DOCUMENT RESUME

ED 043 749 VT 011 700

TITLE	Major Psycho-Social Problems and the Psychiatric Technician.
INSTITUTION	California Society of Psychiatric Technicians, Sacramento.; National Association of Psychiatric Technology, Sacramento, Calif.
PUB DATE	Jun 70
NOTE	141p.; Presentation made at the Joint Annual NAPT-CSPT Convention-Institute (Los Angeles, Oct. 3-5, 1969)
AVAILABLE FROM	National Association of Psychiatric Technology, 11th and L Building, Main Floor, Sacramento, California 95814 ($2.25)
EDRS PRICE	EDRS Price MF-$0.75 HC-$7.15
DESCRIPTORS	Alcoholism, Crisis Therapy, Drug Abuse, *Health Occupations, *Institutes (Training Programs), Job Analysis, Job Development, Manpower Needs, Mental Retardation, *Psychiatric Aides, Speeches, *Subprofessionals, *Workshops
IDENTIFIERS	National Association Of Psychiatric Technology, *Psychosocial Problems

ABSTRACT

Presentations made at institutes and workshops conducted by the National Association of Psychiatric Technology (NAPT) are included in this publication. Drug abuse, alcoholism, crisis intervention, mental retardation, and mental health manpower were the themes for these presentations: (1) "Mental Health Trends in California" by G. Duffy, (2) "The Drug Epidemic of 1969" by J. T. Ungerleider, (3) "The Treatment and Prevention of Abuse of Alcohol, Narcotics, LSD, and Other Drugs" by J. Fort, (4) "Comprehensive Planning for Alcoholism Programs" by N. Khoury, (5) "Treatment and Management of Alcoholics" by K. S. Ditman, (6) "Suicide and Crisis Intervention: Concepts and Practice" by S. M. Heilig, (7) "A Planning Model for the Development of Comprehensive Service for the Mentally Retarded" by I. Mooring, (8) "The North Carolina Department of Mental Health Career Ladder: A Concept and an Activity" by J. L. Moncrief, and (9) "The Application of Sensitivity Training Techniques" by U. Rueveni. Information about the NAPT and other NAPT publications is included. (SB)

MAJOR PSYCHO-SOCIAL PROBLEMS and the PSYCHIATRIC TECHNICIAN.

Presentations made at the
Joint Annual NAPT-CSPT
Convention-Institute in
Los Angeles, California
October 3-5, 1969

Publication of
NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY
and the
CALIFORNIA SOCIETY OF PSYCHIATRIC TECHNICIANS
SACRAMENTO, CALIFORNIA
JUNE, 1970

CONTENTS

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PREFACE

This is the fourth special publication by the National Association of Psychiatric Technology of the presentations made at its institutes and workshops. We offer it to the public to help satisfy the need to know more about the general and special areas of ever broadening and intensifying action on the mental health scene. Certainly the theme, major psycho-social problems and the psychiatric technician, is intended to emphasize the urgency not merely for more action but for more effective action to treat the human casualties that are conveniently labeled alcoholics, drug abusers, mentally retarded and suicidals.

It is evident that there is no single specific solution for any of these major problems. They call for simultaneous action on all fronts: research, education, training, legislation, programming and utilization of as wide a range of people as possible. Above all the size and stubborness of the problems compel new approaches applied in massive, judicious doses. It is natural that innovations should not always receive immediate, spontaneous and unanimous acceptance. However, it is hoped that adherence to the old ways for the sake of "stability" will not degenerate into inertia, inactivity, irrelevance and incompetence.

It is our belief that one of the most promising avenues for meeting the needs of our communities in caring for our emotionally disturbed and mentally retarded is the middle-level professional in mental health. It is only by developing a core of people who can work in a variety of mental health settings that we can expect a steady flow of consistently competent service in all areas of service. This is the theme that is recurringly heard: the need for continuum of care based upon the special needs of individuals not merely on the needs of institutions. It is the middle-level professional working directly with the troubled or impaired individual who is in the best position not only to assess the needs of the individual but also to help him express and satisfy these needs.

We hope that this publication will help express what others are trying to do in these major problem areas. Many of the presentations are by professionals in the Los Angeles area. This is not by accident. The Los Angeles area has been a rich proving ground for exploration and experimentation with new approaches in health and mental health systems and concepts. It has developed programs which often became the forerunners of similar programs adopted by and for the State of California. We hope our efforts can contribute to the exchange of such ideas and in the further development of the psychiatric technician and other middle-level mental health workers in implementing them.

William L. Grimm
Executive Director
NAPT and CSPT

INTRODUCTION

Typical of our times is the waning credibility for any single individual or group that sets itself up as the specialist in solving the varied problems of our society. The problems run together; the base that spawned them is as complex and wide as the activities of man himself. There is no single view of the nature of the problem, nor of its causes and resolution. Sides are taken, each with its most vocal exponents, and the adherents are emotionally and often fanatically and exclusively dedicated to a particular view. In the meantime the sick become sicker, the alienated become outlaws and the deprived become outcasts.

Those closest to the problems agree that our major psycho-social problems, such as alcoholism, drug abuse, delinquency, social violence of all kinds, mental disabilities and retardation are complex and multi-faceted problems which must be treated on a variety of levels. They indicate the need to emphasize the active, voluntary participation of the troubled people and the community at large. The resolution of these psycho-social dilemmas becomes the responsibility of the community. They are conditions which affect all of us either as parents, clients, dependents, taxpayers or as concerned citizens who seek a better way of life for ourselves and our neighbors.

DRUG ABUSE

Of the four major psycho-social problems discussed in this book, certainly drug abuse has been given the most publicity nationally and has proven to be the most heat-engendering public issue. In California it has been stated that drug abuse has reached epidemic proportions and that it may soon become its most serious public health problem. Many feel that instead of supporting community action in drug education and treatment, the state has developed a fixation on study and rhetoric -- and an attitude that law enforcement alone will solve the drug problem. They emphasize the need for honest sophisticated drug education which involves the population-at-risk, making them part of the solution rather than part of the problem.

Typical of the type of drug abuse education programs that are educational rather than propaganda is Project D.A.R.E. (Drug Abuse and Education). This is a volunteer program for youth which was

founded by Dr. J. Thomas Ungerleider, one of our institute speakers whose paper appears in this publication. The program enlists the volunteer work of college and teen-age participants in a variety of projects intended to warn of the dangers of drug abuse. These youthful participants formed an anti-drug "rock" band. They acted in and produced a film about drugs (BEYOND LSD). It is significant of their appeal to young people that these D.A.R.E. teen-agers appear as role models of active, participating non- "drop-outs", and non-users of drugs. They are active in all the youth cult activities: rock music, psychedelic art, hippy dress and the trimmings, but they preach non-drug "turn-on".

D.A.R.E. urges its clientele to become "involved with life" but not with drugs. Project members also try to help parents and their children bridge the communication gap of understanding.

The goals of D.A.R.E. are to help the community mobilize its efforts toward prevention of adolescent drug abuse by admitting that a chronic drug problem does exist among youth. It attempts to openly communicate the problem with the involved youth without creating hysteria on the part of youth or parents, or "putting down" young people who have such a problem.

In contrast to preventive programs like D.A.R.E. there are treatment programs for drug abusers patterned after Synanon and the Mendocino program.

Synanon consists of ex-users who have decided to abstain and to join together in a cooperative living situation defined along the lines of a family. They live together, work together, develop rules for interacting and treating the novitiate. The main rules are no drugs, no violence and no secrets or lack of honest communications. Many "family" groups utilize a complex technique of encounter games to handle interpersonal hostility and aggression. Through such group encounters and therapeutic processes, the patient can immediately become involved in the therapeutic process and become part of the solution rather than simply part of the problem.

The Mendocino treatment program originated at Mendocino State Hospital in Northern California. It has also been adapted by Napa State

Hospital. This treatment approach involves the broad concept of a therapeutic community, one which is totally voluntary with professional staffing and maximum patient participation. It utilizes to a large extent the psychiatric technicians to work intimately with the residents. Peer group pressure is enlisted to help all members stay off drugs and to alter drug-oriented values. The family, like similar community approaches, is a twenty-four-hour-a-day living experience.

The family itself is based upon graduated steps of responsibilities, duties and rewards. Therapy is administered by the residents themselves to their own group rather than having a therapist "do it" to them. The *Game* patterned after the Synanon model, moves each member into a vigorous, gut-level encounter with others where his self concepts and values will be challenged.

The concepts of Synanon and the Mendocino program are carried over to large city programs such as that of the Haight-Ashbury Free Clinic in San Francisco. The clinic is divided into a medical, a psychiatric, and a drug treatment section.

Emphasis at the Clinic is not so much on resolution of pre-existing psychological conflicts in the drug abuser but rather on facilitating his creative potential and helping him project a new self-image into the future. To achieve these objectives, the drug treatment program has basically the same therapeutic tools developed in Mendocino, e.g. outpatient group therapy, sensitivity groups and encounter groups.

Nothing better illustrates national recognition of the drug abuse problem than President Nixon's designation of a week in May 1970 as Drug Abuse Prevention Week. He called on government officials, academic leaders, business, labor, professional and civic groups, the communication media, clergymen, and all those involved with youth to join in establishing information and education programs to prevent drug abuse among young people.

With the emphasis on drug information and education it should be cautioned that programs that are simplistic answers to the problem or that are propaganda using "scare" techniques will have little effect on sophisticated young people. They may have other than the intended

effect of opening up communication. Drug education materials can serve as a springboard for discussion if they are attuned to the complexities and anomalies that characterize today's youth scene.

Both Dr. Fort and Dr. Ungerleider have stressed in their presentations that the best deterrent to drug abuse is the individual's value system and his assessment of the consequences associated with drug involvement. Many of those attracted to the drug experience are unable to derive pleasure from ordinary existence and to find a meaning within or outside themselves. There is no final and comprehensive answer as to why students are interested in and take drugs. Among those usually listed are curiosity, rebellion, the desire to improve social relations, and to find meaning in life.

ALCOHOLISM

Closely related to drug abuse is alcoholism as a spreading psycho-social problem. In California alone it is estimated that there are 1,000,000 alcoholics. The California Legislature's report of March 1970, "Alcoholism Programs: A Need for Reform" indicates that the state spent more than $54,000,000 during 1968-69 to prevent alcoholism and to rehabilitate, educate and treat these alcoholics. Unfortunately, these funds could be better used if the state alcoholism programs were not fragmented, uncoordinated and duplicated. The report illustrates this fragmentation by indicating that thirteen state agencies are engaged in such activities as: the sale and distribution of alcoholic beverages, the enforcement of the penal and vehicle codes, and the custody, parole, welfare support, care and treatment, education and rehabilitation of alcoholics and people afflicted with drinking problems.

The "Report of the Task Force on Alcoholism", Human Relations Agency, State of California, May 1969, identified the following deficiencies in the State's program for alcoholics:

"1. Alcoholism tends to be considered categorically as a medical, social, legal, economic or moral problem rather than as a single problem requiring a broad spectrum of services to deal with the physical, psychological and socio-economic dimensions of the problem.

2. A comprehensive, integrated delivery system for the prevention of alcoholism and the care, treatment and rehabilitation of alcoholics does not exist.
3. Existing programs are not being effectively coordinated to achieve current, united, objectives.
4. Objectives of the various programs currently are unrelated to an overall mission and are either obscure or not clearly stated.
5. Serious gaps exist in the delivery of services to alcoholics, e.g., detoxification, case planning and management, etc.
6. Existing programs do not utilize the full resource potential available for the support and delivery of services to the alcoholic, e.g., for planning, determining cost-effectiveness, identifying the patient and his needs, control and allocation of resources, case planning and management, evaluation, and research.
7. Programs have no uniform capacity to identify the use of available resources such as dollars, manpower, facilities, equipment, specialized capabilities, etc.
8. An imbalance prevails between preventive activities and care, treatment and rehabilitation; . . . "

To overcome these deficiencies growing out of fragmented programs, California Assemblyman Lanterman introduced Assembly Bill 1899 on April 1, 1970, to create within the Human Relations Agency an Office of Alcohol Program Management to coordinate state programs relating to alcoholism. Should this bill become law, it is assumed it would make possible more uniform services for California's alcoholics.

At present there is a wide variance in services. For example, in the Department of Mental Hygiene, service offered by the mental hospitals can include anything from detoxification only, to physical restoration, and attempts at rehabilitation and recidivism prevention. Because no uniform comprehensive programs have been established for all mental hospitals, each hospital, individually, determines what constitutes treatment and rehabilitation of alcoholic patients.

On the federal level there is an equally pressing need for coordination of all research, treatment, prevention, training, education and rehabilitation activities in alcoholism programs. There is a vital need for the coordination of federal activities with those in states and local

communities, with those in hospitals, clinics, research centers, and teaching institutions, and with those of the voluntary agencies. A start has been made in this direction by agencies of the Department of Health, Education and Welfare – notably the Welfare Administration, the Vocational Rehabilitation Administration, and the Public Health Services – to aid state and local agencies in providing needed care to alcoholics and their families.

One of the basic problems of all alcoholics in our society is that doors have been shut to them and the normal things that would have been open to them have been unavailable. Past practices of most general hospitals and of the medical profession at large have reflected prejudice toward the alcoholic. This is supported by society's stigma and probably reinforced by the fact that many alcoholics are difficult and unrewarding patients. The National Institute of Mental Health has urged greater involvement by general hospitals and physicians with the alcoholics' problems.

As Dr. Khoury indicates in his down-to-earth presentation of a comprehensive alcoholism program it is essential for the community to determine what it *wants* to do with the "alcoholic" before it decides on a program. On the whole we have no consistent policy toward the alcoholics because we cannot decide whether to treat them as citizens with special needs, or as patients with chronic illnesses, or as minor criminals subject to legal action.

There is no universally accepted formal definition of alcoholism or of an alcoholic. One widely considered as authoritative is that by Mark Keller of the Center of Alcohol Studies at Rutgers University:

> "Alcoholism is a chronic disease, or disorder of behavior, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the social drinking customs of the community, and which interferes with the drinker's health, interpersonal relations or economic functioning."

This definition is reflected in the American Psychiatric Association's "A Psychiatric Glossary":

> "Alcoholism: Addiction to or psychological dependence on the use of alcohol to the point that it is damaging to one's physical or emotional health, interpersonal relations, or economic functioning. The inability of a person to do without drinking or to limit his drinking once he starts is presumptive evidence of alcohol addiction."

It would seem that the beginning of alcoholism is probably on a psycho-social basis; the individual drinks to relieve psycho-social pressures. Individual susceptibility to the effects of alcohol shows a great deal of variation, although a specific psychological or physio-chemical predisposition to alcoholism has not been established.

Whatever the etiology of alcoholism, it is generally agreed that the problem requires the total involvement of the resources of the community in a continuum of consistent care programs – this includes professionals, laymen, the family, a variety of community agencies and most importantly the alcoholic himself. The development of resources for around-the-clock services to the alcoholic patient is an urgent but yet unfinished business in nearly every community in this nation.

CRISIS INTERVENTION

This around-the-clock availability of service is also at the heart of help to persons in crisis. Suicide prevention programs, crisis centers and emergency centers have this concept in common. To be able to help the person in crisis there must be available a person who is able to respond to him with competency and resourcefulness. The response is to the totality of the person's needs rather than to some fractioned aspect of the person's life; it is not a response limited to a medical, psychiatric, or social crisis.

Although suicide has been with us a long time, relatively little was known about it until recently. This has changed very markedly since World War II. Crisis theory has become prominent and with it the techniques of interviewing in crises. As in the case of alcoholism and drug abuse, there has been increased emphasis on prevention. This requires educational and training programs.

One of the first and primary centers for training and education in suicide prevention in the United States has been the Los Angeles

Suicide Prevention Center, under the direction of Dr. Norman Farberow and Samuel Heilig who describes some of the concepts developed at the Center.

The objectives of the Los Angeles program are 1) to train professionals and non-professional volunteers for early recognition, evaluation and therapeutic response to potentially suicidal persons, 2) to disseminate information about practical treatment and prevention of suicidal behavior, 3) to increase awareness and sensitivity, establish responsibility and improve opportunities in this community for the recognition and treatment of emotionally disturbed people, with special emphasis on suicidal crisis, and 4) diminish taboos surrounding suicide and further explore suicidal behavior.

In April 1970 the National Institute of Mental Health announced a new national training program in suicidology. The program takes a new approach to training in suicidology by including three different courses of varying lengths and emphasis, in order to meet the individual needs of a wide variety of potential trainees and to prepare them for many kinds and levels of activities in suicide prevention, crisis intervention and emergency health care.

The first formal postgraduate Fellowship Program in Suicidology was offered by the Johns Hopkins University School of Medicine in May 1967. This was supported by a five-year grant from the Centers for Studies of Suicide Prevention, NIMH. The object of the program is to prepare individuals of various disciplines for positions of leadership in treating, teaching, administration and research in the study of suicide. The people completing such a program will be qualified to work in suicide prevention and emergency mental health care in such settings as suicide prevention centers, emergency mental health services, and community mental health programs.

Unlike the Johns Hopkins' Fellowship Program in Suicidology, which was open only to applicants with a doctorate or master's degree, applicants in the new NIMH training programs range from those with post-doctoral training in a clinical profession or in the behavioral sciences, to individuals with the bachelor's degree in mental health technology, to suicide prevention center volunteers and community

"gatekeeper's", such as clergymen, policemen, and physicians. The eligibility listing is indicative of the trend to educate, train and involve a greater number of people at all levels of activity in the problems of the mentally ill, the emotionally disturbed, the mentally retarded, and the person in crisis.

MENTAL RETARDATION.

The problem of mental retardation is not only based on the need for more service for the mentally retarded, but for more relevant and specialized services. There is much concern by parents, voluntary associations and responsible federal agencies that the mentally retarded has been forced to become part of a greatly deprived group that is not participating in the privileges enjoyed by other citizens. In a recent report by the President's Committee on Mental Retardation, the living conditions available to the 250,000 mentally retarded in public and private institutions were compared with those for prisoners of war.

While generally recognizing that many fine innovative programs have been developed in public education, day care centers for severely handicapped individuals and employment opportunities for retarded and handicapped individuals in general, the President's Committee deplores the poor status of residential care. Public residential facilities have in general been overcrowded, understaffed and underfinanced.

In his paper "Basic Facts About Public Residential Facilities for the Mentally Retarded" in a 1969 monograph of the President's Committee on Mental Retardation, entitled "Changing Patterns in Residential Services for the Mentally Retarded", Dr. Earl C. Butterfield describes one of the basic deficiencies of the 150 public institutions which house five percent (200,000) of the nation's mentally retarded. Of the 90,000 people employed in public institutions, more than half are attendants who provide direct physical and emotional care to the retarded. Many of them have no particular qualification for the job. Their pay is low and their turnover rate is high. "In 1965, there was one attendant for each four residents in public institutions for the retarded . . . attendants have more resident contact than other types of employees combined, as may be seen by the fact that there was only one physician for each 270 residents, and only one psychologist for each 430 residents. Attendants are the main executors of institutional programs. They are faced with an incredibly wide array of responsibilities, ranging from being a

substitute parent, janitor, and record-keeper to being part nurse, part physical therapist, part psychologist, and part educator."

The deficiencies noted on the general national scene were echoed on the local scene. In the case of California a special Task Force on Review of Mental Retardation Services established by the California State Human Relations Agency completed the first phase of its study. This was limited to the mental retardation service of the Department of Mental Hygiene. In its report of June 23, 1969, the Task Force members noted that "Despite some gains, DMH services to the mentally retarded have not kept pace with newer, well recognized concepts of program development for the mentally retarded. There is inadequate planning with other state and local agencies and organizations toward development of coordinated programs. Treatment and development needs of hospital residents are not being adequately met. With some noteworthy exceptions, control and custody are still the predominant features of most DMH programs. Present administrative structures and personnel utilization and training do not stimulate and promote adequate program development."

Among the task force consultants who accompanied task force members on the field surveys of the DMH hospitals for the mentally retarded was Dr. Ivy Mooring, Director, Mental Retardation Services Board of Los Angeles County, whose presentation on developing a comprehensive program for the mentally retarded appears in this publication.

The task force among its recommendations included the establishment of three broad program classifications of services for the mentally retarded: a) medical programs for the multiply handicapped, b) development programs, and c) rehabilitation programs. It also recommended that basic training for the various basic care personnel to staff these programs should be given in junior colleges with DMH stipends and field practice settings. It recognized the need to assure greater opportunities for upward mobility for all basic care personnel into various management and professional classes in order to fill manpower needs.

The task force was particularly concerned with the development of alternative delivery systems for mental retardation services. It recom-

mended that residential services should be regionalized so as to provide services to all levels from community to state care and as close as possible to the individual's home consistent with quality care.

The task force recommendation for regionalized service structure was incorporated into California Assembly Bill 225 (Lanterman) which became the California Mental Retardation Service Act of 1969. This Act would bring about a major restructuring of the fragmented group of services for the mentally retarded now provided by eight state agencies and dozens of diverse local programs. It would establish a single, coordinated system for providing services to the mentally retarded. This would be accomplished in part through the expansion of existing regional centers for the mentally retarded into a statewide network as funds became available. Regional centers would continue to provide diagnosis, counseling, referral, purchases of service and guardianship services for the retarded. In addition, regional centers would have major new responsibilities: screening all persons for admission to the state hospitals for the mentally retarded and securing care for persons leaving the state hospitals. Under the Act judicial commitment of the mentally retarded would be eliminated except in specific instances.

MENTAL HEALTH MANPOWER

The plans for new or expanded programs in drug-abuse, alcoholism, crisis intervention, and mental retardation are all closely tied to the development of mental health manpower to implement the programs. This means education and training programs, career ladders and new jobs and new job specifications. The nature of the services to be provided is not fixed but emerges with more knowledge of what must be done and how it can be done. The duties of the staff to implement such programs are also variable. It has been suggested that the staff members should be viewed as having roles with relation to the patient/client rather than as having narrowly defined tasks.

The community colleges have become very active in developing a generalist mental health worker to provide mental health services in a wide range of settings. There are now approximately fifty community colleges offering two-year programs in mental health, and this number is steadily increasing.

The mental health generalist is viewed as a person whose major concern is with a client, family or community and all of their problems, rather than with a specialized skill or activity. In this capacity he helps the client, family or community to see all aspects of the problem — medical, psychological, social, and economic — and to appreciate the resources that are available or that could be made available to reduce the problem.

The mental health generalists in their work role illustrate the focus of the papers included in this publication "Major Psycho-social Problems and the Psychiatric Technician". In choosing this theme for our 1969 NAPT-CSPT institute we wished to emphasize the psychological and social basis for some of the most devastating problems that take their daily toll in human dignity, peace of mind and fulfillment. We see the psychiatric technician and the mental health technician as the middle level workers in mental health who will be playing a greater role in this struggle.

Zoltan Fuzessery
Dir. Research and Publications
NAPT and CSPT

MENTAL HEALTH TRENDS IN CALIFORNIA

by

Honorable Gordon Duffy

Assemblyman Gordon W. Duffy of Kings County, California, is recognized as one of the leading authorities on public health matters and has participated in several national symposiums on this subject.

Born and reared in Kings County, he has since 1949 combined a career as an optometrist with active participation in the civic and educational affairs of his native area.

In recognition of his proven leadership as a freshman legislator, Gordon Duffy was appointed as Chairman of the Assembly Committee on Public Heaith immediately following re-election in 1966. In 1969 the Assembly Committees on Social Welfare and Public Health were combined and now function as the Health and Welfare Committee under his chairmanship.

Gordon Duffy received his A.B. degree from the University of California at Berkeley. Called to duty with the Navy in 1943, he served overseas from 1944 to 1946. In 1948 he received his degree in optometry from the University of California.

It's a pleasure to be with you this morning to speak on the broad subject matter which you have selected for your annual convention.

In the complexities of today's world we are finding that many of the problems which we categorize as mental illness, drug abuse, alcoholism, mental retardation or some other category of behavioral deviance are increasingly more difficult to approach. As society itself becomes more complex, so do the problems which emanate from society.

Mental health is certainly one area of health that has reflected the changing attitudes of a changing society. As California has progressed through two-thirds of the twentieth century, we have seen many changes in society's attitude toward the mentally ill.

GOLD RUSH DAYS

The first "mental institution" in California was a converted prison ship anchored in San Francisco Bay. The ship was named the "Euphemia", and in a sense, the title was an apt description of its purpose for Webster defines "euphemia" as – "the substituion of something more pleasant for something that appears offensive." Thus, California in 1949 created an "insane asylum" in order to provide a non-criminal atmosphere for mentally ill persons.

