapist on Unit A who will help the group simulate community living experience, and the assignment of all patients on Units B and C to their own staff representatives.

Representatives from both the employee group and PSAC have taken part in planning these changes.

### Nursing Staffing

Staff shortages are still keenly felt in Area II. The staffing on Unit A was materially improved this spring through administrative action.

### Equipment for Geriatric Units

One lift has been purchased and several more are planned for July. Side rails on some beds have been replaced, and minimal replacements of wheel chairs continue to be made. A major item needed is an electronic device for cardiac monitoring and resuscitation. In the field of hospital supplies, we are faced with constant and often critical shortages.

### Research

Research is pending on a study of acquired megacolon, and also a study of methods of anesthesia, in cooperation with the University of California. Also still pending is a site visit on the Area's Title V grant request; a visit in early July is anticipated.

### New Developments

In addition to the many problems posed last August and settled, at least partially, in the intervening months, the Area has seen:

The reactivation of the Gray Lady program and the introduction of a very enthusiastic Junior Gray Lady group.

Units in the area have served as the clinical setting for the new Nurses Aide training program for patients.

A paper on the geriatrics program appeared in the April, 1963 issue of "Mental Hospitals."

### AREA III

AREA III, the continuous treatment area for more than 600 women patients, has managed to sub-divide many of its problems, the better to solve them. In this way, such staff fatalities as apathy are avoided, and the area makes good use of a wide variety of therapies. An overview of the program was presented last August by Dr. Harry Hook, Assistant Superintendent, Psychiatric Services and Chief of Service for Area III.

August 1962

Area III is a continuous treatment division of the hospital for women, containing six units of about 650 patients. Of these, 392 have transferred in from other California State Mental Hospitals over a period of many years.

There are 667 beds and the rated capacity is 645. Continuous treatment for us, therefore, means great emphasis on intramural programs for the majority, with special attention directed toward placement outside the hospital for the minority.

Very few recent geriatric patients appear on these units, but the majority of the residents are aging schizophrenics with potential medical and geriatric problems. The pattern of operation includes acceptance of overflow from Area I and special treatment cases as listed below. All units are open except Unit D.

Unit D: Patients requiring a locked unit, often for a very brief period. Seclusion has been reduced to about 100 hours per month recently; virtually no restraint is used.

Unit F: Aging schizophrenics who cannot climb stairs. Drug therapy, good medical care and placement of selected cases outside the hospital are emphasized.

Unit F, Dorm 4: Younger, active women able to participate in group living and industrial therapy.

Unit G: Continuous treatment cases and program for women alcoholics. The treatment program for women alcoholics will continue to emphasize a multidimensional approach which parallels the general treatment goals for the mentally ill, while considering the special needs of, and resources for, female alcoholics. The Area Chief functions as the unit physician while the Chief Social Worker continues to coordinate the program. Direct admissions to Unit G are now in effect. There is an average of 20 women alcoholic patients. There are increasing numbers of referrals from community agencies and whenever possible, the patient's family is included in the treatment program.

The clinical phase of the LSD Research Project will be completed within six to eight months. The follow-up study will be for a three-year period. In order to arrive at a base line, there will be a study of 40 patients treated on the unit prior to the LSD project but who fundamentally were exposed, or involved in the same treatment program.

The staff feels a major responsibility in offering consultation and education to community agencies. This has been done through panel presentations to both professional and lay groups. Scheduled for October is such a presentation to the Humboldt County Mental Health Society and other groups interested in the problem of alcoholism.

Unit H: Young and middle-aged continuous treatment cases with fair prognosis. An active milieu-type program is in operation.

Units

Eye, K: Aging, long-term cases in fairly good physical condition.

Area staffing includes Nursing Service personnel - 106 plus 6 supervisory employees; Medical - 4 plus 1 psychiatric resident; Psychology - 1; Social Service - 2; and Rehabilitation Services - 1.

The treatment program is a multidimensional one, including some individual and group therapy, various therapies administered jointly by the Rehabilitation and Nursing Services personnel, and great emphasis on drug therapy.

