Old age - Housing and care

PROGRESS REPORT

on the

"NONPSYCHOTIC SENILE" AND RELATED PROBLEMS

[California. Legislature.

ASSEMBLY INTERIM COMMITTEE ON SOCIAL WELFARE

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[Sacramento?]

March, 1954

P R E F A C E

The Assembly Interim Committee on Social Welfare has approved the release of this brief progress report to provide those who are concerned with the problem of the care and support of the "non-psychotic senile" with a concise statement of:
1. The significant issues raised in the testimony presented at the Committee hearing in Sacramento on January 19-20-21, 1954.
2. A summary of the basic information collected in the preliminary field study.

A complete transcription of the proceedings at the hearing is available in the files of the Committee. This 165 page verbatim report is here condensed as a ready reference for those who are concerned in the development of a sound and economical plan for the care of nonpsychotic seniles. These cases consist primarily of those elderly residents of California who are in need of medical and custodial care but who do not require psychiatric treatment.

The content of the concise report has been checked with the participants to assure accuracy and completeness. Much of this basic material will be included in the printed report to be made on the completion of the Committee project.

Frank Lanterman

Frank Lanterman, Chairman

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The "NONPSYCHOTIC SENILE"
and Related Problems

Scope of the Progress Report

Interpretation of present law as prohibiting the admission of "nonpsychotic seniles" to state mental hospitals precipitated the problems of determining: (1) a sound plan for their care, (2) the location of appropriate facilities, (3) the responsibility of each unit of government concerned with their care and financial support, (4) ways of improving the licensing procedure so that private facilities may be most effectively utilized, and (5) the revision of the Code essential to more precise definition of responsibility and improvement in the commitment process. Certain related problems also require study by the Committee.

Summary Analysis

1. This is a long standing and troublesome problem which requires comprehensive study by a legislative committee.
2. The State Department of Mental Hygiene maintains that "harmless, chronic seniles" cannot be admitted to state mental hospitals under present law.
3. County representatives contend that present law does not prohibit care of nonpsychotic seniles in appropriate state facilities other than mental hospitals.
4. There are thousands of elderly persons who need more than a public assistance grant. The Legislature should make proper legal provision as the basis for a sound plan

for their care and support. The responsibility of the various units of government must be clearly and precisely designated.

5. If counties are to be responsible for the care of these aged persons, state subventions will be needed for the construction and operation of local facilities.

6. Present local public facilities for such cases are overcrowded and in some counties quite inadequate.

7. It is difficult to clearly define the type of aged persons needing care in a mental hospital. The State Department of Mental Hygiene agrees that doubtful cases should be sent to state mental hospitals for a period of observation.

8. Commitment of alleged "mentally ill" persons should be a local responsibility.

9. The present commitment process needs to be so changed that, while safeguarding the individual from deprival of his liberty without due process of law, he shall be treated as an "ill person" and all "criminal-like" action including the use of armed peace officers for notification and transportation should be eliminated except in special cases.

10. The Welfare and Institutions Code needs to be made more precise at several points. A new category should be created to provide legal authorization to "detain and/or restrain" aged persons needing protective custody and supervision.

11. The movement of elderly persons to new surroundings tends to accelerate deterioriation and is fatal in some cases.

They should be kept in their familiar environment with due consideration of the difficulties involved and the possible adverse (mental hygiene) effect on other member of the household.

12. Present licensing arrangement divides the responsibility among three state departments. This results in another type of borderline case and the necessity for moving elderly patients whose changing health condition requires care not now authorized by the "welfare" license. Where proper facilities and staff can be made available the license should make provision for the needed services. This would avoid moving the patient and the making of difficult decisions in borderline cases.

13. The adequacy and relative cost of using privately operated guest and nursing homes, sanitariums, and other community facilities should be studied as an alternative to the construction of additional public institutions. A scale of payments from tax funds should be developed which would take account of both the amount of service needed and provide an incentive for the desirable emphasis on treatment - not just custodial care.

14. Pending federal legislation may have important implications for social welfare planning in California.

15. Preventive medical care and proper nutrition as part of a positive approach which refuses to accept as inevitable a prolonged period of custodial care will do much to reduce the size and cost of the needed program of care for nonpsychotic seniles.

CONCISE REPORT OF THE TESTIMONY
PRESENTED AT THE HEARING IN SACRAMENTO
JANUARY 20-21, 1954

Chairman Lanterman (Assembly Interim Committee on Social Welfare) - read part of H. R. 195 authorizing the study by the Assembly Interim Committee on Social Welfare including the holding of hearings, introduced the members of the Committee, outlined the procedure to be followed, and called for testimony.

