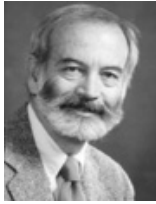




California Mental Health During the past 40 Years

HISTORICAL PERSPECTIVE



By Joe Tupin, MD

Dr. Tupin joined the UC Davis School of Medicine in 1969. He chaired its psychiatry department from 1975 to 1984, then served as medical director of UCD's Sacramento Medical Center until his retirement in 1993.

IN 1957, THE CALIFORNIA LEGISLATURE passed the Short-Doyle Act to create a county-based mental health program. This law reflected changes in mental care throughout the country that emphasized deinstitutionalization and the rights of the mentally ill.

RESEARCH POINTED TO THE NON-THERAPEUTIC ASPECTS OF LARGE STATE HOSPITALS OFTEN LOCATED FAR FROM A PATIENT'S HOME COMMUNITY. PATIENTS BECAME "INSTITUTIONALIZED" AND DEPENDENT WITH LOSS OF SOCIAL SKILLS AND ACCESS TO FRIENDS, FAMILY, EDUCATION AND EMPLOYMENT.¹

There was often little active treatment and effective pharmaceuticals were just being introduced, so confinement was often the dominant regimen. Human rights activists and mental health professionals recognized the need to modify the principals of care, diminish reliance on involuntary and often indeterminate confinement, and take advantage of the new medications while avoiding the crippling effects of institutional isolation.

Successful lawsuits and legislation established rights for patients and deinstitutionalization began in earnest. In California, the Lanterman-Petris-Short Act created a judicial process to determine involuntary confinement, replacing a clinically-based system.

Federal legislation furthered the move to community-based treatment programs. Much in this movement to the community was good. Energy was high, new treatment strategies developed and patients were "at home."

Typically, a community was divided into service areas, each with a community mental health center or program. State and federal financial incentives encouraged cooperation by the counties, but there was some reluctance - partly for financial reasons, and partly from anxiety about the mentally ill living in the community. Finally the state required counties to provide care.

By the middle of the 1960s, the process was underway. There were four state mental hospitals near Sacramento² — Napa, Auburn, Stockton and Sonoma — and others near San Jose, Mendocino and Modesto. Some were closed: Auburn, San Jose, Mendocino and Modesto. Others changed missions as the developmentally disabled and brain injured were separated from the mentally ill. Now only Napa serves the mentally ill here.

Smaller counties usually had only one program, while Sacramento was typical of larger counties. Dr. Ed Rudin, who had been the State Deputy Director of the Short-Doyle program, headed the Sutter Diagnostic and Treatment Center for children, and was pivotal

in forming the county-based community mental health programs. The new UCD Medical School's Department of Psychiatry, founded by Dr. Donald Langsley, developed clinics, and an inpatient program at the then-Sacramento County Hospital. Another early program was run by Dr. Elmer Galioni at American River Hospital.

Patients in the state hospitals were actively identified and discharged to local clinics. Initially, treatment innovations blossomed and success followed. However, by the middle of the 1970's, federal funds were reduced with the expectation — misplaced — that state and county resources would fill the gap. By the early 1980s, programs were reduced and priorities reassessed.

Unfortunately, some mental illnesses are chronic and, as with all such illnesses, continuity of care, stable living arrangements and social and financial support are needed to optimize outcomes. Anticipated help from families did not always materialize and the domiciliary function of the state hospitals was gone.

Furthermore, some of the chronic mentally ill function best in structured living environments with professional supervision. Many patients, but not all, were rehabilitated and integrated into the community. Halfway houses and similar residential programs were established, but there were not nearly enough.

Requiring patients to stay in these facilities and participate in therapeutic programs proved organizationally, financially and legally difficult. Homelessness and substance abuse increased, bringing patients into conflict with the community and in contact with law enforcement.

Not all changes were positive and there were unanticipated problems, but some institutionalized patients did return to their homes and discovered meaningful lives. Others became homeless, made an adjustment in various programs, or ended up in jail.

Mental health programs have endured in the community, and play a vital role. With experience and research, new types of care and clinics developed. Communities and families became accustomed to psychiatric patients in the neighborhood and at home. Private psychiatric resources have grown, and so have the number of mental health professionals. In 1960 there were two dozen psychiatrists in the Sacramento area. Now there are over 90.

Aside from deinstitutionalization, population growth, health insurance, and recognition of benefits of psychiatric care have contributed to this expansion. Also, Sacramento's emerging role as a regional health care center is important.

Child services remain a problem — there are too few child psychiatrists and funding is poor. Training in psychiatry has been active for almost 30 years at UC Davis, but there are few child trainees here or across the country.

Some mentally ill remain trapped in a subculture, distanced from the health care system by their behavior, bumping into the criminal justice system, and without a structured legal or social system that supports their participation in an effective clinical treatment program. Without a long-term care alternative, such as the state hospital system, or an integrated system of care, "revolving door" patients return to emergency rooms and inpatient settings.

We still need to strike a balance between a patient's right to treatment in the least restrictive environment, and society's need for safety. Helen Thomson, the former Assemblywoman from Yolo County, carried legislation creating a pilot program for outpatient involuntary treatment that may provide a legal structure for outpatient care.

Future improvement in mental health care is certain. At the local level, the leadership and contributions of families, volunteers and professionals will continue to develop new programs and advocate for government and philanthropic support. Research has moved to

a focus on brain function using sophisticated imaging technology and biochemistry. This will produce new insight about mental illness, resulting in improved diagnosis and treatment.

Access and continuity of care remain a concern and must improve to take advantage of advances. State and local government working with local families, institutions, volunteers and professionals will be needed to create a system that can capitalize on the advances.

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1. Dr. Donald Langsley, founding chair of the UC medical school's Department of Psychiatry, would often tell news reporters, "Hospitalization is maddening."
2. There was no state hospital in Sacramento itself, but one of the first three mental hospitals in the state was created in Sacramento in 1850 (*Sierra Sacramento Valley Medicine*, May/June 2002). The short-lived hospital was located on M Street (now Capitol Mall) between 2nd and 3rd streets - now part of the Interstate 5 canyon.

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