The hospital-wide Remotivation Program has been implemented to the extent that ten groups are meeting regularly. The team concept is emphasized at unit and area levels. The intramural program in the recent past has included special emphasis on personalized clothing, cosmetics and grooming. Nursing Service personnel have made great initial and continuous effort to insure success of the personalized clothing program. Business Services Division has provided marked improvement in living quarters and many special services.

The remodeling program on Unit F has been especially helpful. A large number of minor construction items have also been very helpful. In general, the standard of living for all patients has improved.

The extra-mural program has improved through the addition of more and better trained personnel. The assignment of two full-time psychiatric social workers has provided rather complete coverage of all units for this aspect of the program.

The goals of the future include greater emphasis on placing patients out of the hospital with the aid of Vocational Rehabilitation Services, Aid to the Totally Disabled and other services already in operation. Within the Area, we should like to provide further personalized care for patients and provide more adequate activity rooms for various types of work with patients.

The Area Training Program has included a "refresher approach" for Nursing Service personnel in the past year and has moved into the hospital-wide Remotivation Program, which will be of considerable benefit to our patients. The Area professional staff will continue to benefit from hospital-wide seminars of various types, plus some training away from the hospital.

Some additional construction requests for the future, and other additions are:

1. Completion of the Unit F remodeling program next year - 5 dormitories and the main service section.
2. Construction of activity rooms for O.T. and group meetings on Units Eye and K, similar to the Solarium on Unit D.
3. A number of minor construction items to serve needs as they arise or as previously recognized.

HARRY N. HOOK, M.D.  
Chief of Service, Area III

dated: August 20, 1962

Since August - a brief progress report

May 31, 1963

At the end of the eleven months, Dorm 4, Unit F, compiled a report to show that:

55 patients were admitted, 12 of whom were transferred to other units,

23 patients left the hospital on Indefinite Leave, and 7 were discharged.

The LSD Study on Unit G has been completed, except for follow-up of the patients which will continue for about three years.

Area III now has only one Social Worker, but is continuing to release patients under the provisions of ATD and OAS. A summary of the ATD program, as of May 27, 1963, shows 24 patients approved and placed, with approximately 31 applications completed. The first application was made in April, 1962.

A three-month study of a new drug called Proketazine was completed in April, 1963, on Unit D under the direction of Dr. Mayfield and Dr. Kraus. Twenty regressed patients were treated; about one-half of the patients improved.

HARRY N. HOOK, M.D.  
Chief of Service, Area III

## AREA IV

AREA IV is the continuing treatment area for male patients, and also includes the admission and treatment unit for male alcoholics. In some units, the patient population is relatively static and the care offered is primarily domiciliary -- these men could leave the hospital (in many instances) if suitably accepting settings and sufficient funds were available. Other units handle more acute disturbances; in the male alcoholic unit, the admission rate is high and turnover is rapid. The following report was presented by Dr. Edwin Peterson, Chief of Area IV.

August 22-23, 1962

Review of Area IV

(stenographic transcription of report by Dr. Peterson)

Introduction:

Area IV has 907 patients (August 22, 1962). These patients fall into three general groups

1. Alcoholic group
2. Long-time hospitalized group which now is mainly geriatric
3. Heterogeneous group; prominent among which are
  - a. the patients with behavior disturbances
  - b. difficulty in controlling behavior
  - c. patients for whom it is felt the acute treatment programs are not appropriate, or of sufficiently long duration

Area IV contains approximately 40% of the population in the hospital and over 50% of the admissions.

Probably, the majority of our patients are in the category for which APA recommends a staffing ratio of 1 - 5. If we could obtain approximately 35 more nursing service personnel in our area we would attain a ratio of 1 = 10 plus 60%.

