THE SHORT-DOYLE ACT

for

COMMUNITY MENTAL HEALTH SERVICES

AN INFORMATIONAL BROCHURE

for the

DEVELOPMENT OF LOCAL MENTAL HEALTH PROGRAMS

by

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TABLE OF CONTENTS

APPENDIX

MESSAGE FROM THE GOVERNOR

Conservation of the mental health of the people of California is a responsibility which the state must share with all levels of government and with the many voluntary organizations that are taking an active interest in mental health. For over a hundred years, the state has provided public mental hospitals which now, for the first time, are discharging their patients as rapidly as new patients are being admitted. A first-class state hospital system is the backbone of a state program aimed at the protection of mental health, but such a program must also include services in the localities where people live.

The problem of mental illness has many sides to it, and as many points of attack, and in many cases hospitalization for mental illness need never occur if local preventive efforts and early treatment are successful.

In view of California's outstanding advances in this field, it is fitting that the Short-Doyle Act for community mental health services should provide a new and promising approach: the joint undertaking by state and local governments in California to protect the mental health of the people in a humane and economically sound manner. In signing the Act on July 6, 1957, I did so with great hopes of its power, not merely as a therapeutic weapon against mental illness, but as an instrument for strengthening the mental health aspects of all our health, welfare, and educational programs in California.

It remains for you who read this pamphlet to employ the Short-Doyle Act wisely and well. I wish you success in your continuing efforts, and I anticipate that your rewards will be commensurate with the high aims of this new program of community mental health services.

GOODWIN J. KNIGHT
Governor of California

PREFACE TO THE SECOND EDITION

Between 1953 and 1957, the Department of Mental Hygiene studied, in collaboration with a number of agencies and organizations inside and outside of state government, the question of meeting California's largely unmet needs for mental health services. As a result of these investigations and several public hearings, the State Legislature passed in 1957, almost unanimously, the Short-Doyle Act for Community Mental Health Services.

The act became law on September 11, 1957, and the official regulations under which it is being administered became effective under Title 9 of the Government Code on November 30, 1957. To date, six counties and one city have completed all the necessary steps and are actually receiving matching state funds for 24 different mental health services. Five more counties have filed their applications for the reimbursement, starting July 1, 1958. The budgets for local mental health services under the act will exceed 2.5 million dollars in 1958-59, indicating the vigorous planning of local programs that has occurred during the first six months of the act's actual operation.

In order to provide adequate consultation in response to the growing number of requests from all over the State, the Department of Mental Hygiene has created a special staff to help the cities and counties implement the act. This special staff consists of a chief of state-local mental health services in the central office of the department in Sacramento, as well as field representatives in the Los Angeles and San Francisco areas. Additional consultation and help on special services such as psychiatric rehabilitation, mental health education, hospital psychiatry, psychiatric nursing, and outpatient clinics is available from all of the department's facilities (hospitals, clinics, and bureaus of social work), as well as by our central office.

The chief purpose of the Short-Doyle Act is to encourage the treatment of the patient in his home community in close collaboration with the family physician, the local general hospital, and the other agencies in the community that play a part in the prevention, alleviation, or rehabilitation of handicapping psychiatric disorders, including mental retardation. One corollary of such a purpose is the closer working together of the psychiatric specialist and the

rest of the medical profession. Before supporting such a far-reaching measure as the Short-Doyle Act, the Department of Mental Hygiene satisfied itself that the medical profession, and particularly the specialists in psychiatry, were ready and willing to co-operate in all possible ways for the success of this new program.

The Community Mental Health Services Act is simply a legal instrument that recognizes the joint responsibility of private enterprise and government at all levels to promote mental health through both therapeutic and protective services. The act offers a balanced program for voluntary adoption by the cities and counties of California, and it should bring together the efforts of various agencies and professions now scattered over different fronts.

While the Short-Doyle Act carries a state reimbursement to match the funds appropriated by local governments for mental health services to only voluntary patients who are unable to obtain private psychiatric care, the consequent expansion of psychiatric services in general hospitals and clinics is bound to indirectly benefit all patients, whether they are private, part-pay, or indigent, or whether they are voluntarily or involuntarily receiving care.

These are some of the reasons why the Community Mental Health Services Act offers the hope of a fresh approach to the prevention of mental illnesses and to the protection of mental health.