California, during these years, was undergoing intensive change. The lure of gold was transforming a tranquil, agricultural society into a lusty, adventuresome, mining community. The rigors of life in California during these years, as well as the type of person seeking a fortune in the gold fields, created a need for facilities that far exceeded the purpose and capacity of the "Euphemia." In 1851, the California State Legislature appropriated funds for the establishment of Stockton State Hospital, the first such institution for the mentally ill west of the Rocky Mountains.

MORAL TREATMENT

Between 1850 and 1880, California was able to maintain a relatively enlightened high quality treatment program. Optimistic ideas about man's basic worth, as well as the robust neighborly congeniality of western life predominated medicine's conception of mental illness. Not surprisingly, success, in terms of treatment duration, was comparable to state hospitals today.

Industrialization and the hardships on many workers during the early years of "technological progress," were soon to give way to more pessimistic ideas about the cause and treatment of mental illness. Medicine, responding to the implications of Darwin's theories about survival, came to believe that the mentally ill person was unequipped to survive, unequipped to adapt to his environment. Mentally ill persons, like Shakespeare's Hamlet, were thought to be tragically destined – doomed to destruction. And the function of mental hospitals came to be the separation of these persons from the rest of society. Thus, humanitarian care and optimism gave way to custodial care and pessimism.

CUSTODIAL CARE

From 1880 to 1940 custodial "warehousing" of patients was the rule rather than the exception. The atmosphere was such that in 1933 a bill which would have humanized the commitment system was vetoed by the Governor because it contained a clause which removed the function of transporting mental patients from the hands of sheriffs, thus depriving them of a source of income.

The state mental hospitals became a dumping ground for society's unwanted and misplaced. California's legal commitment system placed old people, retarded, criminal offenders and mentally ill within the same institution. The fact that many of these people did not "get well" in the sense of responding to medical treatment only served to reinforce an atmosphere of hopelessness and custodial care.

CHANGING CONCEPT OF MENTAL ILLNESS

After 1940, custodial care began to undergo fairly intensive change. To begin with, the separation of patients as mentally ill and mentally retarded has enabled hospitals to adopt treatment programs designed to meet the specific needs of both the mentally ill and mentally retarded. Increased numbers of treatment personnel, the use of tranquilizing drugs, and social assistance programs have enabled state hospitals to reduce the average time required to treat persons.

As California continued to improve the treatment programs in state institutions, it became increasingly obvious that for some persons the very nature of the institutions had a detrimental effect on treatment. They are almost all large, the smallest housing 1200 patients. Most are remote from the centers of urban population where most of the patients live, built at a time when it was thought that the mentally ill should be as far away from society as possible.

All the institutions have extensive non-treatment related functions (farms, dairies, canneries, laundries, bakeries, etc.) of one sort or another that require patient labor in order to operate them. Two of the facilities are leftover World War II Army installations, and the barrack-type construction not only has deteriorated, but it hardly provides a treatment-oriented atmosphere.

The separateness of our mental institutions has made it easier to judge persons as mentally ill and commit them for indefinite periods of time where we didn't have to be reminded of them. The closeness of living in mass urban society also tends to make us less tolerant of eccentric or deviant behavior. It has become much easier to say this or that person is mentally disturbed and is in need of treatment away from us, than it is to seek a social means whereby odd behavior is tolerated.

It seems to a large extent that we have established insanity as a social institution. Dr. Eric Berne in his popular book *Games People Play* defines deviant behavior in terms of "gamesmanship," or social roles people adopt in order to cope with or control their position within the framework of society. Thus, he contends that there is no such thing as "a lunatic," but rather there is a role called "mental patient" which certain people adopt in order to play a certain type of "game."

Dr. T.S. Szasz pursues the social role theory from a somewhat different perspective:

> "Our adversaries are not demons, witches, fate or mental illness. We have no enemy whom we can fight . . . or dispel by "cure". What we do have are *problems in living* — whether these be biologic, economic, political, or socio-psychological . . . The field to which modern psychiatry addresses itself is vast . . . My argument is limited to the proposition that mental illness is a myth, whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations . . . "

Whatever the reasons people have in adapting to society and social norms, there is no question that everyone at some time or another has problems with this adaption. However, no great benefit is accomplished by stating these problems can be as vast as society itself without providing some means whereby people can live with them. If we simply say that man's problems are the result of society, we are closing our eyes to treatment on a personal basis. No psychiatrist, psychologist, sociologist or psychiatric technician can treat society as a patient and hope to "cure" it.

The politician — at least the American politician — knows that social answers are seldom absolute and that social decisions are usually the result of many values. If we wish to treat society as a disturbed patient, we must have a platonic notion of absolute good. No politician in a democratic sense would seek to arrive at social answers in such a fashion. Unless psychiatric knowledge can provide similar notions of an absolute, we should not expect definite and precise reasons why people act in such and such a way.

THE CHALLENGE

The challenge posed to Californians is how best to integrate the individual and his problems with the community in which he lives. Unfortunately, urban mass society in the twentieth century has undergone many changes that make such integration difficult. The eccentric or different person is more noticeable and less tolerated than he was when California's population was small and spread out. The permanence of the family unit has been challenged by the mobility and social intransigence of modern America. It no longer provides a place whereby older — and many times bothersome — family members are cared for.

And perhaps most importantly, we have come to see that many persons for many reasons have become alienated and disillusioned with American society. More recently, however, there is some reason for encouragement.

It is essentially a political question to define what the community should look like and how it should function. It is also a political question to provide community support for persons having problems coping with such an environment. In California, legislators have seen this responsibility and have sought to provide means whereby it could be brought about.

SHORT-DOYLE ACT

In 1957, the California Legislature passed the Short-Doyle Community Mental Health Act creating a state-local partnership for providing mental health facilities in the community close to the patient's home,

job and family. Voluntary services were encouraged. Family counseling and group therapy were encouraged. Unfortunately, care for all persons with mental problems was not encouraged. Alcoholic patients have been treated in only a few programs. Geriatric patients continued to be dumped in state hospitals with little local effort being exerted to find alternative means of care.

Short-Doyle in its original form was good, but it wasn't enough. Society's difficult problems continued to be shut off from the community and shunted away to state hospitals. I don't mean to imply that the state hospitals don't provide good care, because they do. Among large mental institutions, California's quality of care ranks high — extremely high. Nonetheless, it still remains a system of large, impersonal hospitals — remote from the individual and his community — appropriate for some patients, but by no means all.

The question of how best to utilize our resources for the treatment of mental illness is an important one. California currently spends nearly $6,000 a year to maintain a bed in a hospital for the mentally ill. On an average, approximately 2.2 persons will occupy that bed; thus, the cost of an average treatment stay is about $2,700. (Of course, these gross statistics do not include cost by type of patient, length of stay, or illness severity.) The fact that $2,700 is spent for each spell of illness is not as important as the results received from such an expenditure. And the results are not particularly encouraging. Until recently we continued to commit persons for indefinite periods of time. We continued to impose the crippling stigma of a mental illness commitment of a state hospital. We continued to inappropriately commit persons who benefit little by confinement in a state hospital.

LANTERMAN-PETRIS-SHORT ACT

In 1968 the Legislature passed the Lanterman-Petris-Short Act which will go a long way in strengthening the commitment process of mentally ill persons at the community level. The legislation changes the commitment process so that it will no longer be possible to commit persons for indefinite periods in state hospitals and thereby ignore community responsibility. The Lanterman-Petris-Short Act provides that persons believed to be "a danger to others, or themselves, or

gravely disabled, . . . as a result of mental disorder . . . " may be detained for 72 hours diagnostic evaluation in an appropriate community mental health facility. If after evaluation, a person is found to be in need of treatment as a result of mental disorder, he may be certified by the community mental health facility for an additional 14-days of intensive treatment provided he meets the criteria of "danger to self or others" or gravely disabled.

Beyond the 14-day period of intensive treatment, persons may be further involuntarily held only if they present a "danger to others" and then for prescribed 90-day periods.

FUTURE OF STATE HOSPITAL SYSTEM

There has been a great deal of speculation that Lanterman-Petris-Short will eventually spell the end of the state hospital system for the mentally ill. To some degree that seems a valid speculation and I feel an appropriate one. To the extent that state hospitals have allowed society to cover up its own problems, that system has allowed us to ignore them.

But, the state hospital will not cease to exist – there will be fewer of them, but those that continue will serve a much more important function, for they will be dealing with problems and patients unable to be served in the community.

In order to meet this challenge, the structure of the hospital must be flexible and varied. New categories of patients – the seriously impaired drug user, the potentially dangerous disordered and disturbed long-term adolescent – will predominate. Treatment programs will be different, staffing levels will have to be increased. Typical staffing patterns will have to be "thrown out the windows," for the hospitals will no longer be dealing solely with the patient that responds only to the "medical model" approach. The institution, itself, should only be a physical facility for housing different programs – many of which will bear no resemblance to one another. The hospital hierarchy should no longer be an absolute one. The only thing that various programs should share with one another is a common facility and common house-keeping functions, such as food service.

Too often the Lanterman-Petris-Short Act is viewed only as a challenge to local programs. But, the challenge also exists for the state hospital that continues to serve a treatment role for disturbed people. The challenge will only be met if the Department of Mental Hygiene, the state hospitals and you, here today, look on it as a challenge.

Working under difficult constraints at times, California has still implemented one of the most exciting mental health ideas in the nation. Dr. Szasz has suggested that mental illness may primarily be a problem of living with one another. In a democratic society this implies tolerance of diversity. Such understanding can only be achieved by familiarity with mental disorder whether it's treated in the community or in the state hospital. Before Lanterman-Petris-Short, the state hospital system had no formal link to the community; now it need not be quite so remote.

The real challenge of this legislation, however, is a personal challenge to each of us – for it asks us to better understand and tolerate the idiosyncracies of our fellows. No longer is society to use the mental health system as "benevolent substitute" for true concern.

It is time – past time – that we, as Californians, recognize that the mentally ill are citizens within society. It is within this realization that we all must respond to the problems of the future.

THE DRUG EPIDEMIC OF 1969

by

J. Thomas Ungerleider, M.D.

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He was graduated from the University of Michigan with honors in psychology and was formerly Chief of Psychiatry at the United States Army Hospital, Fort Ord, California.

He has published over forty articles and one book on various subjects and has contributed chapters on hallucinogens to six books and one encyclopedia. He is a National Board Diplomat, a Fellow of The American Psychiatric Association and on the advisory council of four states and national professional drug abuse associations.

Dr. Ungerleider has been advisor or consultant on the problems of drug abuse to many agencies nationwide and has reported on the adolescent drug problem at a number of national medical conventions. He has appeared in multiple radio and television documentaries and has been consultant to a dozen educational films on drug abuse. He was recipient of the Chris Award for the film "Beyond LSD" and of the Rush Gold Medal for Scientific Exhibit (A D.A.R.E. "Happening").

In the past four years Dr. Ungerleider has given over 300 lectures on various aspects of drug abuse to professional and public groups and has spoken to over 200,000 college, high school and junior high school students.

I am particularly pleased to talk to you as professionals about one of the greatest problems now confronting us. As a professional I am myself greatly concerned about some of the recent trends in the treatment of drug abusers. Many professionals, particularly physicians, are either too frightened or are not adequately informed to be effective in this field. We have in many cases left the field and forfeited the treatment of drug abusers to untrained people. Here in Los Angeles, for

example, there have appeared many small groups of former drug addicts and other would-be helpers who have very little information and no training in the treatment and rehabilitation of drug abusers.

As those of you, who have worked with me at the Neuropsychiatric Institute (U.C.L.A.) know, I strongly believe that it is the technicians, nurses, physicians and social workers who should come forth to handle the problem of drug abusers. Later Dr. Joel Fort will talk about specific methods to handle the problem. It is my task now to give you an overview of what is happening in this country that leads me to view the problem as a drug epidemic.

THE PEOPLE INVOLVED

We have much at stake in this problem not only because of the great number of people involved but because of their critical position in our society; they are the people who have traditionally been the nation's leaders. They are the educated people who assume leadership roles in our government and who now are "dropping out" with drugs.

What are some special qualifications for individuals who would teach, help and counsel people with drug problems? These are not qualifications that can be gained from any school. First, the individual should like young people because they are the ones who are using drugs. Secondly, he must be absolutely honest. It is difficult to be honest if you are embarrassed by the fact that your generation of adults has not created a perfect world. Finally he must not himself be involved with drugs and secretly believe that LSD and marijuana can put you on the road to happiness. People with such an attitude who work with young people can actually create an increase in drug use and abuse among them.

HISTORICAL PERSPECTIVES

A brief look at the history of drug abuse in this country will point up the changes not only in the types of drugs used and abused but also in the classes of people who are the principal abusers. The history is divided into three phases.

The first phase lasted many years and ended in 1965. It was characterized by the traditional drug-abuse pattern which was very much restricted to high-risk groups. These included physicians who were addicted to morphine and demerol. It also included some people in a lower socio-economic class and in certain occupational groups like jazz musicians; they used marijuana and heroin.

After 1965 the traditional pattern was superseded by the era of psychedelics. It was the era of LSD and the psychedelic proselytizer Timothy Leary who made a splash with this statement that one drug, LSD, was the answer to the problems of the world. The mass media gave much publicity to Timothy Leary and the psychedelic drugs. He trumpeted LSD as instant happiness in a capsule. It would bring instant creativity in art and music, instant problem solving ability in school work, and even instant ability to design the perfect building. The word spread and people began to use it. Not only the so-called professional creative and artistic who had been experimenting with LSD since 1938, but also the young people in college and high school. Everyone started to "turn on".

Then some hard realities broke the spell of the psychedelic proselytizer. Adverse reactions to LSD were reported, first at UCLA and then at Bellevue: the "freak trip", "freak out", "bummer", the "bum trip". Adverse reactions were manifested by psychosis, suicide attempts, anxiety and panic reactions, and confusional states similar to those in organic brain syndrome. There were severe and fatal accidents resulting from perceptual changes. People under the influence of LSD jumped from tall buildings imagining that they could fly. Others walked fearlessly in the midst of traffic under the illusion that they could blissfully reunite with the metal of an automobile. These harsh realities brought fear to everyone and with it a national hysteria.

It is only fair to indicate that these psychedelic missionaries though misguided were quite sincere in their beliefs. They never used alcohol or smoked tobacco; they did smoke marijuana, another psychedelic. They never dreamed of using an amphetamine or a barbituate, an "upper" or a "downer". They gave LSD to infant children. As you who have worked at the Neuropsychiatric Institute know, we have had a number of eighteen to nineteen month old children for treatment. They believed that the family that takes LSD together, stays together. They even "turned on" their pet dogs.

The reaction to LSD brought on a new form of drug abuse. The new era started about 1967 and ushered in the chronic drug abuser, the "plastic hippy", the "teeny bopper", the young people who take anything and everything. This is where we are now.

These are younger people, adolescents who are often not older than thirteen or fourteen. The psychedelic drug users were older, about 21 years old. These chronic drug abusers are indiscriminate in their choice of drugs. However, they avoid LSD, if it is so labelled, but do take it under other names. They of course use other psychedelics such as mescaline.

THE DRUGS INVOLVED

It may be well to indicate the drugs involved. They are the psychedelics, the amphetamines and the barbiturates.

The *psychedelics* are still used though less frequently than prior to the news about adverse LSD reactions. These include LSD (d-lysergic acid diethylamide tartrate) — LSD 25 is the most potent form of this drug. There are a variety of psychedelics of varying potency. These include DMT (dimethyltriptamine), the businessman's LSD which begins and ends so quickly that, supposedly, you can take it at noon and be back in your office working at one o'clock; STP for serenity, tranquility and peace; nutmeg; compounds in the tops of carrots; morning glory seeds; Hawaiian wood rose; the Mexican or magic mushroom containing psilocybin; and the peyote cactus buttons containing mescaline.

The *amphetamines* are the "uppers". Of these, methamphetamine, "speed" or "crystal", is the most potent. Many young people who inject themselves with methedrine, began by taking their mothers' medically prescribed oral amphetamines for weight loss. We physicians and of course the pharmaceutical companies are very much involved with this problem.

The *barbiturates* are the "downers". They kill about 3,000 people a year, including famous movie stars. Users are called "speed freaks" and "downer freaks". The young people in the Los Angeles area originated the "upper" and "downer" games which are now being played in schools all over the country.

DRUG GAMES

In this game you go to school under the influence of a drug, "stoned". LSD is not the drug of choice because it takes too long to wear off. The drug is an amphetamine or a barbiturate. You try to perform your activities without arousing the teacher's suspicions. That is the game. The second part of the game takes place when the teacher notices some abnormal behavior. For example, Johnny may be on a barbiturate and can't walk straight and is falling asleep. The teacher being rather naive wakes him up and asks him what is wrong. Johnny then proceeds to tell the teacher and the class about the terrible fight his parents put on last night which upset and disturbed him all night, so that he could not sleep. The teacher is most sympathetic to Johnny who then goes home while the students laugh at the teacher. If Johnny is on an amphetamine and can't sit still in school, there is another appropriate story for the teacher if she is naive enough to play the game.

Experimentation with various chemical substances is the latest fad among teenagers today. Sometimes the fad is a harmless one, and the substance used for experimentation has no adverse reaction on the body: for example, the smoking of banana skins, wheat, and lettuce. There is nothing psychedelic, hallucinogenic or chemically active in banana skins. It is a giant hoax. The youngsters of course are very suggestible and some pretended or even thought that they were going on a drug trip.

Another game played by teenagers is called "fruit cocktail". The game requires that the youngsters going to a high school party raid their parents' medicine chest and bring five to ten assorted pills. These they place in a big jar. They shake the jar and then pass it around. Each person takes a pill and swallows it; this continues until the jar is empty.

This extraordinary gullibility and naivete regarding chemicals and lack of information, is illustrated by an incident that occured in San Francisco's Haight Ashbury district. Some people broke into the medical clinic and stole clini-test tablets which you all know are blue and white speckled copper sulphate tablets. They of course assumed that they had some drug. Copper sulfate is a corrosive and we were

treating corroded upper gastrointestinal tracts as far south as Los Angeles.

SIZE OF THE PROBLEM

There is no accurate picture of the number of people who are using drugs; statistics are grossly unreliable. For example, for years we had been getting calls, not only from teachers, parents, narcotics officers and the youngsters themselves asking us what we could do about the problem at some affluent schools. However, the administrators of these schools publicly had stated that there was *no* drug problem in their school, despite the fact that the police were raiding the campuses and breaking up drug rings.

At any rate we finally went into three schools at the urging of the PTA. The administrators confided in us that not over one-half of one percent of the student body had every tried marijuana. But in talking to the student body leaders at all three schools, I could find only one student body leader who estimated the use of marijuana as less than 80 percent. Although I don't think these statistics are any more accurate than the one-half of one percent, they do indicate that there is a wide credibility gap.

RISK FACTORS

One of the problems of discussing drugs is the fear it brings out in many people. It frightens them and it becomes a moral issue. Some of the television newscasters do this – although their number is decreasing. They talk about the evils of drugs when we know that drugs are chemicals and are not evil. As chemicals, drugs have different risk factors. Only when the youngster is informed about these risk factors can he be expected to make an honest response, the right decision about drugs – namely not to get involved. When some young people hear the moral approach about drugs their response is "Whatever they are against, I'm for."

Young people do listen when you talk about risk factors. As evidence of this, nobody takes pure strychnine or arsenic despite the fact that they both produce marvelous hallucinations before killing the user. The

same applies to heroin; the number of addicts, sixty to one hundred thousand has not increased during the last fifty years. As I had indicated earlier, there is no big market for LSD anymore. The young people know from their own experience of somebody who under the influence of LSD has flown off a building, or walked into a car or had chronic personality changes after one-time use of the drug or was having flashbacks three years after experimenting with it. They can recall users who have had a psychotic break or have been confined for many months at state mental hospitals.

On the other hand there has been a tremendous increase in the number of marijuana users; the last estimate was 30 million. Much of this increase has occurred since 1965. We do not yet have the risk factor data about methedrine or marijuana. With methedrine all we have is a nice slogan, "Speed Kills".

But we should be interested in planning preventive programs. Knowledge of the side effects of drugs in themselves will not help in treating people who become intimately involved with drugs. It will not help you plan preventive programs for your community. It must be evident that when fifty to seventy percent of high school youngsters are experimenting with drugs or are regular users that we cannot rightfully say that they are all chronic, emotionally disturbed drug abusers that constitute about seven percent of our population. There are many social factors involved in this problem.

THE DRUG SOCIETY

Since the teenager is a large part of the involved drug abuse population, it is essential that we understand him. First of all, he is intensely curious. We have fostered this curiosity because we are the greatest drug using or drug abusing nation this world has ever known. You have only to view the television commercials to realize how much drugs are part of our culture – tranquilizers, sleeping pills, tobacco, beer. Even our headaches are dignified with a commercial designation. The implication of these TV commercials is clear: you have to take pills, or drugs, to get through life.

Eighty million of us use alcohol; we have eight million alcoholics. Incidentally, I am delighted to see that your agenda includes discussion of alcoholism, because people do not usually discuss alcoholism. They take it for granted despite the fact that we could fill every hospital bed in the country tomorrow with an alcoholic. It is estimated that six to eight million alcoholics affect the lives of another 25 million. Viewed in this way you can appreciate the enormity of the problem.

Equally enormous is the traffic in drugs. We manufacture 13 *billion* amphetamines, barbiturates and tranquilizers every year — a fantastic situation. Until 1965 half of the production went into the illicit drug market. We have been aware that a large part of this drug supply goes to Mexico where Americans can buy without prescription as many amphetamines or barbiturates, in the bottles of the American manufacturers, as they wish from drug stores for 15 cents a piece. When one of the drug manufacturers of seconal, secobarbital, or "reds", was taken to task by California State Attorney General, Tom Lynch, for shipping into Mexico enough seconal every year to supply every Mexican adult and child with a hundred pills a year, they pretended to be naive; they thought that every Mexican was on barbiturates. In discussing the size of the traffic with our pharmacist at UCLA we estimated that this one company makes between 70 and 100 million dollars a year in profits from such operations.

It is only natural that the youngster's curiosity should be directed to drugs, since they are bombarded with all kinds of information about drugs. It is a revelation to talk to fifth and sixth graders. At the elementary school attended by my own children the third graders sing, "Marijuana, marijuana, LSD. All the teachers take it, why don't we?"

The ideal time to reach the school children is in the fifth and sixth grades, before they begin to rebel. They are keenly interested in knowing about the risk factor for various drugs. It has amazed me in speaking with them in the classrooms to hear the sophisticated questions they ask! "What about the flashbacks from LSD?" "What about the brainwave changes?" "If the father takes LSD and the mother gets pregnant and has a baby, can the baby be deformed?" And when these questions are answered, a hundred hands are raised again. It is an intensely curious age. We must satisfy this curiosity with honest

information about the risk factor in drug use. Effective beginning instructional programs for these students have often included basic data about drugs, presented in pictorial or cartoon form.

THE AFFLUENT SOCIETY

We are not only a drug society but also an affluent society. I am convinced that the amount of drugs being used in any high school, for example, is proportional, at least in the upper ranges, to the number of cars in the parking lots. This affluence is associated with a lack of responsibility, available extra money, and a great deal of boredom. The high school youngsters tell me that they get tired of taking the convertible up to Lake Arrowhead, or down to Laguna Beach. Then out of boredom and a lack of responsibility it seems natural that they should start to chemically experiment. The situation raises the question of *meaningful alternatives.* In this regard we have been trying to get the business communities to become more interested in young people. They have an excellent opportunity to reach fourteen, fifteen and sixteen year old youngsters by offering them a chance to see what industry is all about through actual participation in meaningful work.

The affluence is also associated with permissiveness. Too many parents feel that they cannot say "No" to their children and still love them; they equate love with permissiveness. In the last few years I have seen several families every week with similar problems. They have older teenagers, 18 to 21 years old, who refuse to go to school or to work, and demand that their parents pay them an allowance. Often the youngsters do not hide from their parents that they will use the money for drugs, and threaten that "if you don't give me the money I'll move out and become a heroin addict." It is surprising how many parents, through fear and a misguided belief that love equates with permissiveness, actually go along with this blackmail. From my own experience within the past year, I know of five young people who died as the result of such permissiveness; — technically it was from a mixture of alcohol and barbiturates.