Dr. Crawfis (Deputy Director, State Department of Mental Hygiene) - agreed that the "problem of the nonpsychotic senile" study by the Committee was precipitated by a State Department of Mental Hygiene directive dated September 15, 1953 (Exhibit A).

Mr. Nichols (Administrative Advisor, State Department of Mental Hygiene) - reported that because the response to the 1949 request that "nonpsychotic seniles not be sent to state mental hospitals" produced only a temporary reduction, their number in 1953 was in excess of the 1949 total and in the proportion they constituted of all patients. Governor Warren quoted as saying "such cases could be better cared for elsewhere," unsuccessful attempts to make other provisions available through legislation reported, and state facilities are now overcrowded.

The interpretation of the Welfare and Institutions Code as prohibiting the admission of "harmless, chronic seniles" was another factor in the decision of the Department staff, including the hospital superintendents, to refuse admission to deteriorating elderly patients who are not mentally ill. Mimeographed copies of selected Code sections were presented (Exhibit B). Such cases considered to be the responsibility of the counties (when indigent) under Code Section 2500. Care should be provided in County hospitals or in private facilities.

Chairman Lanterman - asked if Code Section 7510 of the Code authorizes the State Department of Mental Hygiene to provide "cottage" facilities for nonpsychotic seniles.

Mr. Nichols - interpreted this Section as referring only to "mentally irresponsible persons" and cited other sections as specifically denying mental hospital care to "harmless, chronic seniles" who are a county responsibility. However the Department does not plan to suddenly or gradually return to the counties those nonpsychotic seniles previously admitted but when they are so improved as to

justify their discharge they will be returned to the community in the same manner as any other type of patient.

Dr. Crawfis - because of the very high death rate for such cases very few of the nonpsychotic seniles now under care would still be in state mental hospitals after five years. The problem of continued care for this type of patient would therefore be solved gradually but within a relatively short period of time if no new cases were to be admitted.

Dr. Crawfis - agreed with Mr. Nichols that present law makes the counties responsible for nonpsychotic seniles but borderline or questionable cases should be admitted to state mental hospitals for a period of observation - if mentally ill (psychotic) they should be retained for treatment, if not psychotic they should be returned to the county responsible for their care.

The Legislature should revise the Code to make more precise the responsibility of the various units of government for care and for sharing in financial support. Facilities should be available in all parts of the state so that in the future Judges will not commit cases to mental hospitals because they have no other resource for their care.

Dr. Crawfis - presented a statistical analysis (Exhibit C) of admissions of aged patients in the period 1949-1953. This showed a drop in the number of such cases during the period of voluntary screening and a decrease in the percentage which aged patients constituted of the total admissions. To this indication of the ineffectiveness of the voluntary screening out of nonpsychotic seniles, other tables were cited to show the change in the average age of admitted patients and the proportion of the California population sixty-five years of age and older admitted in each of the past several years to state mental hospitals.

Referring to the figures on the death rate in the mental hospitals, the fact that the rate is high for senile patients was interpreted as indicating the desirability of caring for such patients in facilities near their homes. Frequency of movement from one facility to another and the necessity for making difficult adjustments to unfamiliar surroundings, where visits of relatives and friends are less convenient, were cited as accelerating deterioration and actually causing death.

Dr. Crawfis - requested to distinguish between aged persons needing mental hospital care and those who do not,

described the latter (the nonpsychotic senile) as suffering from mild memory loss, occasionally disoriented (does not know who he is, where he is, or what time it is), occasional confusion, restlessness, wandering away and possibly getting lost, moderately irritable, untidy and careless in toilet habits, somewhat childish and requiring a nominal degree of supervision but not supervision by psychiatric nurses or technicians. "Another important factor is suspiciousness, but you do not have to be old to become suspicious." The type which needs care in mental hospitals (the psychotic senile) is combative and/or destructive, is resistant and will not cooperate, suspicious to the point of being deluded, having false beliefs and out of contact with his surroundings and environment. The individual that is constantly noisy and excited, irritable to the point of actually attacking other individuals. Sexual deviation is not infrequent among male seniles and, when children are involved, hospitalization is indicated. Mild depression from becoming helpless does not merit admission to a mental hospital unless suicidal tendencies appear. Individuals who require continuous supervision by psychiatric technicians or nurses, who are markedly delirious and agitated, obviously should be in mental hospitals.