M. E. Porter, M.D.
Director of Mental Hygiene
June 24, 1958

I. INTRODUCTION

The purpose of this brochure is to furnish general information on the Short-Doyle Act (originally known as the Community Mental Health Services Act), an enabling act which is designed to make possible the establishment of community mental health services. The Department of Mental Hygiene of the State of California is responsible for the administration of both the act and the state reimbursement matching the funds appropriated by local governing bodies for voluntary mental health programs.

While the community mental health services under the Short-Doyle Act are locally administered, the Department of Mental Hygiene is specifically authorized to maintain standards; to review local mental health plans; and to advise local governing bodies, organizations, and agencies interested in the mental health of the people, and active in establishing, or expanding, mental health services under the act.

This brochure, by explaining the objectives and provisions of the Short-Doyle Act, furnishes the basis for a common understanding of goals, services, and procedures. Field representatives from the Department are available to discuss details, regulations, and the interpretation of the act itself, and also to serve as consultants to any persons or groups involved in planning or administering community mental health services.

In the Appendix, you will find the text of the Community Mental Health Services Act, which is an act to add Division 8 to the Welfare and Institutions Code. You will also find there the text of the official regulations under which the act is administered, and which are a part of Title 9 of the Government Code.

It is intended that this brochure explain the act to the public and voluntary agencies, lay and professional organizations, and the planning bodies concerned in promoting mental health services, so that they may be in a better position to carry out their continuing responsibilities in an informed and co-operative fashion. The more thoroughly people understand the Community Mental Health Services Act, the better the local implementation of this legislation will be.

II. BACKGROUND OF THE NEW PROGRAM OF LOCAL MENTAL HEALTH SERVICES

The Need for Services

Statistics of both national [1] * and state [2] origin annually confirm the statement that the "number one" public health problem today is "mental illness." At best, the available statistical data provide a gross kind of yardstick, and these data, while convincing enough, call for more comprehensive measurements of the kinds of psychiatric disorder that occur in a given locality, and not just in public mental hospitals and clinics. Surveys of the psychopathology in specified populations surely cannot be applied indiscriminately to any and every population but yet, taken together and viewed as a whole, the results of such surveys everywhere both confirm and amplify the statistics available from mental hospitals and clinics. For example, when a survey of the school population in two adjacent counties of central California indicates that 12 percent of the pupils are in need of psychiatric attention, the suspicion that this may be a purely local phenomenon is dissipated by the fact that other school surveys in different parts of the country, using different techniques, reveal comparable figures.

The degree and kinds of psychiatric disorders to be found in the population of California have never been scientifically and methodically investigated. It would not be accurate to apply the findings in urban Baltimore, for example, to all of California. On the other hand, it would be surprising if California were very different from Baltimore, where one out of 10 suffers from a recognizable psychiatric disorder.[3] Until the time arrives when mental health needs are more fully met, the relatively minor differences between Baltimore and California can be overlooked.

Mental health needs require not only better measurement, but also clearer definition. Social attitudes, as well as the individual's tendency to resist acknowledging his need for help, both enter into the definition of "need." A legal definition of need, for example, occurs in special cases where provisions must be made to safeguard both society and the individual. Therefore, a true pic-

* See p. 26 for bibliographical reference.

ture of California's mental health needs would encompass both quantitative studies in sample areas and qualitative reviews of social attitudes.

In short, at the present writing, the unmet need for mental health services provided by the Short-Doyle Act is so great that the immediate, practical purpose of surveys is to establish priorities for action rather than to provide an exact estimate of the total problem. Furthermore, the millions of taxpayers who, through hundreds of organizations, promoted and supported the Short-Doyle Act with interest and vigor, testify to both a general and a professional readiness to face mental health problems and to do something more effective about preserving the mental health of the citizens of California. The report of the Governor's Conference on Mental Health, held at Sacramento in November, 1956, contains many recommendations and ideas for action. Local meetings throughout California, following up the Governor's Conference, have been attended by as many as 600 persons. These facts all point to a public understanding of mental health needs that calls for a revision of previous definitions of "need" in California.

Major Goals

The Short-Doyle Act is simply a legal instrument to authorize and facilitate optional action on the part of local governments wishing to establish local mental health services. The act also provides state funds to match local funds appropriated to achieve broad mental health goals.

Two categories of major goals can be differentiated: First, the promotion and conservation of mental health by all possible means, and next, prevention of the many psychiatric conditions encountered today.