SOCIAL PRESSURES

It is difficult to evaluate another tremendous pressure on our youngsters; it is the pressure for creativity and achievement. They look

for recognition and acceptance but feel that their chances for individual achievement have been restricted by the established structure of big business. Even a college degree means relatively little to them. Many withdraw from the battle and seek recognition and achievement in other directions. Some of them have been able to gain instant acceptability on the campus by being drug dealers for their friends. Even those who do not use drugs believe that it is a worthy role. The drug dealer assumes the position formerly held by the football hero, but without the need to train.

There is also great pressure on the young people from their peer groups. Many who actually have not used drugs say they have. In many areas it is almost like a puberty rite to have "turned on" with drugs. This is one of the reasons why the questionnaire technique is such a poor way of obtaining accurate information on the number of drug users.

YOUTHFUL REBELLION

We cannot overlook youthful rebellion as a factor contributing to drug abuse. The drug is a marvelous way to get parents or teachers "uptight", as their language so beautifully expresses it. The mere mention of LSD or marijuana throws adults into a panic, makes them "blow their cool". In other places it might take something else to make parents panic. This was brought out in my experiences in Utah. I had been spending some time in some of the small towns near Salt Lake City, talking about drugs to Mormon communities. There are strong sanctions among Mormons against alcohol and tobacco. The young people do use some marijuana and LSD but not for the sake of rebellion. If they want to express rebellion they leave a cigarette wrapper or a beer can where their parents can find it.

EMOTIONAL DEVELOPMENT

There are certain properties of psychedelic drugs which make them specially dangerous to people in their formative years. These properties are unlike those of any other mind changing drugs. Unlike alcohol or barbiturates, overdoses of LSD and marijuana will not make you pass out. If you take an overdose of amphetamines, you have changes in consciousness when you "go on a run" and you become stuperous

when you "crash". When you are on such drugs it is hard to deceive yourself into believing that you do not have problems. But with too much LSD and marijuana you can pretend that you do not have any psychological complexes. It helps the youngsters in their formative years to deny the fact that they have problems with sexuality and aggression. They go through their formative years, their adolescence and most difficult years, without coming to grips with their angry and rebellious feelings, their sexual feelings, their problems and hangups. They do not have an opportunity to find their identity and determine what they want to do in life, to do their "thing".

I recently saw an extreme example of the results of drug-suppressed emotional development. It was a 29 year old boy who for the last sixteen years had been on as much marijuana as he wanted. His mother furnished him with as much as eight "joints" a day. He never finished junior high school. He could not date or engage in any goal-directed behavior. He had no frustration tolerance. He stayed at home and could not attempt any task without several "joints" of marijuana, and performed even the most simple tasks poorly. He had become a permanent emotional cripple.

If young people are to develop emotionally they must get help in resolving their problems, not in suppressing them. They feel a desperate need to identify with adults. In their secret, covert, unspoken message they are asking if there are any adults who don't take drugs and yet who are *not* "squares". They wish to be shown, not to be lectured. Incidentally this is one reason that we cannot expect to get a totally successful program by using ex-addicts to inform other youngsters. They are asking adults to be *responsible,* they are not asking for total permissiveness.

If you look only at their outward expressions you will not appreciate their concern. Their questions are designed to test the adults. On a superficial level, they are asking for information about drugs, but beneath that they are wrestling with their identity and trying to decide whether they want to join the adult world. They never test by saying, "Oh wise parents, tell us about the evils of LSD." Rather they will say "Alcohol is worse than LSD" and watch the response. They will never thank us. If we tell them something, they will merely say "Big deal".

Later I will show you some film strips that illustrate how youngsters test their parents. In the film the mother had been given a hard time by the children, but she reacted calmly and just smiled at the harassment. The narrator comments to the effect that "the seeds are planted, just wait." This is the case according to the experience of some parents. They have noted that although their children pooh-poohed everything their parents said, they subsequently overheard the children, in talking among themselves, faithfully use the parents' words. They had adopted the words and thoughts as their own without acknowledgement of the source.

We physicians as a group have had a terrible time with this problem. We have been accustomed to having grateful patients come and say, "Tell me, oh wise doctor, about this disease." But the youngsters do not fall into this pattern when they ask about drugs. The doctor responds, but the "client" has read more than the doctor and he quotes some statistics. It ends with the doctor saying, "Never darken my door again."

IDENTIFICATION FIGURES

There are certain identification figures that people identify with youngsters. I call them *primary* and *secondary* figures, those of most importance and those of lesser importance. The *primary* identification figures are the parents, the school and the teachers, and perhaps law enforcement and its officers.

We can expect no solution for a problem when the problem itself is denied. Many parents are too frightened of the idea of drug abuse in their midst, so they deny that it exists. The head of a school district in which I discussed the drug situation was very upset and depressed by his experience with parents. He had identified 40 drug abusing students in his school and had arranged for free confidential counseling and help. He had called forty sets of parents. Thirty six refused point-blank to attend any meeting. Of the four who promised to come, only one appeared.

The teenagers themselves have not been able to get through to their parents despite the variety of verbal and nonverbal messages. One girl I

had seen started smoking marijuana and left the cigarettes in full view of the parents. They responded to the message by saying "The only problem with marijuana is its illegality, so we will help you get it and let you smoke it at home." This was more than the girl could handle and she turned to LSD. She wrote long letters, ostensibly to her boyfriend, describing her experience with it. She left the letters unfolded in the living room and her parents would read it but would never say a word. Finally she managed to be caught passing out barbiturates in school. The school counselor and nurse called the father and mother to say "Your daughter has a drug problem". They naturally were amazed, "No, not our daughter. She could not." These are very primitive elements of denial by very frightened people.

In California all schools are required to give instruction on drugs. There is no uniformity required in how the instruction should be presented. One of the most exciting approaches is one first used in northern California. It is based on the idea of an *ombudsman.* In this case an ombudsman is somebody who could talk with youngsters about drugs without having to report them for drug abuse. There is no pupil-teacher privileged communication similar to the patient-physician privileged communication. The teachers are required to report the students who tell them that they use drugs. Teachers who do not report them feel guilty and lose their effectiveness as helpers.

In northern California, an athletic coach was released after the basketball season to devote full time to become knowledgeable on drug abuse. Then they let him teach real information about drugs rather than a mixture of mythology. Since there was no formal privileged communication in the community, they had to get the parents and law enforcement people of the community to agree to the plan.

Some people thought that the students would be coming to the meeting to obtain tacit approval to go ahead with drugs. Some students might very well have been under the impression that they would be encouraged by – "groovy" teachers who themselves use marijuana and other drugs. But this was not the case at this school. The coach was *not* involved with drugs. As it turned out, nine of the ten students who went to him were seeking to have their parents brought to a meeting. They were the ones who had left the "joints" around as a message to

get their parents interested. He did bring in the parents not merely to give them information about drugs but to make them realize that love and permissiveness are not the same things and that it is not helpful to pretend that problems do not exist.

In contrast to this straight forward student-teacher relationship is the situation in one of Southern California's cities. There, teachers of a narcotics team preface their interactions with students with a caution that to avoid arrest as a narcotics user the students should invent a mythical person when talking about his drug problem. It makes for hypocritical relationships with youngsters who are seeking honest personal relationships and communications.

They are seeking the kind of relationship one of the fathers described. His son came to him and told him he wanted to take marijuana. The father did not panic but asked that they research the subject first. He took time off from work to spend it with his son at the library. There were no final answers on marijuana. After a day and a half his son said, "Dad, I've changed my mind, I really don't need it. Thank you anyway," and he meant it. He was asking for something else from his father: quality of relationship and interest.

Unfortunately, this does not reflect the most usual reaction of parents. Often they are so threatened that they cannot even discuss the matter with their children. Indeed, the most frequent response of parents (whose youngsters invariably have asked them about drugs before using them) seems to be pounding on the table and saying that marijuana is bad because it is illegal and that is all they have to know about it.

The third class of primary identification figures consists of law enforcement and its officers. One of the problems has been the credibitility of the law regarding drugs. The laws have, for example, described marijuana as a narcotic, which it is not. This makes them poor laws which invite the concept that if you do not like to agree with the law, break it rather than work to change it. This lack of respect for such laws extends to the legal processes themselves and various types of governmental institutions, including law enforcement. It has seriously impaired the image of the policeman.

It is interesting to observe that youngsters who cannot get through to their parents and teachers with the message that they need help with their drug problem, finally get the police to listen. As it turns out, the people who use drugs but do not want to be caught, usually can get away with it. Those who do get caught, *want* to get caught, whether they are aware of it or not. They are the ones that cannot get their parents or teachers to listen. It is most unfortunate that they have to get arrested in their desperate attempt to get some kind of control for their problem.

As for the *secondary* identification figure there is the business community and the medical community. We have been attempting to get business people to share in the responsibility for the young people. I think we doctors have not been in the forefront in helping with the problem. This is why I am emphasizing prevention so strongly. I am in general very pessimistic about any type of treatment for the deeply committed drug abuser, whether it is group therapy or individual therapy, except for a few residential treatment programs for selected groups like Synanon.

FILMS ON DRUG ABUSE

Earlier today you had an opportunity to see a very fine film, "The Mind Benders". This film concentrates on the characteristics of LSD, and is one of the most objective of the LSD films. It tells us what is known about this drug: that it is extremely potent but that its perception changing mechanism remains largely a mystery. It has caused abnormal and premature birth in one study. It may cause psychological dependency in some users. The film also examines an LSD treatment program for alcoholics in Kansas City and mentions other experimental therapeutic uses for LSD.

I would like to now show you excerpts of the film "Beyond LSD", which could just as well be entitled "Beyond Any Drug". The film looks beyond drugs, regarding them as symptoms of the communication problems and tries to determine what are the basic problems. This film was awarded the first prize at the National Film Festival. It was made entirely by young people. Even the music was written by them. Its lyrics talk about drugs, about teenagers who are unable to talk to

their parents. It describes where we are "at"; it speaks for our own position regarding the drug situation.

You may be interested in one reaction to the film. I had shown the film in its uncut version to a school district superintendent. His comment was "That is the most marvelous film I have ever seen but I will never allow one parent in my community to see it. It shows that parents are imperfect. They might get angry and fire me." He was very honest and, of course, he still has drug abuse in his district.

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THE TREATMENT AND PREVENTION OF ABUSES OF ALCOHOL, NARCOTICS, LSD, AND OTHER DRUGS

by

Joel Fort, M.D.

Dr. Joel Fort is generally considered one of the world's leading experts on mind-altering drug use and abuse, and a leading authority on youth, human sexuality, deviant behavior and social change. He has become the major spokesman for a sociological, public health, and humanistic approach to drug abuse and sexual deviance, stressing new initiative and reform of our ineffective and extreme laws.

Currently he is Professor, School of Social Welfare, University of California at Berkeley, teaching "Social Pathology" and "Sociology of Deviance". He is also a lecturer in the Department of Biology and Experimental College, San Francisco State College, teaching an interdisciplinary course, "Man, Society and Environment".

He was the creator and director (1965-67) of the famed Center for Special Problems, San Francisco Department of Public Health, and was the Director of the Alameda County Center of Alcoholism.

Dr. Fort is author of numerous published articles in scientific and general magazines, columnist for the fortnightly newspaper, "San Francisco Bay Guardian", author of "The Pleasure Seekers: the Drug Crisis, Youth, and Society", and co-author of six other books.

Invited lecturer and expert witness in all regions of America, and abroad, to high school and college audiences, professional societies, legislative committees, and courts, he has also traveled and worked in over 50 countries on all continents as a Consultant to the World Health Organization, the Government of Thailand, and the Peace Corps. He has also served as Social Affairs Officer for the United Nations.

We have a very complicated subject to deal with today. Unlike my usual public lectures, I'm not going to be talking about the broad causes of

drug use and abuse in American society, and I'm going to deal with the complexities of social policy only briefly. There are also many other important areas that I can't deal with since I'm primarily discussing the treatment and rehabilitation of abusers of alcohol, marijuana, LSD and a variety of other drugs. However, I want to answer a couple of the questions that were raised this morning about what resources are available to people to learn more.

I hope you will not take it amiss if I recommend my own book, "The Pleasure Seekers" coming out next week, which is an extremely comprehensive coverage of all drugs. You will recognize that most books, in fact practically all of them, deal with just one or two drugs. That is, either it's a book on alcohol, a book on tobacco, a book on marijuana or a book on LSD. However, this book unlike those others, covers all drugs; helps people to put them in perspective; and deals with the historical as well as the contemporary pattern of use. It also describes the major myths of "stepping-stone" theories, the relationship between drug use, crime, insanity, sexual behavior and, of course, it has a long section on youth and on social policy. Another book I recommend is a paperback called "Drugs on the College Campus," dealing with basic concepts. Again, it helps gain perspective, and at the back contains a copy of my comparison charts of mind-altering substances that cover everything from alcohol to glue and gasoline, the different patterns of effects, social policy, and our slang terms for them.

THE DRUG PROBLEM

Let me now touch on a couple of basic concepts that are vital for you to know, to understand what the problems are. Of course most of us determine what the problems are by reading our daily newspaper and by listening to what one sociologist has called the "moral entrepeneurs of the society," that is, the rule-makers and opinion-formers, many of them in legislative bodies, in the mass media, or holding high administrative posts, who tell us in the drug area that the only drugs are marijuana, LSD and narcotics, that these are all the problems and obviously the the only way of dealing with them is to pass prohibitory laws. Americans as a whole are a nation of oversimplifiers. They want some very easy answers to some very complicated problems, and they

often reward the person who promises them a simple answer such as passing a law against them. Thus we have a couple of higher legislators who after one article in the Wall Street Journal introduced bills to make it a felony to possess catnip. Because some young people around the country were smoking catnip, they decided it would be wise to bar any pet shop from selling it and bar any cats from using it by just considering the whole thing illegal. And to show you the absurdity of this polarization that we have, that is, the idea that you're hard on something if you call for sending everyone to prison for the rest of their lives, we have two Congressmen who have introduced bills to increase the penalties against airplane hijacking. Although all of us are concerned about airplane hijacking, few of us know that penalty is already the death penalty. These men were able to attract great publicity in their districts by calling for harder penalties for airplane hijacking.

Thus we will always have people who will call for the death penalty for the first offense of marijuana possession and castration for the second offense. But hopefully, as we become eventually civilized, more rational and more humane, we will put this matter in perspective and recognize that there is a variety of ways of responding even to things that we consider evil, or are indeed evil. And no form of drug use, whether it be of alcohol or marijuana, can be clearly or scientifically said to be inherently desirable, beneficial or necessary. All of you could survive without using the very dangerous substance that many of you are now using, tobacco, which kills 360,000 people per year. If you think about it for a moment you will recognize this truth. Many of you will have some resistance to the idea that this is a drug, that it's dangerous, and you certainly will not be able to stop simply because I've pointed that out to you. That should give you some insight into the deep-seated social and psychological roots of drug use in our society and make you recognize the difficulties of wiping it out by any one simple statement or policy.

TYPES OF DRUGS

Drugs include everything from alcohol and tobacco, sedatives and stimulants and tranquilizers and then LSD, marijuana and nacrotics. Narcotics, by the way, scientifically means opium, morphine, heroin or synthetic equivalents of these drugs. There are no "soft" narcotics.

That terms makes as much sense as if I were to lecture you on "soft" pregnancy. A drug is either a narcotic or it is not a narcotic. It is simply fostering ignorance and hysteria to introduce these very emotional concepts in order to make people think that even though a given drug is not a narcotic it is still a narcotic, but, that it is somehow "softer" than some never defined concept of "hardness".

As good Americans we have been taught to fall out of our chairs and march on the State Capitol whenever anybody out of the side of his mouth uses the word "hard." Few of us know or bother to think about what are hard drugs. I think the John Birch Society and the American Communist Party would agree that death is a hard phenomena. Thus any substance that kills you unnecessarily or prematurely is hard. A moral person does not minimize accidental or suicidal deaths from LSD or any other drug just because he expresses concern about the number of deaths, in the case of alcohol or tobacco or a variety of other substances, that exceed by a thousand times the LSD deaths. We should be seeking to reduce unnecessary death and disability from any substance, not by neglecting any of them, but by assigning some rational priorities, even if the alcoholic beverage industry and the tobacco industry tell us, through their two million dollars a day advertising, that their products are inherently beneficial, harmless, and not drugs at all. As we all know, if we think about the imagery of advertising, we will get sexual pleasure, eternal youth and happiness from the alcohol and tobacco and a variety of other things that we pour down our throats or inhale every day. That is the way we produce the drug-ridden society in which we live. It is one of the main causes of young people's use of a variety of drugs just as it's a big component of the older generation's use of various drugs.

DRUG ABUSE

Bearing this in mind for a context of drugs, you will then have to come to different conclusions about the kinds of treatment and rehabilitation programs that are needed to cope with the problem. But before I come to that I want to define drug abuse. We have an interesting phenomenon in our society, in that, with certain drugs, such as alcohol and tobacco, we tend to think of *all* use, including abusive or addictive use, as totally normal, while with other drugs such as marijuana we tend

to think of *any* use, including one time or experimental use, as abuse. We label the latter user as a "pot head" or in the case of other drugs, "speed freak," "acid head," and a whole range of derogatory concepts. Those derogatory designations, by the way, are very important in terms of rehabilitation, because when you stigmatize somebody and label him as a "drunk," a "bum", a "head," or whatever it might be, you've barred him from the same kind of acceptance and treatment that you would give somebody with a peptic ulcer, schizophrenia, tuberculosis or other socially acceptable diseases. So bear in mind this problem of attitudes and the very negative stereotypes that have been developed about certain kinds of drug users through the propagandizing efforts of drug police agencies and the uncritical acceptance of these stereotypes by some politicians and the mass media.

The use of any drug, whether it be alcohol or marijuana, can be one-time or occasional, regular or daily. Only some of that daily use involves large or excessive amounts. Finally, of the cases of daily excessive use, only some involve addiction. Addiction is a physiological process that includes tolerance and withdrawal illness when the drug is discontinued.

The three drugs or drug groups that are capable of producing addiction are alcohol, barbiturates and other sedatives and narcotics. By narcotics I mean opium, morphine and heroin and do not include in that concept a variety of drugs that the law incorrectly and harmfully, in most cases, calls narcotics.

Drug abuse means something other than the way people frequently use it. They often apply the term to anybody they don't like who uses a particularly drug. According to such people the alcoholic is a neighbor who drinks and who might criticize the way you keep your lawn, therefore he must be an alcoholic. The *drug abuser* is somebody who excessively uses a drug, whether it be alcohol, marijuana, amphetamines, or narcotics, to such an extent that it objectively impairs his social or vocational adjustment or his health. That should be your working definition of drug abuse and insofar as you think of people as

"sick" who use a variety of drugs, that term should only be applied to drug abusers, not to people who use drugs in patterns other than abusive.

If, however, you prefer to continue using one of the layman's working definitions of drug abuse, which views it as any use of an illegal drug, you still have a far more complicated situation than you usually conceive.

ILLEGAL DRUGS

Alcohol and nicotine, or tobacco, are by far, the main, illegal drugs used in our society. It is well to remember the age prohibitions against the use of alcohol by those under 21 or 18, and the mass violation of these drug laws, which we hypocritically ignore, and which often start people on the road towards illegal use of a variety of other drugs. Let me add, parenthetically, to show you the interrelationships between the different drug patterns, that if we had not been *taught* that it was somehow acceptable, beneficial, or necessary to put a dried tobacco plant leaf in our mouths, search for a match, put this plant on fire, inhale the fumes of that into our lungs, to destroy our lung tissue and constrict our blood vessels, and then blow that out to pollute everyone else's air space, we would not have the widespread marijuana smoking we have today. God did not give us chimneys in our heads. Smoking is learned behavior. Having learned to accept one form of smoking it is much easier to step up, or step down or sideways, as the case may be, to other forms of smoking.

Any moral or rational person concerned about marijuana smoking should be concerned about *all* forms of smoking since there is extensive scientific evidence of the harmful effects of tobacco smoking. So the goal should be to eliminate or significantly reduce smoking not hypocritically concentrating on marijuana smoking while either passively or actively contributing to hundreds of thousands of unnecessary deaths each year from tobacco, simply because honorable men use tobacco and honorable men tell you that it has no harmful effects. You should think for yourself and again put things into perspective.

TREATING THE PROBLEMS

Let us now see how we may treat these different kinds of problems, keeping in mind our concept of drug abuse and the full range of drugs with which we have to deal. Many of the things called drug problems require no specific treatment in the usual sense of treatment and rehabilitation. I mean that the average marijuana user certainly does not need to go to a mental hospital and to be put in a ward where people are hallucinating and having a variety of delusions, and where a variety of other things are going on that you know far better than I. The average marijuana user does not have to see a psychiatrist. Let me give you an example of pathological frame of reference applied to a drug with which you may be more familiar: alcohol. Suppose we ask ourselves, "Why do people drink alcohol?" Most people would list among their replies the need to "relax," implying that they are chronically tense. A second reason would be "to feel good," meaning that they feel bad otherwise. From such replies you would be led to a diagnosis of a chronically anxious and depressed person who needs a drug in order to survive or function. Obviously that would not be the full picture. Among many things it ignores the broad social factors involved in drug use which are far more important in actual practice than are psychological factors. But using that frame of reference, you can conclude that anybody who uses a variety of drugs that, by official policy are considered evil, is in need of psychiatric treatment; you may even come to think of that as progress. Certainly, in a philosophical sense, it is better than thinking of such people as inherently needing "rehabilitation" in a jail or prison. Parenthetically again, I want to emphasize to you the habit we have in America of substituting image for reality; a habit that is fostered by public relations agents and the advertising industry. If we call a place a rehabilitation center, we build an expensive institution, hire expensive administrators, and label it "rehabilitation." Everyone knows of course that rehabilitation takes place there. You witness that every day. Actually what does take place in our jails and prisons when you send an otherwise generally conforming, responsible, acceptable young person there for rehabilitation because he uses marijuana, is that he gets a post doctorate course in real crime. It is often an introduction to heroin use and to aggressive homosexuality. We call that progress and continue to label it rehabilitation.

Many forms of drug use do not need specific treatment, and should not come to your attention as professional people. They need to be dealt with mainly through preventive means that I don't have time to discuss exhaustively today. Prevention, of course, includes education. By education I don't mean propaganda, the kinds of materials that are generally being disseminated now in crash programs in high schools, in colleges, by narcotics agents that show that within 24 hours of passing by a building where marijuana was present, the individual becomes a heroin addict and ends up in a mental hospital or prison. That is not education. It is propaganda and that, instead of educating, has caused far more drug use because of its lies, distortions, and hypocricies. But prevention and education in attacking the roots of drug use is the ultimate answer for the excessive use and excessive preoccupation of our society not only with marijuana, but with alcohol and a variety of other drugs. This drug use affects all ages, all socio-economic groups, all racial groups.

ATTITUDES IN TREATMENT

Those that do need treatment, then, are the drug abusers. And the first level answer to that is the matter of attitudes that I have touched on a few moments ago. As long as our attitudes are negative, hypocritical, and rejecting towards the drug abusers, whether they be alcoholics, narcotic addicts, LSD bad trippers, "speed" freaks, or whatever we might call them, as long as we reject them and stigmatize them we are not going to be able to treat them properly. For the country at large, there has not been a real attempt at rehabilitation. The pessimistic reports about treating drug abusers, such as you heard this morning, are not really based upon an all-our effort or commitment by society. The effort expended was only a fraction of the tens of millions of dollars that we spend every year in this state for our ineffective and often harmful enforcement of a punitive approach to various kinds of drug problems, ranging from the arrest of the drunk offender, the skid-row alcoholic, to the institutions that we have for the narcotic addict. First of all, we have to recognize drug abuse in all its manifestations as something that demands of us acceptance, understanding, compassion and a commitment such as we presumably have toward illnesses like psychosis, neurosis, ulcers, pneumonia, cancer and many other things that exist in our society Specifically, it means that when a drug abuser

comes to your attention he should have full access, as great access as anybody else in that hospital, to all the resources at your command. Often, I think your profession is the mainstay of those resources, as there are far too few doctors, particularly committed, knowledgeable doctors who are really making an all-out effort to rehabilitate the people in state hospitals or in other programs.