Dr. Crawfis - borderline cases should be admitted to state mental hospitals for observation periods of at least fifteen days, probably closer to thirty days, to determine whether or not they are psychotic. If they are found to need only medical, and not psychiatric, attention they should be returned to the counties for this service. The State Department of Mental Hygiene is glad to help local authorities make diagnoses and to improve their screening process but there will be a considerable number of cases where a period of observation will be needed.

Mr. Nichols and Dr. Crawfis - agreed that, while their Department is willing to cooperate with local physicians, the screening decision should be the responsibility of local authorities. The mental hospital staff will make the decisions regarding return to the community after periods of observation and in the matter of discharge because of improvement through treatment.

Psychiatric services available to judges in all counties would make for more effective screening, prompt diagnosis would reduce the number of times patients must be moved and facilitate treatment, and adequate resources in each county would result in fewer cases being sent to

mental hospitals. However, there inevitably will be cases which should be admitted to mental hospitals for observation and a considerable number of elderly patients who will need prolonged care and psychiatric treatment for serious mental illness.

Dr. Crawfis - court commitment involves both a legal and a medical decision so that clearer delineation and specific assignment of responsibility to units of government for the care and financial support of the several types of cases undoubtedly will require making Welfare and Institutions Code provisions more precise.

Chairman Lanterman - announced the appointment of a Subcommittee on Code Revision: L. Lyon, Chairman; Kelly, Kilpatrick, Masterson and Patterson.

Mr. Nichols - the State Department of Mental Hygiene receives payments from patients, their relatives, and from counties. About $4,000,000 is collected annually just from private sources. The maximum rate is now $111 a month and private sources pay according to their ability up to this amount. The counties pay $20 a month for certain types of cases.

Dr. Crawfis - per capita costs average about $100 a month but seniles require much nursing care and therefore cost more than the average patient. The same quality of medical and nursing care would cost about the same in state or county institutions but the profit factor would enter the situation when care is provided by private facilities. "It is a case of deciding who is responsible, who provides the care, who pays for it, and within reasonable limits of cost what is best for the patient."

Mr. Siegel (Associate Counsel, County Supervisors Association) - counties appreciate the Legislature's comprehensive review, for the first time, of the troublesome field of the care of the seniles.

Mr. McClellan (Chairman, Health and Hospital Committee, County Supervisors Association) - the Health and Hospital Committee of the County Supervisors Association has been deeply involved in this problem for several years. It is a big problem and should be carefully studied. Many smaller counties lack facilities, the Code provisions are not clear, the number of cases is continually increasing, the type of care needed is expensive, the counties have a limited tax base and state aid is undoubtedly needed to provide the recommended care at the local level. Both public and

private facilities will be needed. The State would be expected to set minimum standards but would have to help the counties with subsidies for both construction and operation of facilities. Present county facilities are overcrowded as many counties are now taking care of their nonpsychotic seniles.

Mr. Barr (Superintendent of Charities, Los Angeles County) -- representing the Chief Administrative Officer of Los Angeles County, pointed to the existing confusion regarding responsibility for mentally ill persons. Stated his position that "all mentally ill persons regardless of the degree of mental illness are the responsibility of the State."

Los Angeles County is now caring for some 2200 cases under court commitment to the Mental Health Counselor at a cost to the County of $1,200,000 a year. Another 600 court committed cases are cared for in county operated facilities at a daily per capita cost of about $5.00 as compared with the average monthly payment of $135 for the 2200 cared for in private facilities on a contract basis.

While these patients admittedly should not be in state mental hospitals, they are medically and legally declared to be mentally ill and the State Department of Mental Hygiene in licensing the private facilities for their care admits this mental illness. "All such cases should be the financial responsibility of the State." This position is based "on our County Counsel's interpretation of existing case law and statutory law in the State of California". While the Code Section 5102 prohibits the admission of "harmless, chronic seniles" to state mental hospitals, the Code does not say "that the State shall not have other facilities for persons with a lesser degree of mental illness, including the use of privately operated facilities, perhaps on a contract basis".

Mr. Nichols - took exception to the Los Angeles position and indicated that it is the position of his Department that the term "nonpsychotic" implies there is no mental illness for which care in state mental hospitals is legally authorized although other types of patients "without psychosis" such as alcoholics, narcotic addicts and sexual psychopaths, are admitted by specific legal mandate.