Problems:

- (1) Combating the tendency of long-term hospitalization to encourage social crippling of our patients.
- (2) Finding extramural placements for a group of patients who, by and large, have lost their ties with family or, at least, whose ties have become very tenuous.
- (3) Perhaps one of the most important but not the most important problem - motivation of our staff. To continue working, trying to push up the ski slope this group of patients, is discouraging, for the rewards that we have in terms of many hours put out are relatively intangible.
- (4) Research: Our area offers a natural setting for research into the basis and the management of chronic schizophrenics. Our attempts in this field have been stumbling; we have tried to set up projects; yet, at this time there is not a single research project going on in Area IV.

Programs:

In an attempt to solve some of the problems:

- (1) Our program is to use everybody in this area to the fullest extent. This means staff, every group as well as patients. As far as staff is concerned, the main body is the nursing services personnel. Our aim is to make

Dr. Hook does not look with favor upon asking employees to come to work in the evening; has found not many people wish to do this. Miss Doherty stated in her opinion overtime is more feasible than split shifts for technicians.

Dr. Klatte: (1) how large is the problem?  
(2) how to solve it?

Mr. Minard stated that out of 2300 patient population, 500 patients maximum are involved in the Industrial Therapy program, including housekeeping on the units. Dr. Hook stated these 500 patients are the ones who fit best into the group therapy and activities.

Dr. Klatte said at one time there was a thought about creating units in which industrial patients could be concentrated. Should we consider concentrating them on one or two units? He thinks it may be very realistic to designate some patients as domiciliary patients.

Dr. Van Dusen said we have encouraged chronicity of patients. Dr. Spratt agrees. Dr. Peterson believes they may be considered as retired people in a community. Dr. Klatte asks how ATD program would affect these people in Units 5 and 6. Dr. Peterson stated that social workers are lining up patients for Humboldt County and now have a list 12 such patients; one social worker is concentrating on the matter of family care placements.

## AFTERCARE

AFTERCARE serves as a focal point, not only for follow-up work with patients released from the hospital but also for the increasingly wide range of services which the hospital provides within the 13-county area it serves. In both aspects of its program, aftercare serves as a kind of "ad hoc" demonstration project, exploring the future role of the mental hospital as it implements some aspects of the Department of Mental Hygiene's Long Range Plan. Aftercare's role was summarized last August by Dr. Joseph O'Neill, then Chief of Aftercare.

August 1962

The Aftercare facility staff: O'Neill, chief; Isaac, 1/2 time, 1/3 of which is in Santa Rosa; Hayes, 1/4 time San Francisco Bureau; Erickson, Family Care; Handrich, Sukhon; Clerical personnel, 2; 1 adrift.

ADMINISTRATIVE:

Maintain records and handle correspondence and changes in status of ALL patients on leave, family care, or work placement (with exception of charts in Santa Rosa Bureau).

OUTPATIENT CLINIC:

Traditional outpatient department format at hospital, primarily oriented toward ex-hospital patients. Currently, over 50% community patients. Provide psychotherapy, group therapy, play therapy, medication follow-up. (Incidentally, this is the only phase reported to Sacramento.)

COMMUNITY PSYCHIATRY:

Travel and consultation with various agencies and individuals in Northern California, both regarding specific client problems and/or other aspects of mental health services. This includes follow-up of DMH patients living in Northern California

OBJECTIVES:

- (1) Expansion of direct treatment services to include day-night hospital, possibly in conjunction with Mendocino unit. No definite plan at present.
- (2) Consider expansion community consultative services. Currently preparing NIMH grant request.

NEEDS:

- (1) Continued heavy use of transportation and travel expenses.
- (2) Additional clerical staff.
- (3) Modernization of existing facilities.

Since August:

A more detailed report on aftercare, prepared in February, fills in some of the background and general plans of the clinic:

Administrative:

The Aftercare facility continues to maintain administrative responsibility for all patients on Indefinite Leave, Family Care, and Work Placement. Their records are housed in the Aftercare facility, and correspondence regarding them is handled here. In addition, the facility is responsible for change of status, e.g., discharge, return to the hospital, etc.