It is particularly important therefore that you know more about these problems, recognize the challenge, the importance of helping people who can be led toward a more meaningful, more valuable, more contributory existence in our society. They should not be stigmatized, nor should they be segregated unless it means that they are going to participate in a far more intense, specialized all-out program. Segregating them on a locked ward, as is often done around the country while providing only a token program of so-called "drying out" for either the narcotic addict or the alcoholic, is neither treatment nor rehabilitation. Since we have not used all available resources in rehabilitating drug abusers, we must, for humanitarian reasons as well as for social policy reasons, make such a total effort immediately. We must begin to develop and direct our financial and personnel resources to bring about some solution for the problems of people who are presently rejected or made even worse because of our present system.

REALISTIC TREATMENT GOALS

After you've dealt with the matter of attitudes you must then define realistic goals. If you set an all-or-none goal I think you doom yourself for frustration and create what might be called a self-fulfilling prophecy. In other words, you make it come out the way your bias caused you to think about it in the first place. If you set up the goal that every alcoholic, every narcotic addict, every amphetamine abuser that comes to your attention in a hospital or clinic has to be completely cured and never use the drug again or else you have failed and he has failed, then you *are* doomed to failure. A teacher in a public school would be doomed to the same kind of failure if she defined accomplishment in terms of everyone getting a straight "A".

You have to have a much more intelligent, a more realistic, a better thought-through kind of goal. It should include a definition of progress

in terms of reducing the amount of the drug that a person used, or the frequency that he used it. It should also include any improvement in his social or vocational adjustment even though he might continue to use some of the drug. It is absolutely irrational, for example, to throw an alcoholic out of the state hospital because he broke the rules and got a drink. The parallel to that would be to throw every schizophrenic out of the hospital because he had a hallucination. The point being that this is a symptom of his illness and should be dealt with as such and not seen as a failure on your part or on his part. So, any signs of progress as I have defined them should be emphasized in your interraction with the patient. You should help build up his self confidence by encouraging him towards ever more progress with the ultimate goal of living a drug-free existence while recognizing that not everybody can achieve that. On the road to such an ultimate goal, patients can make significant progress, even while they are using some of these drugs.

NO SINGLE TREATMENT METHOD

The third general principle about treatment that I want to emphasize is that there is no single solution or treatment method that will ever cure all alcoholics, all narcotics addicts or all abusers of any other drug. The reason for that is that these are psycho-social illnesses. They are not simply due to an arrested oral-psycho-sexual development as Freudian psychiatrists would like to have us believe, which is, in any case, a very non-specific explanation that is used for schizophrenia and peptic ulcer as well as for drug abuse. Drug abusers are not the product of any simple psychiatric or psychological theory. In our society there exists strong social pressures to use a variety of drugs. These social factors interract with certain psychological needs. As Huxley once said, "it is highly unlikely that mankind can ever dispense with artificial paradises". All societies, or at least a certain proportion of their population, seem to need some use of mind-altering chemical whether it be alcohol, cannabis products or a variety of other drugs. But certainly the total dependency of the society on these things can be reduced and any one individual abuser of these drugs can be helped significantly toward a more constructive kind of existence. So when you apply treatment methods you should have available the greatest possible variety of these methods and apply them in combination. Every person who is a drug

abuser thus should be treated with two or more avenues of help.

Do not believe the publicity reports, the self-serving statements of any psychiatric approach such as Synanon, which always leaves out of its statistics the vast numbers of people whom they do not accept in the first place or who leave on the first day or week, very much as the surgeon might give you a hundred percent success record if he counted only the people who lived and left out entirely from the statistics the people who died. Statistics obviously can be used like drunks might use a lamp post, that is, something to lean on rather than something to provide illumination. And many people tend to use treatment statistics in that way.

All of these kinds of help, self-help programs such as Alcoholics Anonymous, Synanon, Bay Top Village, Narcotics Anonymous chapters; formal professional treatments like group and individual psychotherapy; social work services; vocational counseling; employment services; behavior therapy or conditioning techniques; drug therapy such as Antabuse for the alcoholic, or LSD treatment which in several research studies has been found to be effective for alcoholics and more recently for narcotic addicts; — as many of these things as possible should be available in a comprehensive treatment program. Several of these in combination should be made available to any individual drug abuser, hopefully with his participation in the treatment decision.

We often fail to involve the patient in the treatment. That is sometimes one of the reasons for failure. He should have explained to him all these methods. This might well fall on your backs because doctors, particularly in state institutions, clinics or hospitals are unlikely to take the time to delve into these things or to sufficiently individualize the treatment. Further, the drug abuser should participate in the decision as to which methods are more acceptable and then these things should be applied over a long period of time.

INSTITUTIONAL TREATMENT

Next I would emphasize to you that institutional treatment is the least important part of treating drug abuse. We have wasted vast resources of

state and federal government in building extremely ineffective and extremely expensive prison-hospitals, generally calling them hospitals although they are basically prisons. In the case of the California Rehabilitation Center at Corona or in the case of state mental hospitals, we have in the past overcrowded the institutions and given undue emphasis to that institutional component of treatment. That can be important when somebody is unable temporarily to manage in the outside world and he is so debilitated physically or mentally that he needs some period of hospitalization. In that case, hospitalization should have as its goals physical rehabilitation, including withdrawal from whatever drug is involved, and physical build-up. The second goal, and a more important one as I see it, would be to introduce the individuals to a variety of treatment methods. Make them known and if possible start them. For example start somebody on Alcoholic Anonymous, start him on Antabuse if he is an alcoholic or on some other kinds of help. But the main thing needed in formal treatment and rehabilitation, and something that I hope more and more of you will involve yourselves in, is the long-term out-patient treatment of the drug abusers in their home environment, where they are subject to the ordinary stresses and strains and often great over-availability of the particular drug, most commonly alcohol, — our most serious drug abuse problem in America. There are more alcoholics in the San Francisco bay area alone than there are illicit narcotics addicts in the entire United States.

This should give you an indication of the disproportionate kinds of attention we give to different drug problems, the hypocrisy, the strong biases that enter into what we see as drugs or drug problems.

LONG-TERM CARE

Of particular importance are long-term outpatient care programs that make available all of these resources to all kinds of drug abusers. I developed such a program in San Francisco in 1965 and recommend that every large community, or even medium sized community, throughout the country set about to establish a specialized outpatient treatment program for drug abusers; in such programs all drug abuse is treated in one context, including alcoholism, chronic cigarette smoking amphetamine or barbiturate or other pill abuse, LSD bad trips, marijuana abuses, and narcotics addiction.

There are many reasons for this. One of them is that if you do not give specialized attention to drug abuse, including alcoholism, the drug abuser tends to be put at the bottom of the list in Short-Doyle clinics or other public mental health clinics. I'm sure your experience would corroborate that in most state hospitals he tends to go to the bottom of the list. Secondly, and even more importantly, if you don't give a specialized approach there are no professional resources available to really understand or help them. Most doctors and most non-medical professionals in such programs do not have specific training and experience with drug abuse. Their attitudes generally are no more sophisticated or knowledgeable than the layman's about what drugs are, what they do, and what kind of treatment methods should be available. Therefore, they would tend to reject or stigmatize the drug abuser in the way I described earlier. So it does little good to just say that we should open up ordinary mental health programs to drug abusers unless we also provide specialized training, in-service or outside the institution, of professional staff members so that they can understand and cope with these problems. That's why we need specialized facilities.

Eventually, when we are able to train enough professional people and can communicate to them the challenge of dealing with drug abuse and can show them the very high rehabilitation rates that can be achieved by enthusiastic and committed people using a variety of treatment methods, eventually, when we've done that, I would hope that the drug abuser can get ideal treatment in any mental health or psychiatric facility, including private practice where presently such help is also unavailable. Until we do that we should develop these specialized programs. We should plan for long-term care for the drug abuser, recognizing that we have no magic solutions. We should also recognize the strong social forces that are conducive to drug abuse and appreciate the importance of even limited progress in terms of reduced intake of drugs and improved social and vocational adjustment.

"DRUG-RIDDEN" SOCIETY

The roots of drug use and abuse are deeply imbedded in the fabric of American Society. We are living in a drug-ridden society, where, from infancy onward, we are taught by the role models of our parents, by the mass of advertising, and by a variety of other things, that we should

accept and indeed live the industrial slogan of "better living through chemistry." We are made to believe that every time we have a pain, problem or trouble, we presumably should have a drink, smoke a cigarette, or drop a pill, and that we must apparently depend on a variety of mind-altering drugs in order to relate or socialize with other human beings and have a good time.

Then we have enormous peer-group pressure to conform through drug use. That's best exemplified again by a cocktail party or some other social event centered around the drug, alcohol, where you can recognize the plight of the abstainer or teetotaler. At the very least, he or she is a considerable source of anxiety to everyone else present and indeed that abstainer may come to be thought of as one of the most dangerous things in American society: a non-conformist. Considerable pressures are of course exerted to get them to go along with everybody else's drug pattern.

Significantly, young people, who are very likely to point out the conformity and over-conformity of the older generation often fail to recognize this in their own behavior. Their dress styles or their hair practices, which they consider to be a manifestation of their individualism, and even their pattern of drug use, often reflect the same kind of conformity or over-conformity exhibited by older people. Young people, like older people, have been taught that being popular is far more important than doing things, or touching upon controversial issues, or showing an individualistic pattern. So that when drug use, whether it be alcohol or tobacco as it has been for decades for people under age, or marijuana in more recent years, is defined for them as a way of being accepted or being popular, they are far more likely to use those drugs than otherwise. This, of course, gives us a very important clue for prevention, and it suggests that we have to help people become much more inner-directed and individualistic so that they can make a much more discriminating decision about drug use than they do presently. I don't think this peer-group pressure can be overemphasized in our society. I think it cuts across the board and must be built into any effective preventive or educational program.

PREVENTIVE PROGRAMS

In any preventive or educational program, the positive approach will be the most effective one. Therefore, if you are conducting drug education or any kind of prevention program about drugs, the more you can make going to school or the education process itself a mind-expanding experience for young people, the less likely they are to turn to a chemical for its alleged benefits of mind-expansion. I would also suggest that a similar thing is true for the rest of us. The more exciting and meaningful our work is to us, the more we are involved and committed in doing something that we deeply like, the less likely we are to feel a need for this whole range of mind-altering drugs.

There is an integral relationship between the society in which the drug use occurs and the drugs themselves. Drug use and abuse is a barometer of our society and is a reflection of deep underlying social pathology and social ills. Sloganeers tell us that we live in a "great society" or "creative society." It is, of course, true that there are many good things in our society. It is also true that we have a long way to go in terms of improving the quality of life for great numbers of our population. These include not only the Black, the Chicano, and the Indian but also the minority groups of young people, which, although not a minority in terms of numbers, are certainly a minority in terms of oppression and discrimination, and in their inability to vote or participate in the decisions that affect them. For these vast numbers of people, the quality of life is not what it should be; anybody seeking to reduce drug use in America and to rehabilitate drug abusers must deal with this problem as well as with the other problems.

I firmly believe that we can communicate an alternative ethic if we are fully committed and if we understand the full problem. We can communicate an alternative ethic to the so-called psychedelic ethic which as you know says "turn on, tune in and drop out." The final message I'd like to leave with you in concluding is that I think the new ethic that we should all work toward is that we "turn on" to the world around us, "tune in" to knowledge and feeling and "drop in" to changing and improving our society.

COMPREHENSIVE PLANNING FOR ALCOHOLISM PROGRAMS

by

Nicholas Khoury, M.D.

Dr. Nicholas J. Khoury has devoted many years to the stubborn psycho-social problem of alcoholism. He is a graduate of Tufts College Medical School in Boston, where he specialized in internal medicine after completing his residency at Hospital of the Good Samaritan in Los Angeles.

Currently he is in private practice in internal medicine in Los Angeles and on the staff of a number of Los Angeles hospitals, including Hospital of the Good Samaritan, California Hospital, and St. Vincents Hospital.

He is a special consultant to the California State Department of Public Health and a lecturer in the Department of Health and Safety of the California State College at Los Angeles. He is also Assistant Clinical Professor of Medicine at the University of Southern California School of Medicine.

Dr. Khoury's specialized knowledge is recognized by State and County medical associations and he has been chairman of the committees on alcoholism of both the Los Angeles County Medical Association and the California Medical Association. This knowledge makes him much in demand to speak on the treatment of alcoholism and to assist in organizing programs to meet the needs of the community for dealing with this prevalent and increasingly serious problem.

In discussing alcoholism and alcoholics I would like first to lay a foundation for communication so that you will know what I mean when I say certain things. I don't ask you to agree or disagree with me, but only that you form your own conclusions. Then having laid this foundation I would like to just ramble, intellectually I hope, to develop a concept of a total community approach to alcohol and to alcoholism. You can't separate the two because without alcohol there would be no alcoholism. But alcohol isn't the cause, or the etiological agent, for the disease called alcoholism anymore than gasoline is the etiological agent

for the traffic fatalities and the mayhem that we commit each year on the highways.

THE "ALCOHOLIC"

Let us begin by describing what we mean by an "alcoholic." An alcoholic is any individual who because of his drinking, or conditions associated with his drinking, is unable to function in an acceptable manner in his environment. We don't say anything about how much he drinks, what time of day he drinks, or what he drinks. We don't say anything about addiction. We don't say anything about any of those other "weasel" words that confuse the whole issue. If you've got a problem with your drinking, you're not just a "problem drinker" — you're an alcoholic.

There are various types of alcoholics. They do not all require psychiatric treatment. About fifteen to twenty percent of the alcoholic population may require rather intensive psychotherapy or psychiatric treatment. Less than ten percent of the alcoholic population require any type of hospitalization and about one percent of them may require state hospital or mental hospital hospitalization. Now whether you agree or disagree, you'll develop at least an understanding of what I mean as we go along in developing a concept of how to approach the problem of alcoholism.

COMMUNITY ACTION

Having defined the alcoholic, we should then consider what the community can do. The community first has to determine what it wants to do with the alcoholic and towards which part of the alcoholic population it wants to direct itself. If all its efforts are directed toward the "skid row", the falling down drunk, or the "sick" alcoholic population it is doomed to failure. In any conceptualization of an approach you must realize that the healthy must be treated, as well as the sick. Nothing you can do in any community will be successful unless the healthy portion of the community is made a partner in your approach. Not only the alcoholic population but the healthy portion of the community must understand what you are doing and what you are trying to achieve. That means education and public relations for any

program that you start. This is your important first step: *to decide what you want to do with the alcoholic.* Do you want to call him or her a "sick" person suffering from a disease? Do you want to absolve him from all responsibility for his behavior and actions in his illness? Do you maintain that you can't arrest alcoholics because they are sick people who should be taken care of by the doctor or the hospital? You will have to decide these points because they affect your approach to the problem. The Supreme Court almost decided it for you not too long ago but they hedged and didn't decide anything.

In the State of California we have approximately a million people who are recognized as alcoholics. This information was obtained by a documented drinking practice study conducted by the State of California Department of Public Health on problem drinkers in the State. As I said earlier, if you've got a problem with your drinking you're an alcoholic. In Southern California, in Los Angeles County, it is estimated that there are about 400,000 to 450,000 alcoholics. Fortunately, these alcoholics don't *all* require public services. Some of these receive care and treatment through private services, private physicians or private hospitals. The program that we have to make available for the alcoholics is one that will meet their needs.

MODEL ALCOHOLISM ACT

In the State of California we have the Model Alcoholism Act called the McAteer, Rumford, Marks Alcoholism Act. It was made final this past legislative session. It states that every county has the local option of designating the County Health Officer or the County Mental Health Officer as the individual charged with responsibility for program planning, coordination and implementation of alcoholism under this act. Having done this, the county then has to make provisions for providing ten or eleven services for the community and for the alcoholic. After the county has promulgated and published its model act or plan, it is submitted to the State Department of Rehabilitation for funding. On the basis of this act there is available funding of 80% federal funds to 20% state funds. Five percent of this twenty percent is the required participation from the local community. A program that started in 1957 with a budget of about $120,000 for the entire state, is now budgeted for almost $4,000,000. It is projected that within five

years the budget for the alcoholism program will be closer to $10,000,000 to $12,000,000.

What does such a program envision and require? You need, number one, the cooperation of all public and private agencies in your area. The biggest obstruction in the field of alcoholism today is not the patient, the medical association, or the hospitals; it's no one individual group. Rather, it's the lack of cooperation and short-sightedness among the so-called public and private agencies concerned with this great problem. We had a meeting yesterday with the California Hospital Association and the California Medical Association committees and some other interested individuals; it was an amazing situation. There were about 18 people sitting around the table and each seemed to be an island unto himself. They didn't hear and they didn't communicate with each other. I think in these cases sometimes a benevolent dictatorship is needed to step in and establish order.

The Model plan now being implemented in Los Angeles County, is proof that the kind of cooperation for which we are striving at the meeting can be obtained. It is a small pilot model (funded under the McAteer Act) but it works and it demonstrates that public and private agencies *can* work together. In this project nobody gets his toes stepped on and nobody loses any money or job, if he is really interested in the alcoholic, the problems of alcoholism, and if he is willing to work cooperatively.

THE DER CONCEPT

What is needed is a focal point for *diagnosis, evaluation* and *referral.* We refer to this as a DER[1] concept. Then anyone — industry, the jails, the police, public welfare, families or an individual himself — can come to the DER center and ask the question "Am I an alcoholic?", or, "Is this individual an alcoholic?" In the DER center there is a psychiatrist, an internist, a public health nurse, a Department of Public Social Service worker, a medical social worker and a Department of Rehabilitation Vocational Rehabilitation Counselor. Formerly we also had a representative from the Department of Mental Hygiene on the county level. These individuals see the patient, screen him and make a diagnosis. It's a tentative or presumptive diagnosis which at least answers the

question, does the individual have an alcoholic problem. If there is such a problem they then try to determine the specific needs of this individual.

After the individual's needs have been established and evaluated, he is ready for referral. The staff arranges the proper referral to existing agencies and sources of treatment or services that will meet the needs of this particular patient. The procedures do not take long; the individual comes in at 8:30 in the morning, he is screened by noon, and then the proper referral is made. It may happen that no agency or service exists for the needs of a particular patient. In that case, the diagnosis and evaluation of need serve as a foundation to justify requirements for services that are not present and available. It's one thing to stand up here and say, "No services exist for the alcoholic in Los Angeles County. We should have a budget of a hundred thousand dollars to set up a mental hygiene clinic over here." But this need has to be justified and demonstrated before you can ask the taxpayers or anybody else to put up the funds. This is the value of the Diagnosis Evaluation Referral Center.

The other value is the chart that is started on that patient. He is assigned a number and as you know, from your own experience, the social security number has become the guide number. What we're establishing, then, is a *central registry* for alcoholics. It's like tagging the salmon when they go upstream. And this is important because we've talked about alcoholism and the effects on the community, but what are we really talking about? We are talking for example, about the single unattached male in the "skid row" area who goes to the Department of Public Social Services and gets aid as a single unattached male. He's sent to one of the hotels for single unattached males, and $110 a month is authorized for his room and board. Two days later he is down on main street, drunk. He is picked up by the police and taken to Lincoln Heights Division 58, where he is given a week or ten days. Meanwhile DPSS is paying a hotel downtown for 30 days room and board. The taxpayer has absorbed the cost of arrest, detention, appearance before a municipal court judge, and sentence to a jail or camp for a week or ten days. These are costs that are accumulating for the same individual.

Let us assume he is sent to camp. He hasn't had a drink for about five days. He goes into withdrawal seizures, or he goes into "DT's" and he's transferred to the general hospital. No matter how you cut it, general hospital costs are at least $80 a day to the taxpayer. He's there three or four days then he's discharged back to the street. He has forgotten the hotel where he was staying. In the meanwhile, the room has probably been re-rented to another single unattached male and is being paid for by DPSS. How do you pinpoint the costs in the areas of biggest need? The judge says "Look at the volume we got in 1958." The police say, "60 percent of our arrests are plain drunks." The hospital says, "Look at the authorities bringing them in to us." And somewhere along the line we have to interrupt this. And the only way we can interrupt and assign priorities is to know where they are going. This is the central registry concept. This is the use of the social security number so that when these people start coming through and the figures start coming in there can be a more valid understanding of what's going on.

TREATMENT PROGRAMS

Having established the DER concept to service areas of high incidence of need, we must then establish a whole complex of inpatient and out-patient treatment relevant to the population of the area. As I indicated earlier, less than ten percent of the alcoholics require hospitalization, and less than one percent need state hospitals. I'm not trying to drive the hospital technicians or staffs out of a job, — certainly, there's enough for them to do. But the treatment of the alcoholic is frustrating and it's wasteful to put him into a state hospital. Prior to 1960 and 1961 we used to commit from the County of Los Angeles on voluntary petitions, about 650 inebriates to the state hospitals each year. They were kept there 90 days doing nothing and then were discharged back to the street.

We conducted a survey for Superior Court 95 at that time to find out why these individuals were going to a state mental hospital, and we learned that the major reason was they had nowhere else to go. By screening them and giving them the treatment they needed, we noted a 90 percent drop in the commitment rate during the very first year of the program in the County of Los Angeles. That year we committed only 54 individuals to the state hospitals on voluntary petitions. The

number has remained steady since then. However, there has been an increase in the number of females being committed. The reason for this is we don't know where else to send the female alcoholic. Strangely enough, in all the elaborately planned services for the alcoholic, it was overlooked that there is a "he" and a "she" in the alcoholic problem.

For those sent to state hospitals, no special in-patient facilities are required. If they're committable it's not just for alcoholism, but for a diagnosable psychiatric problem, and they should be given the same treatment as any of the others being committed for these problems. The same situation applies for alcoholics admitted to general hospitals or the acute hospital wards; they should be admitted to the hospital not merely for alcoholism or for being intoxicated but because of the medical condition that requires an acute or general hospital service. In our program we estimate using a hundred beds in the USC, – L.A. County General Hospital setup, (the medical setup) for acute medical detoxification or withdrawal. We have a ward working there now, Ward 10,700, where the average length of stay is between three to seven days. When alcoholics leave the hospital, is it just to go back to "skid row" and get drunk again? This tragedy can be avoided if they enter a continuum of treatment that progresses from the in-patient to the out-patient.

To meet this need, *the half-way house* concept has to be enlarged and standardized. There must be requirements for half-way houses so that they can participate in this complex of services for the alcoholic patient. The Salvation Army in conjunction with the County Health Department established the Harbor Light Program with about 250 beds for single males. The clinic is called the Civic Center Alcoholism Program, CCAP. It functions right in the Harbor Light complex. The individual is sent there, and if he is not working, the Salvation Army is reimbursed by DPSS. In the past the average period of support under DPSS was from six to eight weeks for the single unattached male.

Under this program this support period has averaged two weeks before the individual is self-supporting again. In the clinic the treatment is fitted to his needs. Here again the treatment team includes the psychiatrist, the internist, the social worker, the vocational rehabilitation counselor, and other counselors such as recovered alcoholics, chaplains, etc.

The other type of service that's required, — is for the female alcoholic who needs a controlled environment or a half-way house. The Millmar Foundation and a few other half-way houses are attempting to meet this need. In Pasadena there are several private, non-profit organizations that are providing housing for the female patient. They are paid and reimbursed in the same way as other agencies.

The essential point is that these facilities are all part of a coordinated joint effort. Without such close cooperation and coordination, a program is doomed to failure because you have nowhere to refer him upon discharge. This is the tragedy! You treat him in the hospital, you get him in shape, then you dump him back on "skid row." You treat him in the clinic, you get him in shape, and then you dump him back into the community with no support. Chronic alcoholism as the name implies is a chronic disease and it requires a continuum of therapy that may go from an intensive in-patient stage all the way to a superficial once-every-three months five or ten minute encounter just to give the patient the feeling he has a place, a physician, or a counselor he can relate to and from whom he can receive the attention he needs.

In the County of Los Angeles, the County Health Department has established six free *outpatient clinics* for the alcoholic. It is supported under the McAteer program. The chart that was started on the patient, whether he was in the hospital, in the CCAP program, or whether he goes to a health department district outpatient setting, follows him, so that there is a continuum of understanding and exposure for the therapist as well as the patient on that chart.

The Department of Hospitals also operates so-called *rehabilitation centers.* In the old days we used to call them "camps" such as were established in Warm Springs and Mira Loma. These rehabilitation centers provide sub-acute convalescent type service for individuals who need a controlled environment other than that at half-way houses that are intended to prepare the alcoholic to become self-supportive again. At the rehabilitation center the alcoholic may stay 30, 60, 90 days or more. In the past, after staying 30, 60, or 90 days the patient was then dumped downtown.