Dr. Sox (Director of Public Health, City and County of San Francisco) - San Francisco City and County operates Laguna Honda Home with 2000 beds including 900 hospital beds, of which 200 are for varying degrees of mental illness. The cost of operating the hospital beds is about $155 a

month which should be increased to $185. The "locked units" for the mentally ill probably cost about 10% more than the open wards. (These patients are under restraint as hospital cases but are not court committed). These facilities, now over-crowded, apparently face increased demands for admission. Because San Francisco has carried an ever increasing load in the past does not mean that it can continue without state subsidy because of the limits to the local tax base. Also, as a densely populated area with apartments constituting a large proportion of the dwellings, care of such patients in their homes is more difficult and may, in consequence, produce more rapid deterioration and make other members of the household more likely to become mentally ill. If such cases are removed from their homes it should be no more traumatic if they were sent to a state institution than to county-operated facilities. Questioned value of convenience for visits by relatives and friends as they can be disturbing as well as helpful.

Dr. Farrell (Medical Director, Sacramento County Hospital) - agreed that it is the act of moving to a new environment and not the distance moved that is therapeutically important, and that having visitors can produce undesirable effects on the patient. It is not clear whether the courts can commit persons to Sacramento County Hospital but, not having a psychiatric unit as yet, some difficulty is being experienced retaining patients who wander away.

Present legal provisions for commitment are cruel and should be changed and provision made to authorize protective supervision for cases not admitted to mental hospitals. Even those that are admitted are now "treated as though they were criminals". They should, from a physician's point of view, "be classified as sick people".

Dr. Staley (Director of Health Services, Sonoma County) - speaking as a physician (not as a psychiatrist) experienced in medical administration, also agreed that it is not the distance moved or the unit of government which operates the institution but the need to adjust to new surroundings that may be harmful to the patient. Few such patients have visitors and when they do it often upsets them and also disturbs other patients who have no visitors because they have apparently been abandoned by their relatives.

The serious problem is how to detain ambulatory patients who sometimes endanger themselves by running away, and to restrain those who annoy other patients. Many patients lack self control and misbehave. When not committed by the courts they constitute a difficult management and supervisory

problem under present legal provisions.

Mr. Siegel - urged that the Committee make a comprehensive study of this difficult and long standing problem and develop an adequate solution. The field of mental hygiene is confused as to the responsibility of the several levels of government and county supervisors cannot do long range planning until the Legislature sets a clear policy. Present State facilities are inadequate for mentally deficient persons who also present problems to the counties regarding care and support. The question of subventing funds from the counties to the state as well as the state making subventions to the counties should be considered. Legal provisions regarding commitment also need clarification. There is considerable variation among the counties in operating policy as well as in available facilities and financial resources. It is desirable for the Committee to give serious consideration to related problems in addition to the specific problem of the non-psychotic senile.

Dr. Breslow (Chief, Bureau of Chronic Diseases, State Department of Public Health) - pointed out the relationship between the incidence of cases plus the rate of deterioration among aged persons and the quality of medical care available in earlier periods of life. Prompt diagnosis and treatment of certain diseases would reduce the number of aged with cerebral arteriorsclerosis. Improper nutrition is a factor in senile deterioration. Good medical care will reduce the number of seniles.

Mr. Cumming (Chief, Bureau of Hospitals, State Department of Public Health) - the whole matter of hospitalization, both public and private, presents a lot of problems in California. There are about 85,000 hospital beds of all types excluding veterans and other federal hospitals. The State has more than thirty thousand devoted to mental treatment and the counties are spending around ninety or a hundred million dollars for this care. Since last July the State Department of Public Health has been responsible for licensing county hospitals which are now legally on a par with the private hospitals where licensure standards have existed since 1946.

In addition the Department of Public Health licenses private nursing homes of which there are about 500 with an approximate total of 9000 beds. These nursing homes are legally defined as hospitals. The State Department of Mental Hygiene licenses nursing homes and sanitariums which serve persons with mental health problems. A third

State department, Social Welfare, licenses homes for children and aged persons. The three state departments have coordinated their licensure programs but there are cases which present difficult jurisdictional problems at the local level. Such marginal cases would probably include a considerable number of nonpsychotic seniles.

Chairman Lanterman - announced the appointment of a subcommittee on Licensing Procedures: Klocksiem, Chairman; Donahoe, and Elliott.