Primary prevention, according to Lemkau,[4] includes not merely the physical protection of brain tissue, but also the preparation of the individual to withstand both predictable and unpredictable psychological stresses. Prevention in the organic area is the responsibility of the entire medical profession, and of public health workers in particular. The educational and consultative services under this act, on the other hand, have the goal of primary prevention in the area of psychological disturbances that are precipitated by the exigencies of life, and this endeavor is synonymous with the pro-

motion of mental health; for the growing preparedness of the individual from birth to maturity to withstand different stresses at different stages of life is what constitutes mental health.

Secondary prevention is implemented by means of all five of the mental health services provided under the Short-Doyle Act; it embraces early recognition, intervention, treatment, and rehabilitation for the purpose of alleviating or arresting a condition which, if neglected, could become more severe or intractable.

Related Programs

Community mental health services in general include the five specific services in the Short-Doyle Act, but they also include the case finding efforts, casework services, guidance services, vocational rehabilitation services, and preventive health services that are found in social, educational, health and correctional agencies, both state and local. Within the general meaning of the term "mental health services," there should also be included those broad services provided by the nursing, medical, recreational, legal, ministerial, and law-enforcing professions which, though they do not have mental health as a primary aim, nevertheless make significant contributions to the mental health of large groups of people. Medical, psychiatric services for individuals able to pay for psychiatric treatment on a private basis, in private mental hospitals or in the office of psychiatrists in private practice, constitute a major resource that should also be counted in any listing of generally available community resources.

The community mental health services provided under the Short-Doyle Act offer specialized psychiatric knowledge and skills. Important and necessary as such services are, they do not include or replace other kinds of professional activities and programs that are basic to the mental health of a community. Such supportive, local, nonpsychiatric services, for which the act offers no substitutes, include the regular guidance programs in schools; welfare and family services; public health activities such as prenatal and well-baby clinics; probationary and correctional services; recreational and group-work programs; special services for particular recipients, such as special school programs and sheltered workshops for the mentally retarded; and the public informational activities of mental health societies—to mention only the more obvious examples. The act, on

the other hand, does provide two services for the benefit of the professions and the agencies representing basic health, welfare, and educational services in any community. Mental health education and consultation, both available under the act, can be expected to strengthen the supportive services by promoting and broadening their mental health content. The three clinical services under the act are, moreover, bound to provide resources for the cases found in schools and other agencies that need individual psychiatric attention. Close working relationships between the specialized services under the act and the general supportive services are necessary to a comprehensive mental health program. Recognition is given to this situation on the state level by the State Mental Health Coordinating Committee representing seven departments.[5]

Psychiatry is no exception to the saying that knowledge is like a little island in a sea of ignorance, and in this connection the specialized mental health services under the act must rely primarily upon the basic research carried out in the universities and elsewhere. But local mental health programs can themselves be centers for applied research, at least to the extent of including program evaluation. Furthermore, theoretical and technical discoveries are not uncommon in clinical settings, with or without formal research programs.

The question most commonly asked in connection with the establishment of new mental health services is, Where will we get the trained personnel? Since there will never be enough staff for all the services needed, the alternative of lowering standards is sometimes brought up. Substitutes in any of the psychiatric professions are frequently suggested as a cheap and rapid solution to the manpower shortage. But unless immediate quantity, rather than quality, of services represents the greatest good to the greatest number, a better solution can be found in a slower but sounder approach. California possesses adequate facilities for training candidates in all of the psychiatric professions (with the possible exception of child psychiatry) but these facilities are not being fully utilized. Here is one point of attack. The universities and colleges can do the job if they get the students in the fields where shortages exist. Special efforts to recruit these students are certain to be stimulated by the existence of desirable local mental health programs which offer attractive opportunities to graduates. The law of supply and demand can be expected to operate in this area, given enough time.

III. GUIDING PRINCIPLES AND PRACTICAL CONSIDERATIONS

Various approaches have been used in California to develop mental health programs over the years.[6] The approach of the Short-Doyle Act represents a combination of the theoretical and practical implications of several viewpoints. It offers some new solutions to the problems of fitting mental health programs to populations, of financing, and of balancing preventive and clinical services. Moreover, this combined approach produces some guiding principles and practical considerations, all of which are in one way or another embodied in the Short-Doyle Act, to wit:

1. The joint responsibility of all levels of government (federal, state, and local) to help in the establishment of mental health services, both preventive and therapeutic;
2. Local autonomy in both initiating and administering mental health services, whether through local government or on some other basis;
3. Flexibility that permits wide, local variations in program, so that each program may fit the special local conditions to the greatest possible extent;
4. Respect for the individual's right to request, accept, or reject treatment on a purely voluntary basis;
5. Equality of opportunity for all citizens to secure services regardless of their inability to meet the full cost;
6. Co-ordination and integration of efforts, now scattered throughout different agencies and professions, into a well-organized program having mental health as a common goal;
7. Recognition of multiple factors in both the causation and prevention of psychiatric disorders, as well as in the conservation of mental health ("mental illness" is not a single disease-entity but a large group of distinctly different conditions);
8. Balancing of a local program by including both treatment services for individual patients and services that protect the mental health of all the people;
9. Sharing of the costs of mental health services by those individuals who are directly served (through appropriate fees);

by the public (through local, state and federal taxes and through voluntary contributions); and by professional volunteers offering services without cost;

10. Understanding that program evaluation and research must go hand in hand with mental health services despite the fact that scientific answers will always be incomplete no matter how long action is delayed;
11. Avoidance of false claims and overselling of programs without, however, minimizing needs or problems encountered (such as recruitment of personnel); and
12. Awareness that it is better in the long run to make haste slowly; that is, to plan and establish local mental health programs step by step.

IV. MAIN PROVISIONS OF THE ACT

Local Mental Health Authority

Both the option and the authority to establish local mental health services are given to:

1. Any county board of supervisors to establish services covering the entire county;
2. Any city council of a municipality with a population exceeding 50,000;
3. The board of trustees of a health district. (This provision applies only to San Joaquin County where the health district has identical boundaries but is governed by a special board.)

Joint mental health services may be established by:

1. Two or more counties;
2. Two or more cities with a combined population in excess of 50,000;
3. A combination of one or more cities with one or more counties.

Joint mental health services may be jointly operated, or one participating city or county may contract to provide service for the others. Costs of services are to be apportioned on the basis of population.

Local Mental Health Advisory Board

Each local mental health authority (local governing body) must appoint an advisory board consisting of seven members: three local physicians in private practice, of whom one shall be a psychiatrist where possible; the chairman of the local governing body; a superior court judge; and two persons "representative of the public interest in mental health."

The local mental health advisory board is to be appointed in such a fashion as to insure that approximately one-third of the board is replaced each year. Since the chairman of the local governing body must be a member of the board, the staggering of terms of the remaining six members can be initiated by appointing two of them for three years, two for two years, and two for one year. Thereafter, the term of appointed members is three years.

The local mental health advisory board is given the responsibility to:

"(a) Review and evaluate the community's mental health needs, services, facilities, and special problems;

"(b) Advise the governing body as to a program of community mental health services and facilities, and, when requested by such governing body, may make recommendations regarding the appointment of a local director of mental health services;

"(c) After adoption of a program, continue to act in an advisory capacity to the local director of mental health services."

It should be noted that, unlike the New York Community Mental Health Services Act of 1954, the Short-Doyle Act provides for a purely advisory, rather than an administrative, board.

Local Administration

One of three choices is offered to the governing body: The local administrator of mental health services must be a licensed physician and surgeon, but the administrator who is appointed may be either a specially qualified local director of mental health services, the local health officer, or the medical administrator of the county hospital. In effect, the governing body has the choice of utilizing one of its two public medical agencies as the administrative setting for the local program of community mental health services, or the governing body may create a new mental health agency under a local director of mental health services who "shall meet such standards of training and experience as the Department of Mental Hygiene, by regulation, shall require."

The local administrator of mental health services, whoever of the three possibilities is chosen, is given specific powers and duties:

"(a) He shall serve as chief executive officer of the community mental health service responsible to the governing body;

"(b) He shall exercise general supervision over mental health services and facilities furnished, operated or supported;

"(c) He shall recommend to the governing body, after consultation with the advisory board, the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable to accomplish the purposes of this division;

"(d) He shall submit an annual report to the governing body reporting all activities of the program, including a financial accounting of expenditures and a forecast of anticipated needs for the ensuing year;

"(e) He shall carry on such studies as may be appropriate for the discharge of his duties, including the control and prevention of psychiatric disorders."

It is understood that, although the act does not specifically mention the administrator's right to hire necessary personnel, qualified specialists in the psychiatric professions (psychiatrists, psychiatric social workers, clinical psychologists, psychiatric nurses, etc.) are required by regulation to perform the five services under the act.