In this area we have initiated an interesting innovation as a pilot project, that is, the clinical charts for patients serviced by the workers in the Santa Rosa Bureau are sent to the Santa Rosa Bureau office when the patient is placed on Indefinite Leave; the information contained therein is thus immediately available to the bureau worker. This arrangement is feasible, as Doctor Isaac spends one-half day weekly at the Santa Rosa Bureau and is able to handle the administrative matters regarding these patients. Should the patient need rehospitalization, the charts are returned to the hospital with the patient. This project has been in effect approximately seven months, and so far has been working quite smoothly.

Direct Treatment Services To Patients:

Direct treatment services are primarily provided through the outpatient department located in the hospital. This is staffed by one full-time, and two half-time psychiatrists, a full-time social worker, and a full-time psychologist. In addition to the Aftercare staff, other members of the hospital's professional staff provide direct treatment services to patients registered in the outpatient clinic.

In addition to those patients seen at the hospital, Doctor Hayes works for the Aftercare Clinic on a quarter-time basis, seeing patients at the San Francisco Bureau office, though her activities are primarily consultative and evaluative rather than treatment-oriented.

Doctor Isaac, as mentioned, spends half a day weekly at the Santa Rosa Bureau; in addition to his consultative and administrative function, <sup>he</sup> provides some direct treatment service.

Community Consultation and Education:

Over the past eighteen months we have steadily expanded our consultative services offered to Northern California communities. Doctor O'Neill's regular two-day visits to Eureka are primarily devoted to community work. His consultative services are available to, and utilized by, various agencies such as welfare, probation, public health department, etc. In addition, contact is maintained with such groups as mental health societies. Similar services are provided by Doctor Norton in Shasta County where, in addition to activities involving the Department of Mental Hygiene patients,

he consults regularly with the Family Service Agency and is available for consultation with the various community agencies, organizations, and individuals.

During the past seven months we have been able to initiate fairly extensive community psychiatric services in our neighboring Lake County. Doctor Cook is in Lake County two half-days each week, where he functions as a community psychiatric resource, working out of the public health department, providing psychiatric consultation to local agencies, physicians, and organizations. During this time he has also been attending Doctor Hume's course on Community Psychiatry, using his Lake County activities as field experience, and has recently begun attending Doctor Hume's course on Administrative Community Psychiatry.

Mr. Sukhon, the Aftercare Social Worker, has just completed presenting a six-month course in group work with adult probationers to the Humboldt County Probation Department, and is currently presenting the same course to the Mendocino County Probation Department.

Mr. Handrich, Aftercare Psychologist, who is also currently registered in Doctor Hume's course in Administrative Community Psychiatry, spends a half-day weekly at the local community Short-Doyle Clinic. At the completion of his course in administrative psychiatry he intends to attend the course in Research in Community Psychiatry, using the Anderson Valley section of Mendocino County for his field project.

In addition to our efforts in counties other than Mendocino we serve regularly as an evaluative, consultative agency for the local juvenile court and probation department, and have maintained quite close contact with the local mental health clinic, public health nurses, and school nurses.

Note:

On July 1, 1963, Doctor O'Neill became Acting Chief of Professional Education and Chief of Service for Area I. At the same time, Doctor Waldo Cook assumed responsibility for Aftercare. A report on current staffing, plans, and problems will be included in the hospital's annual report in August.

## BUSINESS SERVICES

BUSINESS SERVICES include a great many specialists, all with the difficult and delicate role of maintaining a clinical orientation within the framework of individual professional training, skill, and experience. Accounting, budgeting, carpentry, food preparation and service, laundry, painting, farming, engineering, sewing, and many other skills are involved. In addition to working closely with hundreds of patients, especially those with Industrial Therapy assignments, a distinct clinical orientation is seen in the thinking and planning of Business Services, here reviewed by Mendocino's Hospital Business Administrator, Augustus J. O'Farrell.