Mr. Cumming - the cost per day for a patient in an acute private hospital bed amounts to $25 or $30 which would rule out their use for the long time care of nonpsychotic seniles; county hospitals in all parts of the state are usually occupied at nearly one hundred percent of capacity and facilities assigned to the care of chronic and custodial cases are overcrowded. It would seem important to study the extent to which private facilities, both large and small, can be utilized for nonpsychotic seniles and thus take some of the pressure off of the hospitals and other public institutions. Emphasis should be placed, in connection with the licensing procedures, on the development of a treatment program in all types of facilities.

Dr. Rapaport (Director, State Department of Mental Hygiene) - with advancing age most persons show some signs of deterioration, both physically and mentally, and may need assistance from an agency of government. Historically, the Department of Mental Hygiene has been primarily concerned with the care of the mentally ill and more recently has added such functions as the care of alcoholics, narcotic addicts, delinquent sexual psychopaths, and a few others. However, to the best of my knowledge in no state have the mental hospitals taken on the responsibility for the aged as such. Admission should be limited to those older persons who require psychiatric care. "Commitment" is based on the presence of mental illness of such a character and degree as requires care and treatment in such a state hospital or private psychiatric hospital.

"We feel that under present laws, the state mental hospitals of California are prohibited from taking on the problem of the aged but should only be concerned with the aged who are 'destructive, combative, so noisy that they are unable to get along in the ordinary home, nursing home or hospital'. And then only until such time as they quiet down, when they should be returned to the community. We feel that the problem of the aged is primarily a medical problem, and a social problem, but not a psychiatric problem."

There is a borderline type of case and it is difficult to be conclusive about the distinction between the normal and the abnormal. Such decisions must be made by specialists and, whenever the judicial decision to commit or not to commit is questionable, we recommend sending the person to the mental hospital for a period of observation. The Subcommittee on Code Revision can make a constructive contribution in making code provisions more precise, but there will probably be questionable cases where admission for observation will be the better answer.

There should be continued participation of the judiciary in the commitment process but the judges should be advised by a panel including psychologists and social workers as well as physicians, who preferably should be psychiatrists.

There are some 2500 to 3000 nonpsychotic seniles now in our state mental hospitals. Some have been sent there because the counties had no local resources for their care. Appropriate local facilities should be developed and cases should be locally screened but questionable borderline cases should be sent to the state mental hospital for an observation period and diagnostic decision.

The right of the individual to his freedom must be safeguarded but cases of "railroading" persons into state mental hospitals are very rare (one case in thirty years of experience).

The commitment process should be studied from the point of view of the health of the person, not just to avoid depriving him of his freedom without due process of law. The question of competency to handle his affairs should be separate from commitment in order to provide treatment for mental illness.

In cases of mentally ill ex-service men, the Veterans Administration decides whether they go to federal facilities or to a state mental hospital. Under the law, if the illness is established by the Veterans Administration as service connected and there is a bed available, the court may make a direct commitment to a federal facility. Otherwise, the veteran is committed directly to a state mental hospital. Here his rights are protected, forms are completed, and benefits obtained. When service connection of mental illness is established, he is transferred upon notification that a bed is available in a facility of the Veteran's Administration, which pays the State for his care from the time of admission for pre-established service connected cases or from the time of establishment after admission. There are presently about 3000 veterans in state mental hospitals and an equal number in federal hospitals in California. Additional federal

facilities are planned as the number now available is not sufficient even for the service connected cases who comprise about ten percent of all veterans in state facilities.

Many of the mentally ill aged respond to treatment, which includes occupational therapy and other activity programs in addition to the medical and psychiatric treatment, and can be safely returned to the community. At a certain stage in treatment return to their relatives and friends is most desirable. Aged patients often make good adjustments in the community and some are able to work again and become self-supporting.

It will be the policy of the State Department of Mental Hygiene to refuse admission to harmless chronic seniles unless the law is changed. Those now in state mental hospitals will only be returned (on the same basis as other types of patients) because they have "improved" to the point where return to the community is possible and desirable for the health of the patient.

Local provision must be made for taking care of those without homes to go to though some cases might be sent, as a part of treatment, to the family-care homes which are part of the hospital program. Those who are not so mentally ill as to need care in a mental hospital or who have so improved as to permit return to their communities, are a local responsibility. Whether they can get along as recipients of Old Age Security grants or need general hospital, nursing, or guest home services, the care they need should be provided at the local level.