The biggest fiasco was the Saugus Alcoholic Rehabilitation Center. It was the greatest concept, a tremendous facility with dedicated people,

but it failed utterly because one factor was forgotten: where does the individual go after he leaves the center? The tragedy was that the sheriff's department could only deliver him down to the main jail and he was discharged from there to the street. Five minutes later he was on "skid row" getting another drink. Thus, the money was wasted unintentionally, because there was no continuing plan.

We're not just going to dry out a drunk. We're not just going to get him off the street. We're going to provide whatever he needs to restore him to being a normal, productive, self-dependent member of society. This may seem unrealistically ideal, but if you don't strive for this goal you're wasting your time and effort. Even if you succeed only half the time, it's better than failing 100 percent of the time.

In addition to the rehabilitation center, we have also the *in-patient hospitals*. At present there is a contest between two such facilities, Metropolitan and Camarillo to see who gets the alcoholic. Although the intentions are good, the tragedy is that they may be less interested in the alcoholic than they are in maintaining a patient load that will justify their staff size. I wish we could use both hospitals, but evidently somebody drew a dividing line that determines what facility should receive patients living in a certain area. The tragedy is that whoever drew the dividing line forgot one thing: Camarillo State Hospital is in Ventura County and to transport a patient from L.A. County requires special permission from the Board of Supervisors to leave the County on official business. So there's no way to transport the patient to Camarillo. We're trying to correct this problem but are hampered by the disagreement between the two state hospitals.

In brief, the L.A. program now has hospitals, camps or rehabilitation centers, and the half-way houses. We are in the process of developing out-patient facilities. Ultimately out-patient treatment centers will be established in every district health office; there will be 23 centers spotted throughout the county. Ideally, there will be treatment centers at Harbor General Hospital, U.S.C. Medical Center Hospital, and at private hospitals throughout the county. Some of these are being established now. This is the private sector's effort. The funds are available.

COMPLETE SPECTRUM OF SERVICES

The Federal government is interested now, too, since Dr. Egeberg's statement that alcoholism is the number one public health problem. Senator Hughes had his hearings here in Los Angeles too. Of course the tragedy of the hearings is that they were more of an audition for television than a true picture of what happens. But this is the image that goes out on national television — this is the testimony before a United States Sub-Committee. This happens because of the confusion, the disorganization, and the petty bickering and differences that go on among the professional community, the non-professional community and the agencies, public and private, that are *really* interested in the alcoholic.

SUMMARY

The program that I have just outlined is based on the concept that we will accept the alcoholic patient throughout the community wherever he enters the system. He may enter as a walk-in to one of the clinics. He may enter as a referral from his employer who threatens to fire him unless he stops drinking. But wherever he enters the system, you must offer him the complete spectrum of treatment, the whole continuum of treatment, whatever he needs, whenever he needs it. You keep proper records so that you don't lose the patient or lose sight of what you are doing. What has to be done is hard, steady work. There is no magic cure for alcoholism. Anybody who says he cures alcoholism is a fool or worse. You don't cure alcoholism. We may arrest it or help to control it, but until we know a lot more about it, and until we agree on what we are talking about, we won't have a solution. My favorite statement is "a lot of the people you call alcoholics I may not recognize as an alcoholic, so we have to get our definitions and start talking about the same thing."

Alcoholics and alcoholism should not be exclusively a psychiatric problem. You're doomed to failure if you accept this concept. Fifteen to twenty percent of the alcoholic population will need the help of the psychiatrist; these are the ones that require psychotherapy. The remaining 80 to 85 percent of the alcoholics do not. It is this group that frustrated the APA about five years when they announced that

they didn't want to treat alcoholics because it was too frustrating. This only proves that if you treat the patients who need your services your chances for success are much better than if you try to be all things to all people.

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TREATMENT AND MANAGEMENT OF ALCOHOLICS

by

Keith S. Ditman, M.D.

Dr. Keith S. Ditman has had an intensively active career in the field of psychiatry since 1949. After attending Santa Barbara State College, the California Institute of Technology and the University of Southern California, he interned at the U.S. Naval Hospital in Long Beach, and completed his residency in Psychiatry at the Neuropsychiatric Hospital at the Veterans Administration Center in Los Angeles.

Since 1956 Dr. Ditman has been associated with the University of California at Los Angeles. He helped organize the General Psychiatric Clinic, the Psychochemotherapy Clinic for residents of UCLA Neuropsychiatric Institute, was assistant professor in the Department of Psychiatry, School of Medicine, and research psychiatrist and lecturer in this department. His latest assignment was Director of the Alcoholism Research Clinic at the University.

Currently, Dr. Ditman is engaged in private practice in Beverly Hills, California, is research psychiatrist III and lecturer, Department of Psychiatry, U.C.L.A. School of Medicine, and is Vice President and Medical Director at the Vista Hill Psychiatric Foundation in San Diego, California. Recognized as an authority in this field, Dr. Ditman has been called on to give consultant service to many groups throughout the state as well as to studios for films and television programs.

Results of Dr. Ditman's years of study and work are evidenced in an impressive collection of articles and books, including studies on sleep, drugs, and alcoholism. Such descriptive titles as "The Use of Drugs in Alcoholism", "The Concept of Motivation in Psychotherapy with Alcoholics", "Evaluation of Drugs in the Treatment of Alcoholics" and "Drugs, the Alcoholic and A.A." show his particular interest in the topic of discussion.

This paper is on the treatment and management of the alcoholic from the standpoint of a practicing psychiatrist. Alcoholism is an ubiquitous

condition. If affects most age groups, certainly both sexes, all races, all educational levels and all socio-economic classes. Alcoholism is a behavioral condition that can exist in a normal individual. Not everyone would agree to this but there are a number of psychiatrists who have studied the condition extensively and feel that many alcoholics are "normal". However, most alcoholics have a concomitant or an underlying neurotic condition. Others have a psychotic condition that is either concomitant with or underlying the behavioral disorder, alcoholism. Some alcoholics are character disorders — probably this is the predominant group, and finally there are those who are alcoholics secondary to brain damage. For example, in follow-up studies of people who have had lobotamies, the literature indicates an alcoholism rate of 11 percent. In other words individuals with damaged brains from that type of surgery are much less able to handle alcohol, consequently they would fall into the classification of an alcoholic, that is, someone who grossly misbehaves as a result of alcohol ingestion.

WHAT IS ALCOHOLISM?

Dr. Khoury has presented to you his concept of an alcoholic. There are many and varied definitions. When there are a number of definitions of something it indicates that either we do not understand the condition or we do not agree on what the condition is. Many definitions of alcoholism express the negative attitude that many people have toward drinking, on the one hand, and toward drunkenness and behavior while drunk, on the other.

During the past twenty years, due primarily to the efforts of the National Council on Alcoholism, together with Alcoholics Anonymous, the approach has been to view alcoholism as more of a medical problem than a moral one. Efforts have been made to change attitudes toward alcoholism, to obtain legislative changes, and to interest people in the field of mental health to treat alcoholics. Some headway has been made, but not as much as many would like. For example, some of the recent court decisions in the handling of narcotic addicts have stated in effect that the condition of addiction to narcotics is a disease. Consequently, in keeping with the Eighth Amendment to the Constitution drug addicts are not classified as criminals, as that would constitute cruel and unusual punishment. It's been the hope of many

people in the field of alcoholism, that a similar decision for alcoholics would come from the Supreme Court. What has happened is something quite different. In effect, the Court has said that it has not been adequately established that alcoholism is a disease, that the experts in the field really do not agree. This, for the most part, is correct, but nevertheless alcoholism is an identifiable and treatable condition. Some mental health professionals, for example Thomas Szasz, hold the position of "no illness" in many conditions we treat. (See Szasz's book, "The Myth of Mental Illness"). Nevertheless there are things that can be done for the treatment and rehabilitation of the alcoholic. Because of the limitations of time I will only review some of the highlights of an alcoholic treatment program.

AN APPROACH TO TREATMENT

First of all, most alcoholics, like other mental patients, particularly neurotics, do not go for treatment or help until they are under considerable pressure. They are under duress and are suffering, and this discomfort motivates their treatment. Consequently, to be able to treat the alcoholic patient, we must remember the rule that the art of diplomacy is to not give up the advantage. We should be careful in removing the pressure or duress which is weighing on the alcoholic and compelling him to seek treatment. When the pressure is moved too early the alcoholic feels he is "cured", leaves treatment, and eventually goes back to drinking.

The incidence of alcoholic patients dropping out of treatment is notoriously high. It is this loss of contact with the patient that frustrates and discourages many people working in the mental health field. But actually the recovery rate of alcoholics is often no worse than it is for schizophrenics or neurotics or character disorders. Sometimes the recovery rate is actually better, while the improvement rate in many instances is comparable to that for the character disorder and the neurotic.

It seems, therefore, that the discouragement of some persons working with the alcoholic is in part due to their mistaken or unrealistic goals for the individual and their misconception of the underlying pathology of the alcoholic. This futile attitude pervades the field of psychiatry.

Many psychiatrists do not treat alcoholics, because the alcoholic may be irregular about keeping appointments, or because they come drunk to appointments. Many psychiatrists have feelings of inability to do seomthing for the alcoholic. In part, this sense of helplessness is due to the fact that they have been inadequately trained in dealing with this particular condition. Most training programs in psychiatry have minimal or no training for the psychiatrist in handling the alcoholic. Roughly 20 to 30 percent of the patients that psychiatrists would ordinarily see in the practice of psychiatry are suffering from alcoholism and yet they are not trained to treat it. It is a situation that is changing, but slowly. As a result of this it is difficult or really impossible to adequately staff alcoholism clinics with well-trained professional people, that is psychiatrists and psychologists and social workers. Consequently, if one looks at the literature on the results of treatment of the alcoholic he finds that the effective therapist of the alcoholic more often is the lay therapist. The lay therapists have a better record of improvement, or in obtaining abstinence, for the alcoholic than do the professionals, and they treat more alcoholics. To a considerable extent the treatment of the alcoholic has gone by default from the professional to the lay therapist. Witness the rise and success of the organization, Alcoholics Anonymous.

TYPES OF TREATMENT

Treatment of the alcoholic can be classified into three types: *deterrents* aimed to halt or at least impede the drinking, and also to impede some of his destructive behavior, particularly while drinking, such as drunk driving; *palliative* or *supportive* therapy; and finally one that might be called *therapeutic* or perhaps *specific therapy.* It should be emphasized at this point that there may not be any really specific therapy for the alcoholic. Rather, what we have is, at best, an inter-disciplinary, an inter-organizational approach to the alcoholic, doing as much as possible in all areas, and hoping that by all this we contain him, support him and rehabilitate him. But we do not have a specific therapy for the alcoholic as we do in the form of an antibiotic for an infectious disease, or electric shock for depression, or anti-psychotic drugs for the psychoses.

Deterrent treatments include job jeopardy, (various companies have used this effectively for rehabilitating and improving work attendance

of employees); threats to health; court imposed probation with suspended sentence; threats of spouses and significant others; and the drug Antabuse. Antabuse in well controlled studies has been shown to have a 25 percent effectiveness, which is less than many would expect from a drug that prevents drinking.

The *palliative* or *symptomatic* treatments include the brief psychotherapies, sedative drugs, in some cases stimulants, and perhaps some of the hallucinogens such as marijuana. There are those alcoholics who report giving up alcohol for a drug like marijuana or one of the other hallucinogens, or giving up alcohol for an amphetamine which they take periodically or even daily. And of course there are alcoholics who have traded alcohol for barbiturates. This, if it becomes an established procedure, is only substituting one "high" for another, and it becomes a value judgment whether this is an improvement or a deterioration in the condition of the alcoholic.

The *therapeutic* treatments include intensive psychotherapy, which is relationship therapy and insight therapy. Some would deemphasize the value of intensive psychodynamic insight for the alcoholic. Although there have been many studies and views expressed regarding the underlying psychodynamics of the alcoholic individual, none have shown that insight therapy is effective with the alcoholic, whereas relationship therapy with either a professional or lay therapist appears to be relatively effective. Alcoholics Anonymous is effective and lay therapists, many who are ex-alcoholics, are often quite effective with the alcoholic. Besides the psychotherapies there are the religious conversion reactions, or the establishment of a belief in a religion in individuals. Included in this is the AA Fellowship. It has long been known that people who have a religious conversion often establish a permanent sobriety. William James referred to this in his book "The Varieties of Religious Experience," when he asked why the only cure for dipsomania was religiomania. For the alcoholic to find a meaning in some movement, philosophical system or religion is as specific a cure as we have for the alcoholic.

PROGRAM NEEDS

What are the current and future needs of the treatment and rehabilitation programs for the alcoholic? At present they are very

inadequate. The number of alcoholics in California, for example, are estimated at something like 750,000. We could not handle them even if we used all our facilities in mental health. We do not have enough personnel, facilities, or a specific or economically feasible treatment. Treatments for the alcoholic are not efficient or economical, and must be applied for many months, years, and even for a lifetime. It's an often expressed dictum in the Alcoholics Anonymous organization that they must maintain membership for lifetime, going one day at a time, to maintain their sobriety.

We need a good deal more research in alcoholism, and more education, particularly of the general public, to effect changes in attitudes, and structure of institutions and to establish effective legislation. There is considerable interest in the interdisciplinary approach to the treatment of the alcoholic. It is commendable to have many people involved in a problem, but when the whole mental health profession, the alcoholics, spouses, friends and employers, the clergy, the hospitals and the courts are all brought in to help the alcoholic it indicates there may be no specific treatment for him. The hope is that while he is contained he can be rehabilitated emotionally and vocationally.

Fortunately, the alcoholic has one trait that distinguishes him from other patients. Mental health patients differ from patients who have surgical or medical problems. If a person has a broken leg, he does not have to do anything specific to have the leg heal. In fact, the quieter he lies, the less he does, the more rapidly it's going to heal. All he has to do is let the doctor set it and splint it. Whereas the person with a mental illness has work to do. He has to look at himself. He has to develop some self-understanding or insight. The alcoholic has to go even further. He has to do more than just develop some self-understanding; he has to take an active part in his own treatment. Those alcoholics who have had greatest success in overcoming their difficulty are those who become actively engaged in their own treatment and the treatment of other alcoholics. Alcoholics Anonymous is the best example of this. Alcoholics are more involved in their own treatment than patients in any other field of mental illness or medicine. Thus, in treating alcoholics one must engage them in treating themselves and, eventually, other alcoholics. In initiating such treatment we should not give up our hold on them too early by removing the duress that brought them to treatment.

To contain them while helping them to develop an interest and enthusiasm for helping themselves, and perhaps others, is not unattainable. At a state hospital we had a program where the patients were encouraged to do what they could to help themselves and others in the hospital. They were not told specifically what to do, but they became very active and the program grew. They not only established programs for themselves in the hospital, they established contacts with the community outside the hospital and developed programs for treatment and assistance for themselves and others following discharge from the hospital. They involved people in the community. They set up a halfway house, a clinic and got a number of influential people interested in their programs. The patients in the hospital were involved with this program; the community was involved with the patients; and the patients, on leaving the hospital knew where they were going and what resources they had outside the hospital to help them. The alcoholic himself is the greatest resource in his treatment. The alcoholic patients in a hospital are the patients who are in the best contact with reality and they are often great organizers and magnificent manipulators. Unfortunately, they are frequently used by the hospital to do chores, a kind of sponsorship in reverse. This prevents them from getting involved with their own problems and needs. The alcoholic who is not helping himself and working with the therapist to do something about his problems, can be viewed as a therapeutic failure.

FUTURE DIRECTIONS

What is the future of the alcoholic, alcoholism and the alcohol programs? Courts are speaking to these issues. Higher court decisions have gone from defending property rights to defending the civil rights of the individual. In the case of alcoholics a lower court decision has viewed alcoholism as a disease. But the Supreme Court has *not* ruled that alcoholism is a disease as has the House of Delegates of the American Medical Association which voted unanimously that it is a disease. Which way are the courts going to view alcoholism — as a disease or as misconduct? Some judges have taken the view that alcoholism or drunkenness was not a crime between man and man but a crime between man and his God, and therefore should not come under the jurisdiction of the court. If a person wanted to get drunk, that was his right within the law of the country, but not necessarily his spiritual right.

Another issue for the future is the question of voluntary and involuntary treatment of the alcoholic. If we are not in agreement that the alcoholic has a disease and we do not have a specific treatment for him can we involuntarily assign him to treatment? This is what has been happening in most state hospitals where they are doing nothing but warehousing these individuals.

One of the more promising approaches in treatment is the implantation of Antabuse. It is a simple surgical procedure to implant Antabuse under the skin. The person is deterred from drinking for three months or more. The literature suggests that if an alcoholic can be kept sober for a period of six to nine months, his chances for continued sobriety are about 75 percent. In other words, the longer he is away from alcohol, the more apt he is to find new outlets, new interests, new activities and motivations for rehabilitating himself. We should never forget that alcohol is addicting, and that alcoholism is an addiction. In addiction the person loses control over his ingestion of a chemical substance. To expect a person who is addicted to maintain control of himself when the addicting substance is available is unrealistic. Many psychiatrists in the past have overlooked the importance of the addiction in treating alcholics. They have treated the psychodynamics of the individual and have accomplished nothing. On the other hand, if by maintaining the duress they could contain the individual from alcohol for a long enough period of time to involve him in his own treatment, and to reinterest him in other ways of finding enjoyment other than other drugs, then the possibility of permanent sobriety is quite good.

As for the future the answer does not lie in individual treatment programs. For real progress with the problem of alcoholism there must be social and attitudinal changes expressed in legal decisions, institutional changes, and in programs of prevention. For example, liquor advertising should be abolished. Do we seriously entertain the idea of advertising addicting substances? Would we do that with hard narcotics or other dangerous drugs and for a moment entertain the idea that it would cut down on narcotic addiction? It really represents a lack of responsibility on the part of society to permit liquor advertising. In promoting a drug that is addicting it seems self-evident that more and more people will become addicted. Fundamental social changes in

attitude and perhaps in society will be necessary to produce significant improvement in the incidence and management of the condition we call alcoholism.

SUICIDE AND CRISIS INTERVENTION: CONCEPTS AND PRACTICS

by

Sam M. Heilig, MSW

Sam M. Heilig has been Director of Training at the Suicide Prevention Center in Los Angeles since 1961. Born in New York, he came to California in 1947 to complete his education at the University of California at Los Angeles and the University of Southern California School of Social Work.

He worked as a Social Worker at the Veterans Administration Neuropsychiatric Hospital, as a training supervisor at the University of Southern California, and with the Vista Del Mar Child Care Service in Los Angeles. Since 1962 he has included private practice in social work in addition to his other duties which included that of deputy coroner of Los Angeles County.

Mr. Heilig has devoted considerable time to serve as a lecturer to a number of public and volunteer organizations, and has numerous publications which have centered about the theme of suicide prevention. He has co-authored the following publications: "The Social Worker in a Suicide Prevention Center", "Suicide Prevention Telephone Service," "Suicide Prevention Around the Clock", "The Los Angeles Suicide Prevention Center", and "Manpower Resources for Emergency Mental Health Services". The most recent are two studies "The Role of Non-Professional Volunteers in a Suicide Prevention Center", and "Procedures and Techniques in Evaluation and Management of Suicide Crisis".

To give you some general notions of how to conceptualize the fact of a crisis and how to identify some of the components, I thought I might go through with you some of the elements which I've found, illustrating for you a particular kind of a crisis of a suicidal situation, and then mention to you some of what is going on in the community to implement the ideas that have been developed around crisis intervention.

CRISIS ELEMENTS

In the mental health profession the idea of intervening in crisis is entirely new as are the service programs. Let me list some of the elements included in a crisis: these have been developed from theoretical material, mostly that of Gerald Caplan, a psychiatrist at Harvard University who is probably the foremost person in developing the whole concept of crisis treatment. Among the things he discusses is the disequilibrium created as an effect of hazardous events in the lives of people. Lydia Rapoport, a social worker at the University of California, Berkeley, illustrates and points up two other elements that are significant to an understanding of what goes on in a crisis: the existence of increased and urgent tensions in the situation that make for time limitation of the event. To these I might add an idea of my own, and that is the assessment of the probable dangers in the situation.

HAZARDOUS EVENTS

Let me briefly discuss these significant elements of a crisis. First what is meant by a hazardous event? It is an event in a person's life which causes him to feel threatened, anxious or worried about his usual life situation. For example, someone might lose a spouse or other relative; someone might have a serious and sudden onset of an illness; someone might be threatened by a divorce; indeed someone might get married and be ill prepared for it. Good things may also be hazardous to people's usual state of equilibrium. When these events occur and people are threatened, they have to react to the anxiety that's produced in them because of the threat. Their reaction may precipitate critical events. People need to relieve their anxieties in one way or another. Anxiety can't be tolerated indefinitely. People will act in such a way as to relieve the pressure of the stress from this particular hazard.

The hazard might also be conceptualized as a stress — any stressful event that occurs. Stress should be thought of in terms of what might be stressful for a particular individual and not in absolute or generalized terms. As an example, there was a study done of people who were presumed to be in a state of crisis because they lost their spouses as a result of a sudden accident. The assumption was that most of these people would be disturbed by this event. It was found that, indeed,

many were disturbed. However, a fair number of them were not at all disturbed. One could of course assume about this latter group that some of the individuals didn't show their disturbance, or that they were disturbed in a way that people could not observe. However, you might also think, or expect, that some people might indeed have been pleased, consciously or unconsciously, to be rid of their spouses. For some people that particular event might actually bring relief from stress. Someone, for example, who is in a bad marriage, or who had a girl friend he would like to marry might be pleased to be rid of his wife through an accident. Such examples should make us cautious about generalizing about the effects of apparently hazardous events. We have to look at the individual to see how a particular event affects him and whether it presents a threat or a hazard.

DISEQUILIBRIUM

According to Dr. Caplan's theory, when people are threatened with a situation which is either unfamiliar, or with which they are unable to cope, they go into a state of disequilibrium. It is as if people on a fairly stable and continuous course are suddenly thrown off course by an occurrence and they can no longer function in their usual style. They are out-of-balance. When people are out-of-balance, usually because of extreme stress and tension which they are unable to resolve, they go into random behaviors to try to relieve the particular situation that's distressing them. It's as if something is terrible and they have to do something about it. Like myself, for example, with my car this morning. I had to do something to get myself in here and get rid of that car. And I just parked it illegally, period, knowing that it was not a good thing to do. Of course there are more forceful kinds of illustrations. It's this particular pressure to relieve the anxiety and all the bad feelings that people experience when they are threatened by something serious in their lives, such as a divorce, fear of death, loss of a job or status, or getting old, that leads to a crisis. A crisis with seriously stressful situations will simply not be tolerated for long. People will do something to relieve themselves, to make themselves feel better. It is estimated by Dr. Caplan and others who have had some experience in working with people in crisis, that a crisis will usually last from four to eight weeks. During this critical period, the period of crisis, we must anticipate that something is going to happen. People are going to do something to resolve the situation.

For those persons who are involved in the intervention programs for treating people in crisis, trying to help them resolve these particular difficult stresses in their lives, it is important to have some means to identify the existence of a crisis. I'm going to backtrack and comment on a recent research study by a young psychologist in a training program at the University of Oregon. Being interested in this whole mushrooming phenomena of crisis intervention programs, he spent some time in research at the suicide prevention center, attempting to find a definition for "crisis". Despite all his efforts and time, he was unable to find one that was satisfactory in an operational way. He could not produce a definition that would tell the worker in a crisis intervention program that a particular person was in a crisis, and why he was in a crisis.

CRISIS EVALUATION

Based upon the work done in the suicide prevention center, I have been led to conclude that it's most important to make a distinction between the critical and noncritical cases that come to crisis intervention programs. I think we've developed in a suicide crisis service some procedures to measure the degree of danger in a particular case so that the worker or the agency has some estimate of where time and efforts might best be used and how to set priorities for those who need service more urgently. For example, in the suicide prevention center we've had about 25,000 cases over a period of ten years and have currently approximately 8,000 cases a year. As we get experience with these cases we observe that most of them in our judgment are not urgent critical situations. We make a judgment on the basis of the probable danger of death in some particular case. Some deaths might occur under special conditions and those are the ones we consider to be a crisis. We make a further evaluation or judgment in terms of time. We want to make an estimate over the next sixty days as to whether or not the particular person will indeed kill himself. Most people, we have found, who call the suicide prevention center are not in that kind of a critical situation.