THE LONG RANGE PLAN AND THE SHORT TERM PICTURE

August 1962

LONG TERM

Acting upon the long range plan for mental health services in the State of California, Business Services proposes to base its program for the future on the following premises:

- \* that the concept of long term and short term hospital beds for persons with psychiatric disorders may be obsolete; that as long as hospitalization is needed, intensive treatment is implied; that if intensive treatment is not needed, hospitalization may not be necessary; that with the freeing of space, dormitory areas will be converted to treatment and activity areas, and beds will be occupied several times in a year rather than once.
- \* that the development of research programs may mean need for changes in the use to which buildings are put.
- \* that business services and business services personnel must keep pace with training and education in clinical areas.
- \* that hopefully business services will be provided with sufficient funds to enable the staff to keep abreast of new knowledge and findings in their special fields through travel, conferences, study opportunities, and improvement of supervisory processes with emphasis on human relations.
- \* that there will continue to be an obligation to provide an optimum level of patient care; that if the current level is below standard, it should be improved throughout the years ahead, even though significant changes in the manner in which care is given during the next 10 to 15 years are anticipated.
- \* that direct services by the State may gradually give way to community-based programs.
- \* that we may look for an increase in admissions and discharges until the optimal level of efficiency is reached and alternate services are developed to an appreciable extent, and that an absolute reduction in the number of beds for mental patients will accelerate if increased levels of service are obtained and alternate services are available.

SHORT TERM

Business Services takes the position that the State will not abandon its treatment services in the mental hospitals until adequate alternative services can be made available. Business Services proposes the following:

- \* that its focus will be on improving and expanding the present services offered through existing facilities, inpatient and outpatient.
- \* that the focus will be on readiness to change gradually from treatment to other functions.
- \* that it will maintain flexibility of wards and other buildings in order to keep up with changes in approach to treatment.

- \* that construction and maintenance of costly residential buildings will be avoided in the future; that conceivably 50% to 60% of the aged can be housed elsewhere than at the hospital.
- \* that remodeling and renovation of selected facilities will be the goal of our construction appropriations; that the capital outlay program must be adequate to insure replacement, modernization and repair of plant facilities essential to continuance and improvement of the program.
- \* that every employee in business services shall be a member of the treatment team at the hospital and shall be given sufficient training and instruction so that he may function in his job holding the same objectives of those in clinical services.

IMMEDIATE OBJECTIVES

Increase in Operating Expense Funds:

The animated activity of the hospital's new and diversified program of care and treatment, research and training, and mental health education, has resulted in a constantly increasing need for operating expense funds. Business Services has as its goal substantial increases in allotments for office expense, telephone and long distance calls, postage, travel in-state, automobile mileage allowance, personal care, housekeeping, clothing, drugs, ancillary supplies, water treatment, and the establishment for the first time of funds for training and further education of business services supervisors. Of urgent need also are increases in allotments covering medical care, consultant services and rehabilitation therapy.

Staffing Needs:

To improve the level of service provided by Business Services, additional staffing is needed as follows:

- \* Food Service Supervisor Grade 1
- \* Therapeutic Dietitian
- \* Assistant Cooks (3)
- \* Carpenter
- \* Janitor
- \* Window Cleaner
- \* Laundryman (4)
- \* Sanitarian
- \* Supervisory assistance and clerical help for the Trust Office

Equipment:

Equipment is presently allocated to each hospital on the basis of \$18.00 per patient. Strong evidence that this amount is not sufficient is the fact that we are unable to finance necessary replacement items with the amount allowed, much less budget for additional items. This is a serious handicap to our treatment program and to our business services operation. In addition to the routine needs for equipment, we find our treatment program handicapped by the lack of a selective radio paging system for contacting hospital personnel throughout the institution. Of paramount importance, also, is the need for an additional 41-passenger bus for the purpose of taking our patients out into the world again so that they may be stimulated toward greater interest in the outside and greater desire to rejoin the community.