Five Different Community Mental Health Services

Cities and counties may receive a state reimbursement provided that they establish at least two of the following mental health services, (a) to (e):

1. Three kinds of clinical facilities directly serving patients:
   - (a) Outpatient services in clinics;
   - (b) Inpatient services in general hospitals for a period not to exceed 90 days;
   - (c) Rehabilitation services in clinics, general hospitals, or special centers;
2. Two kinds of services promoting the mental health of the community:
   - (d) Informational and educational services to the public and to the professions and agencies concerned with mental health;
   - (e) Mental health consultation for the staffs of schools, public health departments, probation offices, welfare departments, etc., to help them to deal more effectively with their children's or clients' mental health problems before they become severe enough to require psychiatric treatment.

Cities and counties may themselves operate these five services or they may contract with a general hospital, clinic, laboratory, or other appropriate agency to provide them. Mental health clinics existing prior to the act in an agency of local government may be placed under the local mental health administrator by the governing body.

Eligibility of Individuals for Clinical Services

Any person who is "unable to obtain private care," whether for financial, geographical, or other reasons, is eligible for inpatient or outpatient care and for psychiatric rehabilitation. However, "it is the intent of this act that services to individuals shall be rendered

only upon voluntary application." Thus no patient can be forced into treatment against his will or ordered into treatment by a court.

Patients' Fees

The act provides that "fees shall be charged in accordance with the ability to pay for mental health services rendered pursuant to an approved local plan, but not in excess of actual cost."

No patient is ineligible because of financial indigency or inability to pay any fee. In effect, therefore, fees will be charged on a sliding scale, from 0 percent to 100 percent of the actual cost of the service. The state-operated mental hygiene clinics have developed such a scale and methods for determining fees; a copy of the Clinic Fee Committee Report is included in the Appendix as an illustration.

Eligibility of Cities and Counties for State Reimbursement

The financing of local mental health services is shared on a 50-50 basis. In order to qualify for matching state funds, cities and counties:

1. Must submit annually to the Director of Mental Hygiene a plan for proposed expenditures that complies with the regulations and standards established under the act;
2. Must submit an itemized budget showing the net amount subject to reimbursement, and including at a minimum the expenses of the appointed administrator, advisory board, and at least two community mental health services (the Director of Mental Hygiene reviews the plan and fixes the amount subject to reimbursement);
3. Must place under the appointed administrator any mental health services existing in a local governmental agency prior to the act and for which state reimbursement is claimed;
4. May enter into a legal contract with any other city or county, or with any non-governmental agency in a position to furnish any of the five services for which state reimbursement is claimed. For example, a private general hospital with a psychiatric ward or an outpatient clinic supported by a community chest could, if they met standards, be given a contract by the governing body to supply the mental health services that are reimbursible under the act, instead of the governing body's establishing equivalent services for itself. In obtaining services by contract, the governing body would be reimbursed

by the State for half the cost just as services would be reimbursible if operated by the local government directly.

Items Subject to State Reimbursement

Cities and counties may claim a state reimbursement of 50 percent of the net amount expended from local funds for the following items:

1. Two or more of the five specific community mental health services authorized by the act (expenditures are subject to reimbursement whether the local governing body operates its services and facilities directly, or provides them through contract, "or by other arrangement pursuant to the provisions of this division");
2. "Such inservice training as may be necessary in providing the foregoing services";
3. Salaries of personnel;
4. Approved facilities and services provided through contract;
5. Operation, maintenance, and service costs;
6. Actual and necessary expenses incurred by members of the Local Mental Health Advisory Board;
7. Expenses incurred by members of the California Conference of Local Mental Health Directors for attendance at regular meetings of the conference; and
8. "Such other expenditures as may be approved by the Director of Mental Hygiene."

Unlike the New York Community Mental Health Services Act, the Short-Doyle Act places no "ceiling" of $1 per capita of population as the upper limit of state reimbursement to a community for all the services covered by the act. Chart I in the Appendix merely indicates how each dollar per capita might be apportioned amongst the five services and inservice training, based upon the relative costs of the different services and upon the number of persons they could be expected to serve.

Certain items are specifically excluded by the act from state reimbursement:

1. Treatment services furnished to patients who are able to obtain private care;
2. The cost of confinement "incurred by reason of court procedures," i.e. expenditures for involuntary patients;
3. Inpatient services in excess of 90 days' duration;

4. Services employing a physician who is not a citizen of the United States;
5. Capital improvements;
6. Purchase or construction of buildings;
7. Compensation to members of the Local Mental Health Advisory Board;
8. "Expenditures for a purpose for which state reimbursement is claimed under any other provision of law" (such as the special services in public schools that receive state aid through the State Department of Education, for example).