I think that it is possible, in various other kinds of crisis services, to make similar estimates as to the probable dangers in a particular case, including the long-range deleterious effects on the life of a person. For example, I think it might be possible to make estimates or to develop

criteria to make judgments on the probabilities of individuals with critical problems winding up in a mental hospital if they are not given adequate and timely attention. I think that mental health people would agree that it's not a good thing for a person to be hospitalized if it's possible to sustain him in his own community. I think it might be possible, for example, to get estimates or develop criteria which will allow judgments to be made as to probability, for example, that a family might break up in a divorce if it and its problems do not receive speedy attention and service. I would think that if these kinds of judgments can be made, as they are made with suicidal people in some degree now, it would allow people providing service to better use their time with those situations that require urgent attention. Those situations which represent the greatest danger should receive the earliest attention.

THE SUICIDE CRISIS

Let me tell you a little about some of the elements in the particular crisis of suicide. Suicide is a very ambiguous term. At one point in the practice of mental health services, any time someone mentioned the idea of suicide in relation to a case, it was arbitrarily assumed that that case was critical. Ten years ago when I began work in suicide prevention there was a great deal of fear about anyone who either had a history of suicidal behaviors or had suicidal thoughts. The professionals were very reluctant to be involved in the treatment of such people. Such individuals were categorized as dangerous people who might kill themselves. Now as I have mentioned earlier, during the course of some considerable experience, we find that not all people who are suicidal are *equally* suicidal. Some distinctions can be made between those people who are serious dangers and those who simply are troubled by suicidal ideas but don't have the potential at that particular time to act on these suicidal impulses or thoughts.

To help you understand what happens with people who are suicidal, I will give you some notions about what goes on in that particular kind of event. Suicide is a very serious problem and a significant cause of death. In the United States there are more than 22,000 deaths each year reported as caused by suicide; the probability is that there are actually twice that many suicides. There is a great tendency to under

report suicidal deaths. Suicide ranks tenth among the leading causes of death in the United States. In Los Angeles County, there are more deaths by suicide than there are by automobile accidents. My own interpretation of that fact is that probably, throughout the country, the deaths by suicide approximate the number of deaths by automobile accidents, which is about 60,000 a year. In Los Angeles County there are more than three deaths by suicide every day. There are over one hundred each month, or 1300 a year. In addition, there are many people who are in serious suicidal crisis. We've made various estimates that there are approximately ten to fifteen times as many suicide attempts as there are completed suicides; this includes a fairly large number of people. At any one time there is a large number of people who are troubled by suicidal impulses or thoughts and behaviors.

Suicide is not a serious fatal problem among young people. Of the 22,000 deaths per year due to suicide, about 650 are among individuals 20 or under. Many of you may have heard that the suicide rate among young people is increasing. That just is not true. However, the suicide *attempt* rate for young people *is* high. Young people make more suicide attempts than do older people. This is an important fact to remember in the identification of a crisis. It would suggest that the treatment for young people who are suicidal needn't be immediately intervening. There usually is not much danger of impending death. However, they do need treatment, which, hopefully, would resolve their crisis in some way other than through suicide. I think that if they are treated early, it may relieve them of an ongoing course towards suicide.

SUICIDAL PEOPLE

One of the most important characteristics of suicidal people is their ambivalence about dying. By ambivalence I mean that people who feel like dying, also want to live at the same time. They are pulled in both directions. This special characteristic of suicidal people makes it possible to intervene in their behalf and save their lives. No matter how strongly people are pulled towards death there is some part of them, and usually a very strong part, that wants to stay alive. For example I saw a 24-year old woman this morning who last week in Iowa City took a large number of pills. When she took those pills she threw her life in the balance by calling someone, just before she passed out, to let him

know what she had done. She gambled with her own life by not telling the person where she was and made her would-be helper play games to find her. Fortunately he did. If he had not found her she would have died. There are many such examples of ambivalence toward death in which a large number of people, in the very act of killing themselves, make some provision for their own rescue. However, many of these people are not saved, and do die. I myself have been on the phone with people who have played this game; some of them died because we were unable to help them in time. We must not be misled into believing that these unfortunate people are not serious about killing themselves just because they are ambivalent toward death. They are very serious and they do kill themselves if they are not rescued.

Another element that is clearly observable among people who are suicidal is that they will communicate the fact that they are suicidal. They will make various comments to that effect. They will say, "I am going to kill myself." Many suicidal individuals, if suicide prevention services are available with that listing in the phone book, will call the suicide prevention service. In our own experience, more than half of the people who call for help are calling for themselves. Very often they are very serious cases and the fact that they are calling for help does not minimize their dangerous plight.

ASSESSING THE SITUATION

It is most important in working with people who are suicidal, and indeed with all people who are in crisis, to make an assessment of the probability that the individual's crisis will end in some disastrous outcome. Let me illustrate how this can be done in suicidal situations. I might have a call from two women in one day. One is from a young woman, about 25 years of age, who tells me in a voice filled with crying, that she cannot stand how she feels. She doesn't know what's come over her. She feels that she may destroy her children or herself. She doesn't think she can control herself. This has been going on all day and she's afraid that she may do something dreadful. When I ask her some questions like, "How long have you been feeling this way, and have you ever felt this way before?", she might tell me that, yes, she feels this way about every two months and it's usually associated with her menses. There are some women who have a particularly disturbing

response to their menstrual period. If I asked her further how long this has continued in the past she might tell me that it usually lasts about a day and a half or two days, and then it simply passes away. "And what do you do when you feel like this?" "Usually I call my doctor and I get some pills." If I know that this is something that happens quite regularly in the life of this woman, that she has this particularly unfortunate kind of recurring event, I can be reassured that since she has been through this before she'll probably get through it again. I might try to help her become aware of the fact that she has been through this crisis before and that it will pass in a couple of days. I might suggest that in the meantime she might try to get some pills from her doctor. Knowing these facts I would be less worried about her killing herself.

Then there is the other woman who calls up and also reports that she doesn't know what has come over her. She is having strange sensations. She's thinking about killing her children or herself. This has never happened to her before. When I ask her if anything happened in her life that might have precipitated this event she might tell me that, yes her husband had abandoned her the night before. If this woman also tells me, in response to my questions, how she plans to destroy herself or harm her children, and if she has the means to do it, I would be led to evaluate her as a much greater danger than the first woman. This is a woman who is having a critically unusual event in her life. It is a situation she has not experienced before. She too, like the first woman, is out of control, but hasn't the benefit of a prior experience to help her deal with the crisis.

If given the choice of where I should put my effort, I would refer the first woman to her physician for medication which has helped her before, and try to put all my beans in the basket of the second woman. She needs all the help she can get to deal with an overwhelming event that is entirely unfamiliar to her.

What I have described are two cases that present themselves in quite similar fashions in terms of the distress they are experiencing and the fears they are having, but that also represent different degrees of danger. A judgment must be made to differentiate between the two cases so that we can apply our helping efforts judiciously.]

LETHAL POTENTIAL

To aid in making these judgments, we have developed at the suicide prevention center some criteria in an attempt to measure the lethal potential of people who are suicidal. The critical issue in dealing with suicide lethality, is the potential for a death to occur. Currently, we are working on some scales to firm up this particular kind of capability in making a judgment.

One of my colleagues is just back from an international meeting in London of the International Association for Suicide Prevention, where there had been a great deal of interest in establishing some hard criteria for such a rating system. No one has yet been able to come up with definitive items which will select out those people who are dangerously suicidal. There are certain clinical impressions, almost intuitive impressions, which tell when you have a serious case. But when you try to pin them down on paper by describing the specific elements on which those clinical judgments are based, you are presented with a very difficult problem.

A great deal of work remains to be done to test out a set of criteria on which to make such judgments. We know, for example, that men are more suicidal than women; men commit suicide twice as often as women do. Older men are more seriously suicidal than are younger men. These are facts which are known statistically and to which we can give a weight.

The most important item for the short term evaluation of whether or not someone is in real danger of committing suicide is the nature or method of his plans to kill himself. People who have planned and prepared specific suicide plans, and have the means to carry them through, will tell you about their plans. Obviously someone who plans to shoot himself at a particular time in the very near future, and who has a gun with bullets, is in much greater danger than someone who may plan to shoot himself but isn't sure when he'll do it and doesn't even have a gun. The latter doesn't have a lethal suicide plan. I would worry less about someone who tells me that he plans to cut his wrists at six o'clock in the evening than I would about someone who intends to shoot himself. Those people who have a very lethal plan are more

dangerously suicidal than those who have a less lethal plan. People who have good resources available to them in their crisis — families, physicians, therapists, co-workers, neighbors, doctors — are in less serious danger than those who do not have such resources. People who have money, for example, can buy services. They can buy hospital care, psychotherapy and other treatment, and are therefore in less danger than those who do not have these resources.

Another item in short-term evaluation is consideration of the symptoms which are presented. In general, we evaluate symptoms on two continua. On a depressive continuum, people who are most severely depressed and not functioning as a result of their depression, are in more serious danger than those who are less depressed. We also evaluate people on the symptom continuum of control. People who are out of control are in greater danger than people who have effective controls. People, for example, who are severely mentally ill and are responding to various hallucinatory or delusionary activities going on around them, may unpredictably, in the course of their random behaviors, destroy themselves if they have the idea of suicide.

The last important item that I will mention, is the general lifestyle or character of the individual. In general, these people who have a history of impulsive behaviors who do very significant things in their lives suddenly without judgment or thought and have a history of this kind of behavior, are more capable of suicide than people who have more stability. They are in greater danger of suicide because they do act on their impulses and they may have an impulse to destroy themselves.

CRISIS PROGRAMS

Let me tell you something which tends to be characteristic of what is happening in communities that have been trying to develop crisis services. There are two general functions of crisis programs that are characteristic of the practice of all of them. In general what they attempt to do is provide quick, around-the-clock services. Most emergency programs or crisis intervention services make some effort to be accessible and readily available to the population they are trying to serve. Another element of most crisis programs is that they provide brief, intensive service. This is probably a more efficient and practical

way to provide services for dealing with mental health and other kinds of problems.

I think, that, for the most part, the manner in which mental health services have usually been offered over a long period of time, really has not been meeting the needs of communities and people. Many people who need urgent services never receive them; others are placed on waiting lists. I think crisis programs may be in a position to offer services readily and quickly and deal with problems as they arise in people who in their own ways are making efforts to deal with them. I think that all people who are presented with problems in their lives do make some effort to resolve the problem. If the problem is a critical and urgent one, people will resolve that problem one way or another whether or not they have help. I think if services are readily available that people who put themselves in the position of offering help may be in a position to help when and where it counts most.

It is characteristic of crisis programs that they offer problem-focused services for approximately six weeks. Some effort is made to identify the particular stress or problem and to deal with it. This is in marked contrast to what has usually been done in most mental health programs. Historically in mental health services, there would usually be a four to eight week period of intake or diagnostic service. During the beginning phase of this period, when people are most troubled and need the most help, some effort would be made to identify the situation. Very often, by that time, people would have resolved the problem that brought them to the agency. Another thing that illustrates this phenomena is that mental health clinics have found that people coming to mental health clinics would usually stay only for approximately four to six weeks and then they would leave. I think that they either found some help for their problems or that they did not have help but worked out other solutions to their problems without the help of the agencies.

Suicide prevention centers have served as models for community crisis programs. There almost seems to be a nation-wide suicide prevention movement. Ten years ago, when the suicide prevention center started in Los Angeles, this was the only program of its kind in the country. In the past five years there are over 110 suicide prevention services throughout the country.

Another similar kind of program that addresses itself usually to teenagers and drug problems are what have come to be called "hot lines," which is also very much patterned on the suicide prevention model. This offers telephone consultation around-the-clock to anyone who needs help. There are some differences between these kinds of programs. In some cases the "hot lines" tend to be only, what the kids call, "rap sessions" which offer some rapping on the telephone, some talking up and back in an attempt to discuss the problem. Suicide prevention programs are modeled on the kind of outline that I have been describing to you in which some effort is made to evaluate the particular danger in a suicidal crisis and to get help for people who are in serious danger. "Hot lines" do not tend to do that.

As a result of some major legislative actions, both nationally and in this state, there is a current development of emergency mental health services in local communities. About three years ago the National Institute of Mental Health initiated a program to establish a nation-wide network of Community Mental Health Centers. All of these centers are required to have as one of their services an emergency mental health program or a crisis services. In Los Angeles, as throughout California as a consequence of the Lanterman-Petris-Short Act, all the counties in the State of California will be required to provide some crisis services in addition to other services. These will very likely take similar courses. The National Community Health Centers and the state or county programs will probably have, as I see both developing in Los Angeles, quite similar kinds of services. Many of them will have some walk-in programs. Some of these are now established in Los Angeles. Services are provided very often close to a community, a very immediate community which the mental health wants to service. Here people can come in as they need the service, and they can receive immediate attention. In addition, for Los Angeles County, as probably in other counties, there is some requirement that the counties provide a mobile crisis team. I know in Los Angeles there is some problem in getting staff to provide this service, to serve on the mobile crisis team which requires that a properly staffed vehicle be available. I think the requirement in Los Angeles is that it be staffed by a psychiatrist, a social worker, a public health nurse, and probably a psychiatric technician, someone I guess very like yourselves; he would be available around-the-clock to make home visits in situations that are evaluated as being mental health crises.

STAFFING THE PROGRAMS

Concurrent with the development of all of these services is an acute shortage of qualified manpower to staff these services. As I came in today I heard some of the discussion about the development of training for psychiatric technicians working in hospitals. I can tell you that there is considerable interest in developing training for psychiatric technicians who will be able to provide some services in a direct fashion to people in the community. Much of this will be done in connection with delivering appropriate crisis services. For example, a great many of these services are now being provided by untrained volunteers. People who serve in suicide prevention programs, in community mental health centers, in "hot-line" programs are unpaid volunteers. There is good evidence that people with some imagination, without professional training in the usual terms of graduate school training, professional medical training or nursing training, can be trained to provide a fairly sophisticated level of mental health services. I'm sure that crisis programs can be adequately implemented only if sufficient manpower is available for utilization in imaginative and innovative ways.

Let me make one final comment about crisis intervention programs. They offer rewards to the people who provide these services that are usually not found in the more traditional long-range mental health services. The work in crisis intervention is personally more gratifying because you can see the consequences of your work. In a sense, crises, by their very nature, allow you to participate in the real resolution of a serious problem in someone's life. People who are in crisis, as I said at the outset, are going to resolve their problem in one way or another. For those people who are involved in offering services in crisis there is a built-in payoff for their efforts. They will be able to see the resolution of a serious problem for someone whom they had tried to help. That doesn't always happen, unfortunately, in mental health services. I am sure that many of you work with people in hospitals over a very long period of time but see very little positive results as a consequence of all of your efforts. I think all too often this is what is seen in long-range mental health services. In crisis work you see the results of your own efforts and this makes it a rewarding experience.

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A PLANNING MODEL for the DEVELOPMENT of COMPREHENSIVE SERVICES for the MENTALLY RETARDED

by

Ivy Mooring, Ph.D.

Dr. Ivy Mooring is currently Director of the Mental Retardation Services Board formed under a Joint Powers Agreement between the State of California, County of Los Angeles and the County and City Schools. The Board is the recognized planning and coordinating agency for the mentally retarded population of Los Angeles County.

Her interest in the mentally retarded grew out of her work as a teacher of English in the elementary and secondary schools and as a remedial reading teacher. After obtaining her doctorate in educational psychology she became the special education coordinator of psychological services in the Los Angeles Unified School District. Prior to her present position, Dr. Mooring was Director of the Mental Retardation Joint Agencies Project-Welfare Planning Council in Los Angeles.

Her doctoral dissertation at the University of Southern California in 1959 was entitled "An Evaluation of a Special Class for Children with Minimal Brain Damage." Other publications include "Psychiatric Consultation Services in the Public School System", "A Conceptualized Model for Community Services for the Mentally Retarded", "The Mental Retardation Joint Agencies Project" and "The Mental Retardation Survey of Los Angeles County".

In addition to the media of publications and personal appearances Dr. Mooring has also made use of films and television to reach a large audience. She has made thirteen films "Paging Parents" dealing with problem children, under the auspices of the National Congress of Parents and Teachers.

In introducing me to you, Mr. Grimm mentioned that I had at one time developed a class for children who had minimal brain damage. As I was

listening I recalled one of the incidents that took place about ten to twelve years ago when I was the school district psychologist.

I remember one little boy, a very bright child in spite of his brain damage, who was very difficult to control. He had many of the behavior mechanisms of the brain damaged child; he would perseverate and be stubborn and be persistent in whatever he was doing.

The little fellow had come to school but he wouldn't go inside. He was sitting on the sidewalk and had taken out his lunch pail and inside it there was a long sausage. He had a knife and he was whittling away on this sausage.

So the bus driver said to him, "What are you doing there?" He said, "I'm whittling." "But you know it's time for you to go inside, you have to go in to do your school work now." And the little boy said, "I can't. I'm busy making a bus driver." So the bus driver thought, "These kids are hard to manage; I'd better get some help on this."

So he went inside and asked the principal to persuade the little boy to come inside. The principal came out to him and the bus driver said, "I can't move him, he insists that he is making a bus driver out of this thing that he is whittling. So, the principal came to him and said, "Johnny, you know, it's time for you to come inside and do your work." And the little boy said, "I can't, I'm busy making a principal." The principal thought, "Well, the best thing to do is get the teacher. These kids only respond to people they are with every day. They do much better than with strangers, and he doesn't know me very well."

So he got the teacher and explained to her what the little boy had said. So the teacher came out to him and said, "Come on, Johnny time to go inside now." And he said, "Sorry, Miss, I'm busy making a teacher." By this time she was at her wits-end and so was the principal. So the principal said, "You know that high-flown psychologist happens to be at this school today. She knows all the answers. Let her get him inside."

So they came to get me from my office and of course I knew all the answers with these children. After all, I was the expert and I knew it wouldn't be difficult at all to get Johnny inside if they just knew how to handle him. So, to be sure that I was successful I asked the principal

and the teacher to tell me *exactly* what kind of conversation they'd had so that I could shortcut all the unnecessary little folderols and show them how effective I was.

When I came up to Johnny I said, "Johnny, it's time to go inside and don't tell me that you're making a psychoiogist." He looked at me *very* seriously and said, "No Mam, I wouldn't. I don't have that much baloney."

ATTITUDES TOWARD THE MENTALLY RETARDED

I know that I have been responsible in my professional career for slinging my share of baloney, particularly about the mentally retarded. But it's not just my profession that's being adept at this; I think that maybe our whole society has contributed. Maybe we're still going to sling a great deal of baloney in the next few years. But I hope that we're coming out of some of the dark ages that we have passed through in our treatment of the mentally retarded. What I am saying is not an indictment of the state hospitals. What I *am* saying is that the state hospital has been just like all our other institutions — the victim of society's perceptions of the mentally retarded. We have viewed them as *non-normal* individuals. We have viewed them as deviant. And rooted in our psychiatric model of these people who are sick we did the same thing to them as we did to our mentally ill.

In the beginning we erected huge institutions, called them *"sick"* and we staffed the institutions on the medical model — the now much maligned medical model. And as long as we view, or did view, the mentally retarded as sick, many of the things that happen in the state hospitals become an outgrowth of just this model. If somebody is sick, he lives in a hospital. He doesn't live in a house; he lives in a ward. He isn't a resident; he is a patient. He doesn't wear his own clothing; he has to wear the sort of stuff that's issued when you go to the hospital, even to those hideous open-down-the-back white coat things that they wear if they are in bed. He is tended by "nurses" or "nursing personnel" who are entirely responsible for the emotional tone and the entire atmosphere of the place in which this individual lives. And remember, I am talking about *living*. This is where this person lives. The programs are not geared towards training, but are called treatment programs and they are

primarily centered around medical treatment such as drugs and therapy. You know we have physical therapy, occupational therapy and what have you. The whole thing fits into this concept that this sick person is a patient in a hospital.

Well, those of us who haven't totally encompassed the medical model frequently have done even worse and have viewed the mentally retarded as sub-human. When we view the mentally retarded as *sub-human*, a sort of menace who can't be responsible for what his limited brain permits him to perform, then we think of him as an animal-like being who is assaultive and destructive and therefore needs a prison-like environment.

If you visit some of our state hospitals I think you know that there are many of these little legacies from the past: the cells, the little isolation cells, the locked doors. It always horrifies me to this day when I walk through a state hospital and find that I am having somebody with me with a key to let me in and let me out. It's the letting out that I always get concerned about. And toilets are all open — you know there is no door on the toilet. We couldn't do that kind of thing unless we felt that people were less than human, unless we thought of them as sub-human, animal-like. You place the mentally retarded in these categories when you attribute these kinds of behaviors to them. If they are sub-human they shouldn't have possessions or rights. In many of the places where they live they don't even have as much as a shoe box in which to keep their own possessions. They have no furniture of their own, no attractive kinds of aesthetic environment in which they can grow and develop.

In addition to being viewed as sick or as sub-human, some people create the image of the mentally retarded as the *eternal child*. We build Garden-of-Eden like atmospheres for them in which we keep them confined, never expecting them to progress beyond this totally dependent child attitude. We keep them extremely sheltered and give them very loving, tender custodial care which is bound to keep them as our eternal children.

These are the attitudes that society has condoned toward the mentally retarded over the past years. We are just beginning to break out from

some of these concepts into an entirely different concept which I'd like to present to you now.

IMPAIRMENT VERSUS HANDICAP

A person may have an impairment but he doesn't have a handicap until you withdraw from him the opportunity to learn or develop certain tools. For example, you may have an impairment of sight. This does not become a handicap if you are taught Braille or you're given glasses to correct your vision.

If you are given an opportunity in society to use the tools which you have learned, you can *decrease* the impact of that impairment and *decrease* the handicap. This is how we want to view the mentally retarded, first of all, as individuals who have an impairment in intellectual functioning of adaptive behavior. We have therefore a responsibility in society to develop for them, and with them, the tools which will minimize that impairment. This means that rather than a custodial atmosphere in which we take care of them, we have to develop a strong therapeutic milieu, which says, "This impairment of intellectual functioning can be decreased to the degree that we expect this youngster or this person to develop tools that will minimize this impairment.

MEDICAL MODEL

I'm sure some of you will say, "Well, you haven't been inside some of the hospitals and seen these chronically disabled people that we have to deal with every day. What kind of tools are you going to give to them?" I'm suggesting that we haven't begun to tap the depths of the potential of many of the residents in our hospitals. Notice that I don't use the term "patients." These are *people* who are staying with you and no matter how retarded they are or how impaired they are, their level of functioning can be improved, even if it's only to a very limited degree. And so you say, "Yes, that's fine if you give us ten times as many staff as we have now." I'm sure that the people in California are familiar with the Nelson report* which has just come out. Essentially it says that increasing the staffing will not change the functioning of the mentally retarded unless the attitude of the people who are responsible

for caring for the mentally retarded is also changed. This means that as long as our hospitals or our places of residence for our mentally retarded are primarily hospitals, geared to a medical model directed by the medical profession, which by its very training is dedicated to loving, tender care for the "patient," we are not going to change the entire emotional atmosphere of treatment for the mentally retarded.

I think that California, at least, is coming to recognize that we'll have to have some alternative methods; at least we've made a start in this direction. But I'm sure it must be terribly discouraging to people who work in state hospitals to see what is proposed as a promising alternative. The patient now is no longer a patient in a state hospital, he becomes a client of the State Department of Social Welfare. He goes out into the community and has the glorious opportunity of sitting in front of television all day long. And this is now considered a great improvement in treatment. I share with you your discouragement if this is what we think is an advancement in the treatment of the mentally retarded.

I don't think our society is going to condone such an alternative for very long. Particularly if it takes the point of view that the mentally retarded are people. As people they are entitled to every service that every other person is entitled to. They are also entitled to receive it from the same generic agency that has the responsibility for providing that service to every other person.

It's too bad that the mentally retarded are not as well organized and as well disciplined as some of the other minority groups, because they are discriminated against to a far greater degree. They are excluded frequently from our public school programs and many of our other community service programs. Their sole sin, and the sole reason they are excluded is because they are mentally retarded. California's conscience has finally been pricked and she is trying to do something for the mentally retarded — at least at the community level.

ALTERNATIVE MODELS

I want to share with you today what one county in California has tried to do. I present this to you only so that you will know that this is a

beginning. I am sure it is not the panacea to all of the ailments. I'm sure that in ten years we will look back on this and say, "How little we knew." But I think it's a step in the right direction.