PROBLEMS OF EXPANDING ACTIVITIES

- \* Office space for expanding departments becomes a greater problem every day.
- \* Increasing number of requests for transportation funds for the purpose of obtaining training and education for the job.
- \* Increasing usage of drugs in treatment.
- \* Staffing needs throughout the hospital.
- \* Training needs, staffing and costs of operation.
- \* Unexpected construction, such as the need for handrails on all geriatric units, particularly in hallways and bathrooms.

SPECIFIC CONSTRUCTION NEEDS

- \* Administration Building Annex
- \* Professional and In-Service Training Center
- \* Remodeling and rehabilitating of various buildings
- \* Rehabilitation Therapies Building
- \* Air conditioning throughout the hospital
- \* Multi-purpose treatment facility
- \* Maintenance shops and warehouse building
- \* Remodeling of Building 8 to Research Center
- \* Chapels
- \* Employee housing unit - 40 singles - 5 apartments - 2 residences

MINOR CONSTRUCTION PROGRAM - PATIENT AREAS

Financed:

- \* replace patient toilet facilities Units One and 3
- \* construct yard sun shelters RT-1, RT-A and Unit A
- \* lawn installation west of Fashion Center
- \* construction of closed soiled linen and garbage storage facilities on 7 units
- \* installation of water coolers on Units F, 5, One and RT

1963-64 financing anticipated:

- \* ramp for RT-3 to outside
- \* installation of fire escapes, Unit 6

- \* laundry ventilation to be installed in sorting and pressing rooms
- \* replacement of Bradley wash fountains in Units A, C, 5 and 6

Proposed Construction in line with new concepts of treatment

- \* Convert Unit 7 from 10 single cottages with all services centralized to 4 treatment centers of two cottages each, plus two single treatment centers. Treatment center between each two cottages to consist of treatment room, doctor's office, nursing station, activity room.
- \* To have Unit One made into a coeducational infirmary.
- \* To have Unit B made into a coeducational psychiatric unit based on family style groups.
- \* Construction of activity rooms for O.T. and group meetings on Units Eye and K, Area III.
- \* Improvement in Aftercare facilities.
- \* More wall clocks, calendars, newspapers (Patients' Benefit Fund)

DESIRE TO PARTICIPATE

As a sidelight, our top supervisors in Business Services feel the need to know more of what is going on - a need to be informed - perhaps the monthly activity report fills the void somewhat.

FOOD SERVICE

Problem I - Training of cooks, supervisors and food service assistants

- \* What is being done? - Infrequent lecture series for food service assistants.
- \* Why more is not being accomplished? -
  1. Lack of training personnel.
  2. Lack of time to attend classes on part of employees

Problem II - Upgrading of serving techniques

- \* What is being done? - Little, except continual enforcement of established techniques.
- \* Why more is not being accomplished? - Lack of funds for detergents, aprons, serving tools, dish towels and adequate dinnerware

Problem III - Modernization of equipment

- \* What is being done? - Attempting to keep up with minimum replacement needs.
- \* Why more is not being accomplished? - Funds not available to maintain status quo satisfactorily, much less to make substantial improvements

Problem IV - Development of adequate diet kitchen and diet program

- \* What is being done? - Nothing.
- \* Why more is not being accomplished? - Funds and personnel have not been granted for this program

Problem V - Improvement in food quality

- \* What is being done? - On unit food preparation, close review of food at source of preparation; new developments in menu planning.
- \* Why more is not being accomplished? -
  1. Lack of adequate training personnel
  2. Lack of adequate number of cooks and food service assistants
  3. Lack of suitable equipment

Problem VI - Development of better transportation

- \* What is being done? - Nothing.
- \* Why more is not being accomplished? - Operation would be considerably improved if food transportation would be under Food Service

Efforts for improvement:

Improvements in Food Service operation have followed the line of working with established procedures due to the limitations of manpower and funds. Successful programs have been developed in diet kitchen, main kitchen modernization, and food portion and customer count control.

Present situation:

Most aspects of these programs have been curtailed due to lack of manpower and funds.

T R U S T     O F F I C E

Scope

The Trust Office is charged with the responsibility for locating, administering and preserving the assets of patients who are admitted to the hospital.