Mr. Schottland (Director, State Department of Social Welfare) - most of the more than one million persons in California sixty-five years of age or older live in their own homes or with relatives or friends. Some 271,000 are recipients of public assistance through welfare departments. A relatively small group of aged persons are in facilities operated or licensed by the Department of Mental Hygiene, or in county hospitals for more than two months, and are thus not eligible. A state subvention of $35.20 per patient month is made to the counties for the care of former Old Age Security recipients under care for more than two months. The federal government does not share in the $35.20 subvention but does contribute $35.00, to which the county adds $6.43 and the state $38.57 making up the $80.00 OAS grant. Since 1950 the federal share is available for the first two months of hospital care and would be made for the entire period of health care if California took legislative action such as was proposed in A.B. 2692-Lanterman. This bill was presented, but not passed, in the 1953 session.

The Department of Social Welfare is not directly concerned with whether a person is senile. It is primarily concerned with whether a person has reached the age of 65 and where he is. The federal policy, excluding financial participation in care of persons in certain categories or who receive care in certain types of facilities, may be modified soon and this would have implications for the Committee and its recommendations for legislation in 1955. "We are conscious of the tremendous loss of federal funds for nonpsychotic senile care and are hoping to convince them that this is not the type of mental illness now specifically excluded. There is currently no federal sharing in cases otherwise eligible but who are in state mental hospitals or private facilities licensed by the Department of Mental Hygiene."

The situation is different with regard to payments through Old Age and Survivors Insurance. These continue without regard to medical or psychiatric diagnosis or type of institution in which they may be receiving care.

Mr. Nichols - Income from OASI beyond the $500 placed in a patient's personal account for incidental expenditures and ultimate burial expense may be used to pay hospital charges.

Mr. Schottland - two bills affecting public assistance in California recently have been introduced in Congress. The first (HR 7199 - Reed) provides:

1. Increased OASI coverage to include an additional ten and one-half million persons.
2. More liberal arrangements for working and earning.
3. Easier extension of OASI to government employees without abolishing present retirement systems.
4. A raise in the wage base from $3600 to $4200.
5. Increased benefits with higher minimum and maximum payments.
6. Retention of present financing provisions which means gradually increasing the payroll tax.
7. Vocational rehabilitation services to aid in self-support and freezing rights of the disabled by changing the time periods used in figuring the average wage that determines the amount of benefits.

If these legislative proposals are enacted, California will benefit through having a larger number of assistance recipients with resources and through an increase in the amount of the resources which must be supplemented.

In contrast, the other legislation (HR 7200) may result in a financial hardship to California. This bill changes

the basis for federal contributions which is now largely determined by the number of recipients and the amount of the payments made. A new principle has been suggested which would use the average per capita income of all residents in determining the proportion of federal sharing in public assistance costs. Thus, the wealthier states would get less from the federal government and the less wealthy states would get more. California is one of the wealthier states.

The present formula is complicated but the new factor makes it even more so because of the weighting factors which are introduced. The situation in Washington is being watched with care and steps have been taken to estimate the effect on California of this new legislation. As soon as the estimates have been completed and additional information obtained from Washington, this Committee will be informed along with other state officials concerned. California has an important stake in the situation and it may be that, prior to the 1955 session, you may be called on to consider legislation essential to supplementing the federal enactments.

EXERPTS FROM EXHIBITS
presented by the
State Department of Mental Hygiene

Exhibit A - "COMMITMENT OF SENILE PATIENTS TO STATE MENTAL HOSPITALS" - September 15, 1953.

. . . we should like to call to your attention the problem of the commitment to our state mental hospitals of the many aged persons who are merely suffering from the infirmities of old age. . . . very often not mentally ill, they should be cared for in their homes or in some private or public facility in their communities. Their mental condition is such that they do not need care or treatment in a state mental hospital . . . (quotes Section 5102 specifically prohibiting admission of persons with "harmless chronic mental unsoundness" to state mental hospitals, and Section 6733 of the Code which provides that such patients "shall be discharged" and "returned to the county from which they were committed)
Therefore . . . the Department . . . will discharge all newly admitted . . . court committed cases, health officer application and voluntary admissions . . . who are found to be not mentally ill but are merely affected with harmless chronic mental unsoundness. (Describes the procedure to be followed in making such discharges and lists the persons to whom the memorandum is sent)

Exhibit B - "STATUTES RELATING TO HARMLESS SENILES" - July 23, 1953

Mimeographed copy of Sections 200, 202, 2500, 5102, and 6733 of the Welfare and Institutions Code, and Section 212 of the Health and Safety Code. (Cited as legal basis for admission policy regarding nonpsychotic seniles)