In the last California legislative session there was a new bill passed called Assembly Bill 225 which indicated that every area in California was to be divided up into comprehensive health planning areas and there was to be an area board which would be responsible for the development of community services at the community level. The state hospitals, as we now know them, could be phased out except for the care and treatment of the physically handicapped, multiply handicapped, severely or profoundly retarded individuals. Ultimately they would be totally phased out. In other words, no new hospitals would be built for the mentally retarded, no new hospital beds authorized for existing hospitals.

I'm sure that as State employees you must all be saying, "What in the world is going to happen to me?" I'd like to suggest that in this model you should be absolutely in the forefront of trained personnel, the cadre of people who could now go out into the community as consultants to show the people in the community what has to be done in the training programs that, hopefully, will develop. The area boards that are going to be set up would be very similar to the one which has been existing in Los Angeles County for about four years. This is what I want to show you now.

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Editorial Note: Dr. Mooring illustrated the remainder of her presentation with diagrams on slides projected for the audience. We feel the reader will be able to get a comprehensive picture from Dr. Mooring's remarks.

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THE LOS ANGELES PROGRAM

We have in our County a board which consists of the representatives from each of the State departments, all of the County departments, and the City and County schools. The new boards will not have State

people on them. They will have parents and the general public. It will look like this. They will have the responsibility for planning every service that you see listed there. In other words, the Department of Education will have the responsibility for educating the retarded, no matter how retarded they are. The Department of Employment will have the responsibility for finding employment and the Department of Vocational Rehabilitation the responsibility for the whole programming of the mentally retarded. This will be the responsibility which will be handed to them via these area boards.

I want to show you how the area board in Los Angeles has operated in these last few years. If you are going to plan services, and this doesn't matter whether you are in charge of a hospital, a hospital ward, or a total county, you have to determine the territory over which you have responsibility. This is Los Angeles County, the area for which this particular area board is responsible. You can see that it is as large as the seven largest cities in the United States. This gives you some idea of the vastness of the territory. All you have to do now is to break it down into *manageable units,* so that everyone knows how his unit fits into the plan. That is the first premise of the planning that must take place. This is the way we divided Los Angeles. The yellow line that goes through the center is the State hospital dividing line. Those people who live north of the yellow line go to Pacific State Hospital; those who live south of it go to Fairview. It was designed in that particular way because we didn't want to make any one of the hospitals a ghetto area. It cuts right through the socio-economic patterns of our particular county. The green lines are the mental retardation services areas. The little tiny black lines are public health districts. The very smallest unit we ever plan for is a public health district. We clump them together into slightly larger units and call them mental retardation services areas.

In all planning you have to break your unit down into its very smallest unit. That may be just one patient. Then you have to group the units into manageable units that encompass your entire territory. If you have thirty people for whom you are responsible and you can only break them down into groups of four, this gives you an idea of how many groups you can have. But you have to do something with the area of responsibility to make it manageable.

Once you have broken down your planning area into some logical sequence, you can do as we did. There you can see the number of mentally retarded persons who are in each of our planning areas. You will see that there are approximately a million and a half people in each of those planning areas. We have projected how many mentally retarded persons there would be in each area and then we corrected it for poverty. We were very surprised to find that even profound and severe mental retardation is correlated with poverty. However, it is not too surprising when you begin to understand that many of the factors correlated with poverty cause premature births, poor prenatal care, poor nutrition and all of the other correlating factors of mental retardation. Once you have some idea of the area for which you are responsible, you must know something about the people for whom you are responsible.

We were not satisfied to just assume two percent across-the-board prevalence rate of mental retardation in Los Angeles County. So we set about finding where they were. This is a non-duplicated list of all persons in Los Angeles County who are receiving or waiting for services. And they are below 50 I.Q. This is the poverty area in Los Angeles County. This is what gave us the clue that poverty and severe and profound mental retardation were correlated. It is true that if you are a Kennedy you are just as likely to have a mentally retarded child as if you live in Watts. But if you are a Kennedy living in Watts and you have prenatal care, you are likely to have more of a retarded child because of all the other damaging factors which are likely to be present in a poverty environment.

Once we saw this, we wanted to see what were the characteristics of these people. These are the admissions to the State Hospital. You will notice that the poor, somehow, don't find their way into the State hospital. The admissions tend to come from the more affluent or middle class areas. We also found that there were very few services in the poor areas. This began, then, to define where our needs were. We now knew something about our territory and about the people whom we must serve. We now had to determine what services they needed. We said they would need all kinds of clinical services, social services, vocational and education services, as well as research, training, and public education services.

Our next job was to find where these services existed in the community. One of the major gaps in services identified in the survey was the opportunity for pre-school education for the retarded child. So we had to set up a little network of *nursery school* classes for them. There are pitifully few of these nursery classes. But the plan is to have a network throughout the County where these children can go from the age of three to the age of five before they are acceptable to the public school program. At the nursery classes they can receive training, and toilet training and behavior shaping which will make them acceptable to the public school programs.

After they have gone through a nursery school program they will need some kind of *day care program.* Now currently, or in the past, we have had these kinds of facilities. For example here is a day school program with only two people in it and here is one with about three hundred people in it, but the State still considers these day school programs. Yet one of them consists primarily of baby-sitting for a couple of kids during the day. The other may have a highly developed therapeutic program. So what the State has finally said is, "You can't do it that way. What you must have are programs which are the responsibility of the State Department of Education."

You have known for a long time that there have been programs for the educable mentally retarded and for the trainable mentally retarded. But we have been saying, "No, these are for even those people who can't get into the classes for the trainable mentally retarded; these are also for people with a below 25 I.Q." I'm sure you must be raising your eyebrows about the idea of these people going to public school. But I assure you that they are able to go. These are the current classes in Los Angeles County. They take these youngsters if they are excluded from any other class. The only requirement for entry is that they are not eligible for any other class. They can be blind, deaf, cerebral palsied or severely mentally retarded. They can be a complete basket case and still be able to go to the public school setting. They are the responsibility of the public school and are taught by public school teachers.

I think the trained technician from the State hospital ought to be the person to act as a consultant to the public schools to show these people how you adapt many of the training methods that they have used so

successfully in the hospital. You must remember that educators, just because they are educators, don't necessarily know anything about dealing with these severely retarded people. They should welcome the idea that people who have been dealing with the retarded for years can be of significant help to them in working more effectively with the children. These youngsters are going to go to school to learn. Learning may consist of learning to tie their shoes or learning to swallow or learning to brush their teeth or learning to keep their clothes on or learning not to hit Johnny, rather than learning about Mr. Shakespeare and Mr. Browning — but it's still learning. Since the children will have to be taught, the public school teacher will require consultation from those people who have known in the past how this should be done.

These programs at the moment are permissive. Public schools are not forced to put in these kinds of programs. If the Governor had not vetoed the last bill, there would have been many more programs in Los Angeles County at this particular time. The Governor also vetoed the programs for the expansion of the nursery school classes. The concept that is gradually developing is that if these youngsters, or these young people, are going to come out of the State hospital, they can't come out to nothing. They'll have to come out to community programs which will have to be developed with the State money because it is State money which is being utilized in the State hospital, and local communities are not going to be picking up the tab for caring for these people. The Boards of Supervisors are much too smart to accept people into the community that have in the past been 100 percent the responsibility of the State.

After the youngsters have gone through development center classes and have reached the age 21, they next have to go on to the *activity centers*. There are pitifully few of them yet in Los Angeles. This usually means that when the person reaches the age of 21, even if he has been able to get into a public school program, he usually has nothing as an adult. There are of course, the workshops, but unfortunately they are workshops for all the handicapping conditions, not just for the mentally retarded. Although it looks as though there are plenty of programs, there are very, very few of them that actually absorb the mentally retarded.

You can see that community programs have a tremendously long way to go, but this is now becoming the wave of the future since every community is now being mandated to develop master plans. Our Board determines where all the services are and then projects what is needed. We know, for example, how many beds, diagnostic and evluation clinics, classes, workshops, and activity centers are needed. Then when applicants apply for Federal money for construction, they have to go through this coordinating board to see whether their application is in harmony with the needs of the County.

I mentioned that Assembly Bill 225 also said that there were to be area boards established and planning bodies set up, very much like those in Los Angeles. It also says that there must be developed a network of community services and that this network will filter through the regional centers. I am sure those of you who are Californians know about our regional centers. The plan for Los Angeles County will not be unlike the plan for the whole of the State of California.

There are our *Service Areas.* Each Service Area will have a major medical backup unit because the first step is to be able to find these people. These are the existing medical backup units that have extensive mental retardation diagnostic programs. These are the proposed ones so that you'll see that there will be one in each Service Area. This is Pacific, which is earmarked as the diagnostic facility for this service area in through here. This is the new Martin Luther King Hospital which will have an intensive mental retardation unit, earmarked to serve this area which is the Fairview area. This is the Neuropsychiatric Institute unit and the Kennedy Child Study Center which is earmarked as the major medical backup unit for this area. This is Children's Hospital and County Hospital which is the backup unit for this area and this is Olive View Hospital earmarked as the medical backup unit for this area. So each service area will have this highly, intensive major medical backup unit.

Satellited around these medical centers will be what are called either primary *ambulatory care units* or *counseling centers,* or whatever you like to call them. But there will be one such intake point in each health district. Let me show you how this will work. Let's just take that central point in Los Angeles. There is at least one counselor. We've

worked out the number of counselors you need for each health district based upon the number of retarded persons. The counselor is situated in the local health district, probably housed at the local public health office. She is the first point of contact for any professional in the community, whether pediatrician, school official, or anybody else who suspects there is a mentally retarded person. The retarded person is referred to the counselor in the health district. The counselor has at her disposal the entire medical backup team of her own medical backup unit.

It may well be that this person, when she comes to the counselor, has had innumerable diagnostic workups and doesn't need another diagnostic workup. Maybe what the person needs is a nursery school. It is the responsibility of that counselor to find that nursery school and either have its services paid with public monies or to procure the money from the Regional Center. The retarded person will only need to know where his Regional Center is located. He will go there to have a free diagnostic workup and will then be told what service is appropriate. The Regional Center will be responsible for providing the service out of public monies or would arrange to send the youngster to a public school, or would give the parents the financial resources to see that it can be provided privately. This money will come from the State Department of Public Health.

The Regional Centers will be the route to and from the State hospital. If a person, for example, in this Regional Center is going to go to Pacific State Hospital, the workup is done at the Regional Center, and the person is sent to Pacific State Hospital as his hospital of residence. When the reasons for his hospital stay are no longer valid, he is sent back, through the Regional Center, into the community. The concept being, that the hospitals will act as a backup to the community facilities. The hospital may be the only place, for example, where you can find a program in behavior shaping, or in chalk therapy, or that includes medical treatment. It may well be that the hospitals will be utilized as the training centers. For example, a nursery school is being established. Nobody knows quite how to do this but there is a nursery school at the State hospital so this is used as a sort of training center so that professionals can be trained in the community.

THE UNFINISHED WORK

Many people, I think, have been deeply concerned about the State's plans for the concept of developing community services and phasing out the State hospitals. I would say, that with this new approach, if the hospitals are wise, and if the personnel in the hospitals are wise, they would begin to say, "How can we currently make our program so dynamic that the community will come to us for this kind of guidance." And I would like to suggest that you can't use the sole excuse of limited staff. I share with you your frustration that you do, indeed, have limited staff, and that we, as taxpayers of California, should be embarrassed and ashamed when we deal joyously with the idea of receiving a 10 percent cut in our income taxes, if it means that our mentally retarded and our mentally ill patients have to be deprived of additional staffing at the State hospital that could make their lives more productive. But I don't think we can wait for the day when society's conscience is so pricked that it says, "We do have a responsibility to increase the Staff staffing." I don't think that's going to be tomorrow or next year.

I think every professional person in the State hospital has a responsibility to act as a consultant to every other person who is a ward person. I think we have to stop this fighting and bickering between professionals as groups about role responsibilities. I think we have to say, "What can we do, even if there are only three of us." Let's take the most tragic ward of all, the one that receives all of the bad publicity. Let's take the Lux Ward at Sonoma State Hospital which everybody picks on all the time. Let's say, "What could we do with that Lux Ward?"

The first thing I would do would be to indict my own profession and say, "What are you doing, the psychological staff, sitting in your office? You have no business sitting in your office You have a responsibility to come out to that ward and show those three poor fellows who are responsible for that hundred patients, or however many patients there are, how they can apply some of the techniques which you know from research would work." And you would say, "My goodness. We've got too much to do already. You mean that the three of us are supposed to do some fancy work with these patients?" And I would say, "Yes."

What I would do is have two of you doing the policing that you seem to be so busy doing right now and I'd release one of you who would work under the guidance and direction of either your psychological consultant or whoever you can drag in there to be a consultant to you so that you could improvise and do some one-to-one work, even if it's only with one patient.

I would infuse into that staff the idea that there is more to caring for the mentally retarded than this business of custodial care and giving them tender loving care. I would tell the nurses, "You are so hung-up on the idea of these people being sick that you forget to infuse into them the responsibility to do something for themselves." And I am going to infuse into my staff this feeling that the retarded person can be helped if we are not quite so busy doing it for him. I suggest that you're the people who can carry this banner. You by your profession and your training and your type or personality are much more likely to bring about this kind of change than the nursing profession is, the psychiatric profession, or the psychological profession. I hope you won't drop this ball.

*Dr. Thomas L. Nelson, Associate Dean of the California College of Medicine, University of California, Irvine, was the chairman of the California Human Relations Agency Task Force on Mental Retardation Services. The report, including extensive recommendations, was concerned with the operations of the California Department of Hygiene in delivery of services to the mentally retarded.

THE NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH CAREER LADDER – A CONCEPT AND AN ACTIVITY

by

James L. Moncrief

James L. Moncrief's interest in helping people may have been stimulated by his training and duty as a Hospital Corpsman in the Navy during the years 1952-1955. Part of his experience was in neuro-psychiatric nursing. After his military service he completed his college education with a Master of Science degree from the University of Southern Mississippi in 1959. He served as an instructor in social science at North Florida Junior College and assistant professor of history at Jacksonville State College. As Dean of the College, Jefferson State Junior College, in Birmingham, Alabama from 1965 to 1968 he was instrumental in the development of the Health Technology Division. This included the establishment of an Associate Degree Nursing Program, a Certified Laboratory Technology Program, an X-Ray Technology Program and a Mental Health Program. In 1968, he became Project Director, Community College Mental Health Workers, Southern Regional Education Board, Atlanta, Georgia.

In his present assignment as Careers Program Director in the North Carolina Department of Mental Health he has helped develop an Associate degree program for mental health employees in the State system.

Thank you Bill. I just left a Federal Affairs Workshop in Washington for the American Association of Junior Colleges in which we dealt with specific legislation to enable community colleges, senior colleges and universities to establish new health careers programs. All of these specific programs dealt with the funding opportunities for the mental health technician or mental health worker program on a two-year basis. We have our annual convention, the American Association of Junior Colleges, in January and in the past two conventions I felt a little paranoid because we had no sessions set up on health occupations in general, and absolutely nothing on mental health technology. So I exercised my right as a member of the Commission on Legislation and

demanded that we have a session for mental health technology at our convention. This January we will have an entire half day session devoted to mental health technology and the training of mental health technicians. We were able to get all other sessions for that afternoon cancelled so we should have a fairly good audience in this grouping.

Last year, Harold McPheeters, the Director of the Mental Health Unit of the Southern Regional Education Board addressed this convention on the topic of our community college mental health worker project at which time I was still Director of that project. Now this talk, and the development of our program in North Carolina, is really an offshoot of the activities that I directed there plus what applies specifically to the State of North Carolina. We are attempting to expand this program and the influence of this program regionally and nationally in order to provide for better competence of training for those of you in this most vital field.

When I first went to the State of North Carolina to assist in the development of this type of program the Commissioner of Mental Health, Dr. Eugene A. Hargrove asked me what the first problem would be that we would need to overcome. That reminded me of an old ghetto saying which I encountered when I was working at a N al hospital in Chicago. I was down in the ghetto picking up a sailor who had obviously run afoul of some of the local citizens because of his attitude toward the people of that area, and I was talking to one of the gang leaders. He said, "You know, you people come down here and you talk our talk but you don't understand us. If you're going to talk that talk, we want you to walk that walk." It means you'd better get off your theories and get something going.

And this is what we are trying to do and what we are presenting to you this morning. It's an extremely popular position that I now occupy. It's very unusual to have such popularity. But I understand now that it's almost as popular to be a director of a new careers program as it is to advocate black and student power in this country. I am not a recent advocate of new careers or career ladders. This is a program in which we have been involved for a number of years. When I first began working in this field, I started out as a discipline representative in the registered nurse field. Later I realized that if you have a discipline designation, it

may become a stumbling block in dealing with people. So I became a social scientist but after reading a few articles recently about David Reissman, I no longer call myself a social scientist. I'm a Mental Health generalist, whatever that means. But so much for the current issues of our problems, and on to the specific activities which we are reporting to you.

At the December 1968 Mental Health Board meeting in Charlotte, North Carolina, Dr. Gene Hargrove, our Commissioner, introduced the problem of subprofessional manpower as viewed by the Department of Mental Health. The problem as he saw it was: The attendant did not believe that enough was being done to provide for his upgrading and training. Simultaneously, the Department recognized that additional training must be provided for this position. To implement this goal, the career ladder concept of training and education was introduced to the mental health system by establishment of the career development program in February of 1969.

When work was started, our primary concern was to involve the technician in any evaluation, planning, and redefinition of the role and scope of his position; however, one other major concern was that of providing the system with technicians of greater skill and competency.

You know we so-called consultants who go into a program or system do fine jobs in making evaluations and recommendations. However, we never talk to the people about whom we are making recommendations. We don't involve them in the planning, or in the development, yet we develop a highly theoretical system; generally we don't really know what we are talking about. To avoid such problems we stipulated that our working field would be with the people that we were trying to assist, not with the professional groupings.

The rapid expansion of mental health services in recent years has magnified the already acute shortage of professional personnel. There has occurred an increasing awareness that many time-consuming tasks being performed by professional workers could be delegated to qualified persons who have been educationally prepared for an assisting role. However, this employee category is also limited.

In response to the demand from mental health institutions for additional subprofessional workers, the Department of Mental Health, in search of solutions to this crisis in skilled manpower, joined with institutions of higher education to establish a career ladder training program, which will involve all levels of manpower from the technician trainee to the graduate level.

The first phase of the program is the completion of a functional job analysis which will produce seven output items:

1. a detailed analysis of needs for subprofessional personnel;
2. preliminary functional job description of subprofessional entry level position;
3. detailed job description for all employees and analysis of the total state mental health personnel practice system;
4. analysis of state personnel system programs, policies, and practices and problems;
5. analysis of education and training resources, staff, faculty, and curricula;
6. analysis of education and training problems; and
7. analysis of recruitment and selection problems within existing state mental health and educational programs.

Before you can define or redefine job descriptions and mount a statewide educational program you must complete a functional job analysis of the system. This must be done through interviews with subprofessionals working in their own environment. The supervisor, the unit nurse, the psychologist, the social worker, the psychiatrist, and a representative from the administration will be interviewed, but the main force and main source should be from the subprofessional. Sample questions asked the technician: "What jobs are being carried out by you? Should you be doing this? Do you need additional training to carry out these assigned tasks? If so, what type training would you like? Should you be working at other tasks you are not currently carrying

out? And should you perform tasks that you are being assigned?" An important part of this interview is a request for recommendations on how this person should be prepared for his job.

Our survey was organized along eight major task areas:

Physical patient care
Care of the ward
Transporting and transferring patients
Medical care of patients
Making reports and research
Observing patients
Controlling patients, and
Working with other staff and their personal relations.

Each task was grouped into a number of component parts; i.e., the categorization of the physical care of the patient, such things as: routine bath, undressing patients, transferring to bathroom/wheelchairs, lifting, etc. We discovered that in such mundane tasks as the physical care and non-medical activities at the attendant personnel and the technician level, that twenty-five percent of their time was devoted to these activities.

There were five basic items brought out on each of the component parts of these eight that we have mentioned. For example, under the categorization of "physical care of the patient," we dealt with:

Purpose and consequences
Instruction
Standards of carrying out those assignments, and
The skills and knowledge needed to carry out those specific assignments.

As can be seen, the extension of this comprehensive survey for the *eight major task areas* and *five basic items* for each component part of the eight areas represented a monumental task. If we took only the major items, there would be over forty areas for each employee in a group of one hundred. But from this we will have a higher ratio of return, for we are surveying one hundred attendants from each of our four psychiatric hospitals; one hundred attendant personnel from our mental retarda-

tion centers; one hundred attendants from each of our four alcoholic rehabilitation centers; and one hundred attendant trainees or technicians from our comprehensive mental health centers throughout the state. We have completed this survey at the Dorothea Dix Hospital in Raleigh, North Carolina, and Cherry Hospital in Goldsboro, North Carolina. A general introductory survey has been completed at the Broughton Hospital in Morganton, North Carolina.

We met with the technicians in groups of eight to ten, with three interviewers working with them in groups and individually to elicit meaningful responses. Representation was based on shifts – evening, day, and night. You know, one superintendent of a hospital who had been there for ten years, said that he didn't believe there was any difference in the type of work that the shift level personnel did. So he learned a little from our survey. We also had a cross-reference on the breakdown of age, sex, race, longevity as an aide-attendant, technician, length of time in other positions, and educational stratification. Each part is fed in to provide a comprehensive sample of the various types of employees in the technician classification.

If I slip into the term aide/attendant, as contrasted to technician, please forgive me because the first task I had when I got to North Carolina was the change the title from aide/attendants to technicians in our mental health system. So I'm still a little schizoid about this, I had some battles with our superintendents of administrative personnel. They said, "Well, they are aides and they are attendants." "Well, I said, "who are they aiding?" And really they aren't aiding anyone, except the patient. And I said, "Why do you use the designation 'attendant'?" And they said, "They attend the patients." And I said, "Well, according to our statement of purposes we are not running a custodial institution. These are technicians in a specific area of competency so these people are now technicians.

The tasks were pulled together into a task cluster description summarizing the two hundred responses in our initial pilot survey. There will be a total of four hundred responses as output from each of the overall statewide surveys in mental retardation, alcoholic rehabilitation, and psychiatric techniques. Just a representative sampling of forms which we used on the psychiatric technician interviews were

recorded. We used a *task cluster description sheet,* a *job task summary,* a *level of effort sheet* (how much time was spent on a specific task), and a fourth form on *decision making* and *types of choices.* Also we filled out a *criterion sheet* which was handed to the attendant for his use in rating the decision making opportunities, time required for the task, difficulty of the task, and the importance and satisfaction of completing his work. In answering these questions, the technician is given an opportunity to express himself completely and freely, for we emphasized that the sheets would be unsigned and that the interviews were confidential.

With the completion of the overall task clusters at each institution, we set up a series of conferences to discuss the results of the composite interviews. The group was composed of one representative from within each of the four disciplines within the hospital. That was fine! We did this as a placebo to the professional groupings. But we offset this by putting four technicians on this same committee. From this conference came the factoring of the basic job descriptions in which we fit the technician at a new level with built-in characteristics of upward mobility. We have set up five new steps in our state personnel classification system and we are now calling this worker a technician.

In addition, we are launching a similar survey for all employees in state mental health system in North Carolina. This includes Commissioner of Mental Health and all the professionals in our system. One of the problems that we encountered, I think, is best expressed by David Reissman in an article in this month's Psychology Today in which he referred to sociology as the soft underbelly of society. And this was the type problem we were dealing with. We were advocating change within a society: the mental health institution and the mental health hospitals. One of the reasons that we are surveying and working out the same type of job descriptions for our professional personnel has been brought out in two major studies, one completed by Hans Isaac of the University of London in 1952 on the outcome of therapy studies. This was a series of studies done to determine the effectiveness of therapy by psychiatrists and psychologists. It took the aspect of psychological analysis and psychiatric analysis and psychotherapy. In this study it was found that of those neurotics who received psychoanalysis, forty-four percent of them got better; and of those who

received no treatment, seventy-two percent of them got better. These results emphasize the need for adequate surveys of existing structures in the whole field of mental health.