This search for assets and assistance to the patient takes many forms: claims for benefits, guardianship, financial counsel, etc.

Problems

- (1) The staff is sadly inadequate to take care of the increasing workload. There has been no increase in staff since 1953. In comparison, witness the tremendous increase in workload and new areas:

- \* changes in the Federal Social Security Act which affect patients
  - \* amendments to the State Unemployment Code
  - \* extension of hospitalization insurance coverage for mental illness
  - \* day care and after care programs
  - \* short term admissions
  - \* county billings
  - \* increase in personal deposit fund receipts and expenditures
- (2) Loss of contact with patients - Gradually, the personal touch is disappearing. Patients frequently leave the hospital before the Trust Office has found time to determine the financial needs of the patient or to participate in rehabilitation planning. Referrals from medical and clinical services have declined in number for at least one-third, due probably to the inability of the Trust Office to provide adequate and timely consultation.

#### The Future

The Trust Office plans for a greater role in the rehabilitation of the patient, at the hospital, in family or aftercare, and on indefinite leave. The Trust Office hopes to continue its role as a member of the Treatment Team.

#### Budget

The Budget Committee of the Department of Mental Hygiene recently approved for inclusion in the 1963-64 budget the request for one position to be added to the Trust Office staff.

### I N D U S T R I A L T H E R A P Y

A major problem to the industries of the hospital is the shortage of patient help. The demands of other therapies and of other phases of the treatment program leave less and less time for the work program of the hospital. In anticipation of this situation becoming more and more difficult for Business Services, the Department has taken steps on a long-term basis to replace patient help with employees.

One example of this development is the 1963-64 request for four additional employees for the hospital laundry. These positions were first requested in 1962-63, using the specific justification of decreasing patient help, but the press of other budget needs forced postponement of the request for another year. It is hoped that the 1963-64 budget request will be granted.

At this slow pace, however, it will be many years before hospital industries will be able to operate without patient help. In the meantime, the critical imbalance between Business Service needs and available patient hours will probably become greater. One ray of hope is that the rapid and sudden shortage of patient help which first appeared several years ago has leveled out so that Business Service adjustment can be more gradual and better planned.

TRAINING NEEDS

Proposed for top supervisory level:

- \* University Extension - at Talmage
- \* Correspondence - University of California - University of Wisconsin
- \* Certificated courses in public administration, medical care administration, general business and business administration
- \* Technical and professional courses for adults
  - Civil Engineering - University of Wisconsin
  - Electrical Engineering " " "
  - Mechanical Engineering " " "

Specific skills

- \* 6 to 8 weeks - summer courses, institutes, such as Hospital Engineering Courses
- \* month-long public administration courses, such as offered at Cornell
- \* Inter-agency management development courses - 5 to 10 days - State Personnel Board
- \* attendance at least once each year at conference of his profession

Rotation assignments

- \* to work side by side with those in similar positions at other hospitals
- \* to work side by side with those in higher positions at this or other hospitals
- \* assignment to central office of the department
- \* assignment as members of departmental committees
- \* field trips to hospitals and other facilities

In-service training and education at local level

- \* attendance at consultant lectures
- \* completion of three-months course in elementary psychiatry
- \* completion of patient relationship program offered by hospital
- \* Business Services group meetings and workshop on patient relationships

Proposed for first line supervisors and non-supervisory personnel:

- \* correspondence courses - University of California, University of Wisconsin, International Correspondence Schools, etc.  
50% participation in fees by State and employee
- \* vocational teacher training at college level to prepare journeyman for teaching positions opening up in vocational work
- \* refresher courses in trade work such as laundry training, American Laundry Corp, etc.

Rotation assignments on limited scale

- \* visiting other hospitals and other agencies for one to five days
- \* conferences with trade groups on matters of mutual interest

In-service training and education on the local level

- \* participation in hospital meetings, workshops; completion of patient-employee relationship course offered by hospital.