Exhibit C - "ANNUAL ADMISSIONS OF AGED PATIENTS TO CALIFORNIA STATE HOSPITALS FOR THE MENTALLY ILL - July 23, 1953

The proportion of elderly patients in the total number of first admissions to state mental hospitals . . . comprising 22.7% in 1949 . . . dropped to 15.5 in 1950 when the Department undertook to encourage the care of harmless seniles at the county level . . . gradually increased during ensuing years to 20.6% in 1952-53 - probably because county facilities are now overcrowded . . .
Table I - Age Distribution of Admissions 1949-1953
Table V - First Admissions by County of Residence - Total and Rate per 100,000 Population by Age Group and Legal Classification

Table VI - Estimates of Release Rates in Four Year Period Following Admission

Exhibit D -"THE RATE OF ADMISSION OF ELDERLY PATIENTS TO CALIFORNIA STATE MENTAL HOSPITALS" - August 19, 1953

. . . From one-third to one-half of these admissions are harmless seniles requiring only simple nursing care, and their hospitalization leads to the diversion of personnel and facilities from the care and treatment of the seriously mentally ill.
Table I shows that patients aged 70 and over constituted 17.5% of total first admissions in 1949 in California, 25.5% in New York and 19.3% average for all states.
In 1950 the California figure was 10.8% compared with 25.8% in New York, in 1951 California 13.4% and New York 27.0%, and in 1952 California 13.8%.
Table II shows that patients aged 65 and older comprised 163.1 per 100,000 general population of that age in California and 416.9 in New York. The National average was 209.3 per 100,000 of the same age group.
Table III shows the ratio of patients 65 and over to the general population of the same age in California was 254.0 in 1949, 165.7 in 1950, 188.2 in 1951, 193.2 in 1952, and 247.5 per 100,000 in 1953.

Exhibit E - STATE-COUNTY RESPONSIBILITY FOR THE MENTALLY ILL - exerpt from pages 123 and 124 of "The Mental Health Programs of the Forty-Eight States," a report of the Council of State Governments published in 1950.

Approximately one-fourth of the states reported that they received reimbursement from local governments for the care of patients in state hospitals for the mentally ill in 1949, such payments usually coming from the government of the county where the patient has had legal residence. In some of these states the amount received was negligible, and in only a few states was the amount a substantial proportion of total maintenance expenditures of the hospitals. . . . Iowa received 92% of operating cost from counties . . . New Jersey 38% . . . Maryland 18% . . . Connecticut, Michigan, West Virginia and Wisconsin received sizable sums . . . the proportion ranging from 7.5% to 10%. . . . of the above-mentioned states Iowa, Michigan, New Jersey and Wisconsin also provide state aid for county mental hospitals.

Exhibit F - "ANALYSIS OF DEATHS AT METROPOLITAN STATE HOSPITAL IN FISCAL YEAR 1952-53 - November 6, 1953

Of the 44 patients who died within one month after admission 29 were over the age of 60 as were 68 of the 78 who died in the first year.

Brief Report on

PRELIMINARY FIELD STUDY

The problem of the "nonpsychotic senile" is not new. It has been discussed and recommendations made toward a solution by three Governor's Conferences in the past five years. As a matter of serious concern to the State Department of Mental Hygiene, past efforts have been made to persuade referring agencies to discontinue sending to state mental hospitals those elderly persons who need care but not psychiatric treatment. Since this resulted in only a temporary reduction in the number of such admissions, the Department issued notice that, after October 1, 1953, all newly admitted "harmless, chronic seniles" would be returned to the counties for appropriate care - medical rather than psychiatric - in accordance with their interpretation of pertinent sections of the Codes. The situation thus created requires legislative attention and the Assembly Interim Committee on Social Welfare decided to make such a study as a major project.

Preliminary field investigation has involved conferences, at several staff levels, with key persons from three state departments; directors of welfare, executives of institutional facilities, and supervisors in sixteen counties of varying sizes but including more than eighty per cent of the population of the State; psychiatrists in private practice and social workers in private agencies. Some information has been obtained on the situation in other states and arrangements are being made to utilize the findings of several research projects now under way on this and related problems.

The following brief statement of some of the basic information that has been gathered to date was presented in part to the Committee at its executive meeting preceding the hearing held at Sacramento in January, 1954.