One of the hospitals surveyed, the Dix Hospital, is launching a management and supervision training program to train middle and upper level personnel. The technician would also participate in such a management and supervision training program because we envisioned the eventual utilization of the mental health technician as the chief unit administrative officer of the geographic units in our psychiatric hospitals. The survey detected that the large and powerful technician group has a strong identity. In the State of North Carolina 3,652 out of 7,631 Department of Mental Health positions are for technicians. Nationally, there is a similar ratio. However, currently the group is unaware of its potential power. The technician's primary concern is with providing better care and treatment for the patient. To do this they strongly feel the need for additional knowledge and training. There is a definite desire for more education and training.

One technician gave me quite a humorous anecdote. He reported that with less than a week's experience, he had been placed in charge of the admitting ward. One night five deputy sheriffs came in with a handcuffed patient. "They had blackjacks," these are his own words, "and pistols on their hips, and this guy had beaten hell out of four of them. They took the handcuffs off, opened the door and pushed him into the room with me and said, 'Here he is, he's yours!' Now what am I going to do? I don't have anything in here with me but my hands, and these five big burly men pushed this guy in and said, 'Here he is, he's yours!" When I asked him how he reacted to this he said, "I looked at him. He looked at me. I looked at him. He looked at me, and I said, 'Ah, sir, would you mind getting up and going downstairs?' and the man did."

Another attendant said that when you are standing in front of a patient who is six feet two inches, 215 pounds, holding a chair in his hand and you are alone, there "aint no time for no therapeutic group conferences." These are self-taught reactions to an employment situation which these people have developed into learning experiences alone. And yet we as professionals are stating that they would not take

advantage of special educational programs. They would, for they wish to know more.

Other major problem areas have emerged from this survey. However, we must not make final judgment on these until we have had complete verification.

One problem is that of discrimination. Discrimination based on racial characteristics is strong and present but it is in the area of rule breaking and not in prestige or privilege granting. It is felt, and this has been documented on a provisional basis, that rule breaking is dealt with more harshly for the black than for the white technician. All things being equal, the black is often given tasks to which the white technician is not assigned.

The second major area of concern is communications. Prior to December and January, the technician felt that communications were quite poor. However, this is improving, but in the process there is a price to pay. This is applicable to any mental health setting. Inconsistency in policy from unit to unit becomes observable especially at our technician representative meetings. Prior to this, the exchange of ideas and concepts was not facilitated. This is now taking place but there will be a problem until policies are consistent throughout the institution. The Department of Mental Health has received a vote of confidence from the technicians because it is attempting to establish better communications.

To use a hip phrase – the technicians are *turned on*. They strongly support programs for their upgrading. They are quite interested in this because they are now involved in a project of their own. They are beginning to develop an identity with the Department of Mental Health through this project, for they feel that something concrete is now being done for them. We are "talking their talk" and "walking their walk". They are quite interested in not only the input from this survey but also the output in the form of activities. They are turned *on*, therefore, we must turn something *out* or else they may turn *on* us with strikes. We are quite confident that their support for the departmental program will continue to grow if we respond properly.

The method that has been selected to accelerate the confidence of the attendant and to implement this project is a training program.

A. The first phase of the educational training program will be structured around general education courses taken from junior colleges and technical schools. The type of courses offered will be determined by the specialized need of the particular institutions and the technician. While the focus will be on the inculcation of occupational competency, the courses will carry full collegiate credits, applicable toward an associate degree. This will give the aide/attendant technician a mechanism to achieve upward mobility. This program will replace our old in-service education with credit courses being awarded for work the technician was formerly doing in in-service education for no observable rewards except time taken off the unit. Additionally, the training aspects are taking place on the hospital grounds, in the units, in classrooms, and not on a college or university campus. We are also paying our employees to attend these classes and we guarantee the employee that he will have at least one course open to him each quarter. He attends these classes during his normal work time.

B. The second phase of the program will afford the attendant who has the initiative an opportunity to enroll in the regular associate degree program of the community college. At the same time the graduates from the two year mental health technician curricula will be brought into the system. The educational activities will be conducted at the local mental health institution. With the achievement of intermediate plateaus, the employee will be eligible for job reclassification and also for increased salary benefits. Upon completion of this level of training, graduates can move into Phase III.

C. Phase III is a baccalaureate level of training needed for graduates of associate degree programs in mental health or transfer students from related programs. This door is opened with Phase III of the career ladder program. Student employees will be accepted with full credit awarded to junior college graduates for previous work toward a degree in mental health technology. The program of study will give the student employees an opportunity for professional advancement through a recognized academic program, with a structure that affords a greater depth of skill acquisition, and theoretically a higher degree of

competence as represented by his college degree. Graduates completing this training program will have an opportunity to enter Phase IV.

D. Phase IV consists of advanced training in mental health to provide a new reservoir of graduate manpower recruited from within the mental health ranks. Many of these individuals will have availed themselves of the Career Ladder mobility from the technician level through an associate degree, baccalaureate, and then into a master's degree program. Full acceptance of credit earned through this progression has been guaranteed by the Board of Higher Education of the State of North Carolina. To financially assist students in these programs we provide for employment continuation where at least partial pay will be afforded.

We are now reclassifying all of our positions in the State of North Carolina as mental health workers. This includes the psychiatrists as well as the technicians. There will be about fifty to seventy-five steps called mental health worker steps and each person, regardless of his education, if he meets those requirements, will be able to move up in this particular classification. For example, we have step seventy-five. Formerly this called for a psychiatrist because of certain legal implications. However, the job description is now being rewritten so that theoretically a person with two years of college training and the necessary know-how could fit into that position at that salary level. We are now setting up a salary level of a two-year mental health technician that is identical to the Associate Degree registered nurse. Since both are two-year trained individuals, both are registered, and both are doing their own thing in their own discipline field, the salary level is also the same for both classes.

We, as the representatives of the fields of mental health, must answer some basic questions about our nonprofessional employees:

1. From what sources will funds be derived for salary increases for the technician who qualifies for a higher position?

2. Upon completion of each educational step, what supervisory positions will we have available for the attendant to move into?

3. Do you mind losing some of your better attendants or technicians when they complete their education, for many will receive offers of higher paying positions?

4. What steps are you as a chief administrative officer taking to assure the acceptance of this person by your professional staff?

These are questions with which we must come to grips and resolve locally, state-wide and nationally if a program such as this is to be successful.

The Division of Community Colleges of the North Carolina Board of Education, individual community colleges, technical schools, the Board of Higher Education, and individual senior colleges and universities have been contacted and have signed contracts to participate in this educational program. The State Personnel Department is involved in the planning and has been apprised of each activity in the job analysis. Representatives from that department will participate in the conference covering the program of job analysis. I quote from an article which I prepared for publication in December of this year (for the American Association of Junior Colleges). "The future of mental health technology training programs is extremely bright, and a few trends have been identified. First, the rapid development of technician training programs is a commonly recognized phenomenon, for the beginning of January of 1970 will see the number of colleges offering such training programs more than doubled. This has been brought about by two factors: the community demand for better mental health treatment, and the recognition by the mental health professionals of the critical need for qualified manpower to assist them in their programs. The community colleges responded to these sensitive needs and proceeded to launch a new training program for associate personnel

"A basic trend which is not as widely recognized has been the movement from the extremely highly specialized mental health technology program to a more generalized or generalist approach. This has been evident in individual discussion and conferences and is documented by a curriculum survey completed by the Southern Regional Education Board in 1969. Programs which started with highly specialized curricula are now in the process of curriculum revision and

are developing new curriculum with more concentration in the area of generalized studies in the mental health field. The obvious reason for this change in training activities stems from the need to fit this person into a broader field than was originally defined for the mental health worker."

The trend in mental health treatment has progressed from the illness classification in grouping of patients on wards or units, to the geographical unit classification. Under the latter system workers assigned to a variety of tasks, from those of recreational therapist assistants to those performed as a member of the group therapy treatment team. Thus a person trained in narrow or highly specialized skills would not feel comfortable in the broad role he would be required to play under the new treatment team approach. Additionally, the institutions of higher education can train this mental health worker to serve not only in psychiatric hospitals, which is only one phase of employment need, but to function in the comprehensive community health center, which is a most valuable addition to the national mental health system.

The State of North Carolina has divided itself into four regional mental health areas. Each regional mental health area is served by one psychiatric hospital, one mental retardation center, one alcoholic rehabilitation center, and a grouping of comprehensive community mental health centers. Our State has been further subdivided into thirty-eight mental health areas. These mental health areas are administered through area program directors. Let me explain to you what we are doing. We are taking our old concept of the psychiatric hospital and are attempting to transform it into a research, training and long-term care facility. Now I'm speaking of four hospitals. The thirty-seven mental health areas relate to a specific geographic unit, designated by counties, and that particular regional psychiatric hospital in its area.

As an example let us take Dorothea Dix Hospital in Raleigh. We have four geographic units. We have grouped the twelve counties that Dorothea Dix serves into four major geographic groupings. In each of these four major groupings we have one comprehensive mental health center. One unit at the psychiatric hospital is related directly to that

geographical area. One unit at the mental retardation center is directly related to that area. The alcoholic rehabilitation center is also related directly to that specific geographic unit. The technician personnel that functions within that unit in the psychiatric hospital is no longer a hospital employee; he is an area employee. One day he may find himself working in the community at the comprehensive mental health center. The next day he may be involved with a patient from that county in the alcoholic rehabilitation center. We have designated unit directors for each of these geographic units. Additionally we have a program director who is responsible for the area program. He is the chief administrative officer. The chief administrative office is responsible for coordinating all of the efforts of the comprehensive community mental health center, the activities of the psychiatric hospital on his unit, as well as those of the mental retardation center.

So while we are changing our mental health system from the old custodial psychiatric or mental illness hospital we are not closing the hospitals. We are transforming the role, the scope and the objectives of that institution. We are making it a community based program divided up into fragments relating to the community. We are also training the personnel to function outside of the old psychiatric setting, in a community comprehensive mental health setting that will provide the technician with an opportunity for additional advancement through upward mobility, and an increase in responsibilities and salary. No one is closing our hospitals. We are transforming their objectives, their philosophy and their purpose. We are providing higher forms of education for our personnel to make them more useful and meaningful members of the society of which they are a most vital part.

The mental health generalist's functions are not confined to the mental health system. Outside the mental health system there is an opportunity for him to work, for example, as an assistant in the school programs as a guidance counselor, to provide first-line consultation and referral to the masters degree counselor for all these positions. This will enable the school system to employ a large number of associate counselors and guarantee the students and their parents access to a guidance counselor when the need arises.

With a generalist background, the student-employee can perform in various Red Feather United Fund agencies which in many cases are

dependent upon individuals with limited training or who cannot devote a great deal of time to such activities. With the current manpower shortage in the field of mental health, the need for this type of worker is extremely great. There is at this point no danger of flooding the labor force with this graduate, for we envision the retraining of our currently employed aides and technicians through these programs. They will become a part of the pool of the associate degree trained personnel. I might add parenthetically that they will not be caught up in a locked step or in an employment position that cannot go upward.

A statement on the shortage of health manpower does not need repeating. This type of training program for the associate worker offers the most sensible and coherent answer to a complex, chaotic and confusing system of education, training accreditation, certification, etc. This type of education training program will at least assure the patient that he is receiving competent care from an individual who is basically trained as a "people worker," rather than a stop-gap employee thrown into the system to fill critical personnel needs on an ad-hoc basis.

The North Carolina psychiatric technicians are being organized into a unit of your association nationally. This is a responsibility which we have taken as one of our major tenets of our program. We are currently working with the State of South Carolina to assist them in accomplishing the same goal of becoming affiliated with your association. At the recent meeting in Washington, we met with the representatives from the U.S. Office of Education, Mr. Joseph M. Hardman, who is in charge of the evaluation and accreditation unit for the United States Office of Education. He assures me that as soon as your organization can develop specific plans and guidelines for a national program, that your organization will be recognized for the certification of technician training programs just as the National League of Nursing has been recognized for the registered nurse programs in the country.

The Career Ladder Program then, provides a two-fold benefit for the North Carolina Department of Mental Health and the nation. First, it is a means of meeting employee demands currently being articulated through protest and passive resistance campaigns for it provides an avenue for advancement and for financial rewards, and restores to the individual the concept of his dignity and worth through his work status. Secondly, it will provide for the rapid delivery of high quality care to the patient. We are talking that talk. We are now walking that walk. Thank you!

THE APPLICATION OF SENSITIVITY TRAINING TECHNIQUES IN THE DEVELOPMENT OF INTER-PERSONAL SKILLS AND EFFECTIVE TEAMWORK AMONG MENTAL HEALTH AND COMMUNITY WORKER STUDENTS

by

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INTRODUCTION

Mental health and community workers have become an important part of the mental health team. Although their job requirement varies, many of the mental health and community workers are actively engaged in leading groups, serving as research technicians, as liaison agents and coordinators between the mental health center and the community, as activity aides, care aides, and in a variety of other important mental health tasks. It is quite clear that the skills needed by the community and mental health worker are in the area of interpersonal relationships, communication, group leadership as well as sensitivity to the need of patients and others they come in contact with. An earlier study (Rueveni, et. al, 1968) has demonstrated that a group of mental health and community workers participating in a sensitivity training program

were able within a short period of time to learn effective human relations skills. Similar results were obtained with medical students (Rueveni, 1969) and nurses (Rueveni, 1969). This paper is an attempt to describe some techniques used during the first year of a sensitivity training program with a group of 56 mental health and community worker students, aiming to develop teamwork and effective interpersonal skills.

PROGRAM DEVELOPMENT AND OBJECTIVES

During the fall of 1968, the Community College of Philadelphia introduced a new, two year curriculum for mental health workers. The curriculum called for graduates, after the completion of the two years of study, to receive an Associate in Science degree leading to community and mental health worker positions within mental health centers and other psychiatric facilities in the Philadelphia area. For the first program, 56 students were accepted to include high school graduates, veterans, and housewives. None of the students had any previous college experience. The curriculum focused on a variety of mental health areas with special concentration in such fields as behavior and social sciences, social psychology, group dynamics and preventive and treatment therapy. In addition, student trainees supplemented their curriculum with clinical practicum in hospitals and other psychiatric facilities. The curriculum for the sensitivity training program was designed as a two-hour-a-week program each semester. Four groups of 13 students participated in a sensitivity training program for the entire years. The objective of the training was:

To develop an effective skill of communication.

To enhance the students' skills in interpersonal relationships

To enable the students to develop a greater awareness of themselves

To enable students to become aware of the nature of the helping relationships.

To increase the teamwork functioning as mental health and community workers.

The design of the program was as follows: For the first semester, one hour was devoted to the process of interaction, group development, and self-awareness. The second hour was primarily devoted to lecturettes, group presentation, and small group projects, all in the area of group dynamics to include group leadership and application of group dynamics in the practicum experiences which the student had with patients. During the second semester, the entire two hours a week were devoted to the process of group interaction.

PROCEDURE

A variety of exercises were utilized during each session to enhance the application of some of the course objectives.

1) **Inner-Outer Group (Micro-Lab)**

During the process hour, we have conducted the miro-lab technique consisting of two concentric groups. While the inner group was interreacting, the outer group was listening. Groups changed each 10 minutes so each of the groups had its turn both to interreact and listen. We have found this technique quite useful, at least for the first few weeks of the program, it enabled much expression of feelings and the development of close and friendly relationships among the group members.

2) **Scavenger Hunt**

During the first day of the semester, students were asked to assemble in two groups; each group was assigned a task which was to leave the room and look for objects such as symbol for the group, something masculine, something feminine, an authority figure, something borrowed from the neighborhood, etc. Each group was asked to come back within 30 minutes. Upon their return a discussion followed about the items that they have brought back. This exercise enabled a quick "jelling" of the group. It also enabled the emergence of leadership styles, ways of cooperation in the group, and an immediate exposure of group members to each other.

3) **Expressing Negative Feelings**

In this particular exercise, members were encouraged to express any negative feelings they had, particularly with regard to their fellow group members and other instructors or supervisors. This was a more difficult thing to do for many group members. Initially, we encountered much resistance to talk about those feelings but as the group developed, more students were able to express many negative feelings they had about their surrounding school environment.

4) **Dealing with Patients**

During this exercise, group members were encouraged to share their feelings with regard to the patients they came in contact with during the practicum hour each week. Each group member was encouraged to describe an incident or an episode with a patient and share his feelings about it and in return received suggestions and comments from other group members as to what had happened between him and the patient, how could this relationship be improved? and most of all, what had the student learned about the experience? This exercise enabled many students to receive immediate comments which were quite helpful to their relationship with a variety of patients.

5) **Dealing with the Shy Group Member**

During the first semester, there were quite a few times when group members expressed concern of being excluded and isolated. We have found that many a time the following technique described by Schutz (1967) was quite helpful in this situation:

> All group members were asked to stand up and form a tight circle by holding their hands around each other's waists. The group member who expressed this feeling of

isolation was asked to stay outside the group and his task was to fight his way inside the group by utilizing any mode he could think about, i.e., tickling, pushing, jumping, etc. When this was done successfully, the group members were asked to share their feelings with regard to the individual involved.

6) Eyeball to Eyeball Confrontation

In this technique, also described by Schutz (1967), two group members were asked to face each other, look in each others eyes and move towards each other until they felt like stopping. They were also instructed to do whatever they felt like doing as long as they did not communicate verbally. This technique was found to be effective when conflicts of misunderstanding between two group members occurred; we found it quite useful in sharing the group members' feelings about each other during the exercise and in particular, it enabled many group members to become active and involved during the sessions.

7) Fantasy Sharing

Group members were asked to close their eyes and create a story or share a fantasy. Each group member was urged to express his feeling into the fantasy. This particular exercise was quite useful in that it developed a greater cohesiveness and group participation.

8) Diagnostic Period

During these ten minute sessions, group members were instructed to discuss their group progress as well as their own progress in achieving the goal of the program. Members shared with each other their feelings about themselves, other members, and the entire group development.

9) **Verbal and Non-Verbal Communication**

The group was divided into two smaller groups consisting of six members each. Each group was given a large sheet of paper and was instructed to draw on it the group symbol. Members were given three minutes to accomplish the task and the only group rule was that they were not allowed to communicate verbally while they were doing it. As soon as they completed the task, they were given another sheet of paper and this time were instructed to do the same thing except that they were allowed to communicate verbally. This exercise was found very useful in that it enabled an understanding of the principles of verbal and non-verbal communication.

10) **Role Playing**

In this exercise, students were asked to role play relevant situations such as other students, patients, supervisors, and teachers. An effort was made to discuss and share with the entire group what was being communicated and how to transfer what had been learned into effective awareness of self.

11) **Group Projects**

Each group consisting of five to six students was assigned a project in the beginning of the semester. The project was to develop a proposal of utilizing the group approach in a variety of situations that a mental health worker could be confronted with. This project was left entirely up to the student to plan and carry out and was designed for two semesters. We found that as a result of these projects, the groups were able to produce many interesting reports but the main purpose of these projects was to help group members learn to work together and this purpose seemed to be efficient.

EVALUATION

Pre and post measures on the Semantic Differential were administered to each student. Preliminary analysis of results indicated that at the end of the program, most students perceived the role of mental health worker on a more realistic basis compared to their initial perception of this role. Their perception of self was much more critical and negative compared to the same perception at the beginning of the program. A marked increase was noticed on such dimensions as interpersonal communication, awareness of self, and teamwork compared to the same dimensions at the beginning of the year. Students' subjective evaluation has supported some of those findings. The majority of students felt that participating in the sensitivity training program was an excellent experience for them. They stated that the experience helped them understand their own feelings better as well as the feelings of their colleagues and patients. The following statements and comments were characteristic of most students' reactions:

"The course helped me bcome a more sensitive human being".
"I can communicate more effectively with my patients".
"I have become more accepting of other people".
"I have learned to express my feelings rather than keep them to myself".
"I have learned my strengths and weaknesses in interpersonal relationships".
"I have learned that I have been superficial in my relationship to others and was able to change this".
"I can tolerate people to a far greater degree which in turn makes it easier for me to live with myself".

The variety of group encounters exercises and interreactions which the student trainees had during this year may have contributed towards the development of such important skills as interpersonal relationships and teamwork among the students. The program calls for a second year of training of a similar nature where the emphasis would be on a greater depth of self-awareness and the ability on the part of the mental health and community workers to participate actively in therapeutic work with a variety of patients.

The author wishes to thank Mr. Edward A. Brawley, Associate Professor of Mental Health, Head of the Department of Human Service Careers, Community College of Philadelphia, for his help in preparing this paper.

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1 Requests for reprints should be sent to Uri Rueveni, Hahnemann Community Mental Health Center, 314 N. Broad Street, Philadelphia, Pennsylvania 19102.

ABOUT NAPT AND CSPT

The National Association of Psychiatric Technology, a non-profit organization, is the outgrowth of local and state organizations of psychiatric attendants, aides and technicians. These local associations were formed to improve their members' skills and knowledge in order that they might provide more effective service to the mentally ill and the mentally retarded. The associations also sought to develop greater roles for the technicians in the state hospitals through upgrading their training and education. The present NAPT was sponsored by one such state association, the California Society of Psychiatric Technicians. The California association was established in 1950 by a group of hospital attendants who recognized the need for professional representation. The national association was formed in 1961 to encompass other state associations. It is now in a period of expansion to include not only associations of psychiatric technicians but other middle-level professionals in mental health.

The National Association of Psychiatric Technology has as its objective the logical advancement of the middle-level professional in mental health through the development of open-ended career ladders and educational programs that permit entry to all individuals who can and are willing to help the mentally troubled and the mentally retarded. The Association believes the best interests of mental health are served by careers that allow upward and lateral mobility. The continuing chronic shortages in qualified mental health manpower compel the better utilization of existing classes of mental health workers and their continued training to prepare them for increasing responsibilities in a variety of settings. We believe the problems also require the best utilization of existing mental health facilities while developing a new complex of therapeutic settings — community mental health centers, psychiatric units in general hospitals, day, night, and weekend hospitals, halfway houses, and sheltered workshops. We believe that the psychiatric hospital is, and should remain, an integral, necessary component of the therapeutic continuum. It should be sensitive to social change and continually reappraise its role to assure the best service to the mentally disordered, the emotionally disturbed and the mentally retarded.

NAPT strives to attain its objectives through the establishment of a code of ethics to regulate the personal and professional conduct of its

members with other professionals, the patients and the public. Through standards for training and educational programs, training materials, workshop and institutes it seeks to qualify the workers in mental health for more effectively fulfilling their responsibilities and prepare them for greater roles in this rapidly expanding field of human services. It encourages continued scientific study to develop and improve therapeutic and rehabilitative techniques that would extend the competencies of the technician. In pursuit of its objectives it maintains professional and informational liaison with educational institutions, professional and lay organizations, and governmental agencies at all levels that are concerned with or responsible for preventive, therapeutic and rehabilitative programs in mental health. It sponsors and supports legislation to enhance the individual and the professional status of its members and to increase the scope and effectiveness of mental health programs.

We invite all psychiatric aides and technicians, mental health technicians and assistants as well as individuals in other therapeutic and rehabilitative or habilitative services for the mentally and emotionally handicapped to join NAPT and assist in advancing its goals. For further information regarding NAPT write or telephone the National Association of Psychiatric Technology, 1127 11th Street, Sacramento, California 95814. Telephone (916) 444-2452.

OTHER NAPT PUBLICATIONS

NAPT has compiled presentations given by prominent individuals in mental health at its institutes and workshops. Copies of these publications are available at the National Association of Psychiatric Technology office in Sacramento. They include:

"Mental Health Manpower and the Psychiatric Technician" **Price $2.00**
Some of the titles . . .

"Mental Health Manpower in Transition"
"Private Psychiatric Hospitals"
"Mental Health of California: The Dynamics of Revolution"
"Programming for the Future"

"Community Mental Health and the Psychiatric Technician"
Price $1.75
Includes pioneer work in developing new roles and educational programs for middle-level mental health personnel.

"Purdue Trains Mental Health Workers"
"Maryland's Design for a New Health Career"
"New Careers Program in Mental Health"
"Job Role of Mental Health Technician"

"New Frontiers in Psychiatric Technology" **Price $1.75**
Presentations at Second Annual Workshop of Colorado Psychiatric Technicians Association.

Hominology – The Approach To The Whole Man
Innovations in Mental Health Training
Motivation Through Life Enrichment
Operant Conditioning
Cultures and Psychiatry

Copies of these publications and additional copies of "Major Psycho-Social Problems and the Psychiatric Technician", may be ordered from the National Association of Psychiatric Technology, 1127-11th Street, Sacramento, California 95814.