1. It is estimated that on January 1, 1954 there were approximately one million residents of California who were sixty-five years of age or older. About one-half of this group were economically independent and able to care for themselves. More than one-fourth of the total were receiving public assistance grants. Although seven out of eight recipients were able to care for themselves, a sampling analysis of their health condition reveals that 2.3% of the total recipients were bedridden, 8.1% required considerable care from others because of physical health conditions, and 1.8% needed care because of mental conditions. From this group of more than thirty thousand come most of the so-called "nonpsychotic seniles"

2. Changing culture patterns result in a large proportion of those aged who are unable to care for themselves receiving care outside of their own or relatives' homes. These services range from boarding or guest homes licensed by the State Department of Social Welfare which care for several thousand OAS recipients and benevolent or fraternal institutions with some 3000 recipients, through the nursing homes and sanitariums licensed by the State Department of Public Health where more than five thousand receive care, to the nursing homes and sanitariums licensed by the State Department of Mental Hygiene and the state mental hospitals. Patients in the latter facilities are not receiving old age assistance grants but it is estimated that about half of the aged thus cared for would be eligible if they were in other than psychiatric facilities.

3. County hospital geriatric facilities in 1952-53 included 5,741 beds for chronic cases and 3,639 for custodial care. About three-fourths of the 1,262 beds for mental cases are occupied by elderly patients.

4. Some counties, especially Fresno and Kern, make extensive use of private facilities to relieve the hospital facilities for more acute cases. Three of the larger counties have auxiliary facilities including "locked" or "closed" units for patients with mental conditions:

County	Open	Closed	Total
Los Angeles	1400	600	2000
San Francisco	1600	200	1800
San Diego	358	124	482

Los Angeles County also has more than 2200 court committee cases placed in private facilities on a contract basis.

5. California counties vary in wealth, vision, and the proportion which the aged constitute of the total population with a consequent difference in the extent of facilities needed for the care of "nonpsychotic" aged persons. In the thirty counties supervised by the Sacramento Area Office of the State Department of Social Welfare, 17 have no facilities licensed by the Department of Public Health and 26 no facilities licensed by the Department of Mental Hygiene. In each of the thirty counties there is either a county hospital, or access to a district hospital, with ward or auxiliary facilities for chronic and custodial care. It is reported that these facilities vary in adequacy and in the quality of services. There is apparently a need to make an evaluative study of the resources in each county.

6. On the basis of information now available there is considerable difference in cost of operating public facilities and in the charges for the care of public assistance recipients in private facilities. Daily per patient costs in

the auxiliary facilities maintained by the three larger counties averages about $5.00. This makes about $150 a month as compared with the monthly per patient cost in state mental hospitals of $90 to $111. While nonpsychotic senile patients are said to cost more than the average patient in state mental hospitals, it is obvious that the taxpayer would only gain by keeping nonpsychotic seniles out of state mental hospitals through making the beds available to more acute mental cases and thus avoid the necessity for building more state hospitals.

Charges for court committed cases in Los Angeles private facilities average $135 a month - the range is from $80 to $150, with the rate for each patient decided by a county physician and subject to change with variation in the amount and type of care needed. A similar scale should be developed for all private facilities caring for persons paid for from tax funds. Such a scale should take account of the quality of the services provided and include a monetary incentive for the development of a treatment program. Charges are reported as varying from county to county and within counties. They range from $50 to more than $200 a month for public assistance recipients who are often taken at a lower rate than private patients for whom as much as $500 a month is sometimes charged.

Frequently the charge for a guest or patient who needs but little care is the $80 received as an OAS grant but in such cases with relatives who can pay the rate may be higher. As the elderly guest or patient deteriorates and requires more care, especially for increasing incontinence, the rate goes up and the county often has to supplement from general assistance funds. Some counties, not yet authorized to make such supplementary payments, are having difficulty in finding facilities. At the other extreme, one county is spending one-fourth of its general assistance funds for this purpose.

7. Apparently no one yet knows exactly how many nonpsychotic seniles there are in California. It is essential in making a sound and economical plan for the care of such cases that their number and whereabouts be determined. As an alternative to expensive construction of additional public institutions, the extent to which private facilities are, or can be made, available will receive further study. Three subcommittees will include in their assignment the determination of ways to extend and improve this potential resource through (1) revision of Code provisions, (2) improvement of the licensing procedures, and (3) education of personnel in gerontology and geriatrics. Unless preventive measures are taken the problem of caring for nonpsychotic seniles will increase in size as the ever growing California population includes a larger proportion of aged residents. Careful study is also needed to demonstrate the economy of a positive approach in which the amount of care needed may be reduced by proper treatment.