National Mental Health Funds

The net cost of a local plan subject to 50 percent reimbursement is determined after deducting any fees received from patients or any other revenues received by the governing body. The one exception to this rule, however, is that national mental health funds, temporarily granted to a local governing body for the establishment of one of the five services in the Short-Doyle Act, need *not* be deducted in computing the "net amount" for which reimbursement is claimed.

The letter of instructions from the Director of Mental Hygiene to applicants for national mental health funds is included in the Appendix to provide more information on the grant-in-aid program.

Fiscal Details

Reimbursement is made on a quarterly basis. The Director of Mental Hygiene may make investigations and audits of expenditures; and claims must be in such form, at such times, and for such periods as he shall determine. When certified by the director, claims are presented to the State Controller for payment. The Controller may make such audit as he deems necessary, before or after payment. Claims are payable from appropriations for the fiscal year in which they are filed, regardless of when the items of expense were incurred. The director, after consultation with the California Conference of Local Mental Health Directors, may withhold reimbursement in whole or in part for failure of a city or county to comply with the act or with rules and regulations.

California Conference of Local Mental Health Directors

The California Conference of Local Health Officers, established under the Public Health Act, is the prototype for the California Conference of Local Mental Health Directors established in the

Short-Doyle Act. The conference ensures that the regulations, rules, and standards established by the Director of Mental Hygiene not only reflect the thinking of the local directors, but are effectively carried out.

The act specifies that the members of the conference shall consist of "all regularly appointed directors of community mental health services." Until 12 programs were established and 12 administrators had been appointed, the conference consisted of members of the California Conference of Local Health Officers in addition to the first local mental health directors appointed.

The conference is organized in the following way:

Officers and Committees	The Conference shall annually elect a president, vice president and secretary, who shall serve as the executive committee. The president, after consultation with the Director of Mental Hygiene, may appoint other committees to advise the director.
Meetings	The Director of Mental Hygiene calls official meetings on 10 days' notice, at which he shall preside. Members present constitute a quorum. The executive committee may determine to hold additional sessions at which the president or other members may preside.
Expenses	Members' expenses in attending not more than three official meetings a year are charged to the unit they represent. Expenses in attending committee meetings called by the Director of Mental Hygiene are charged against state administrative funds.
Consultants	The president, after consultation with the Director of Mental Hygiene, may appoint psychiatric and other consultants to serve without pay, but receive expenses.

Rules and Regulations for Administering the Act

The State Department of Mental Hygiene administers the act. Rules and regulations are required to be adopted by the Department in accordance with the Administrative Procedure Act in the Government Code. It is also provided in the Short-Doyle Act that they be adopted only after consultation with the California Conference of Local Mental Health Directors and approval by a majority of conference members present at an official session. The regulations cover:

1. Standards for approval of local mental health services;
2. Standards of education and experience for professional and technical personnel employed in local services; and
3. Standards for organization and operation of services, including maintenance of records of services, finances and expenditures.

Duties of the Director of Mental Hygiene

1. Administer the act according to its provisions;
2. Promulgate the standards, rules, and regulations approved by the California Conference of Mental Health Directors;
3. Review all local mental health plans submitted, and determine their compliance with standards, rules, and regulations;
4. Offer such advice and consultation as is necessary to the local mental health authorities;
5. Provide such training facilities as are needed to help relieve personnel shortages;
6. Withhold state reimbursement, in whole or in part, for failure of a city or county to comply with the provisions of the act or with the official standards, rules, and regulations, after consultation with the California Conference of Local Mental Health Directors;
7. Certify claims for state reimbursement and present them to the State Controller for audit and payment.

Effective Date of the Act

The act took effect on September 11, 1957.

Because of the requirements of the Administrative Procedure Act, in addition to the provisions relating to the California Conference of Local Mental Health Directors in the Short-Doyle Act, the regulations did not take effect until at least 60 days after the Short-Doyle Act became law. Actually, the officially adopted regulations could not be printed for distribution before December 1, 1957.

Since no local mental health plans could be either submitted or reviewed until official regulations were promulgated by the Director of Mental Hygiene, the earliest effective date for state reimbursement was January 1, 1958.

Some local mental health authorities, however, proceeded to appoint their advisory boards and to develop their plans soon after September 11, 1957.

V. IMPLEMENTATION OF THE ACT

The Community Services Division of the Department of Mental Hygiene is designated by the Director of Mental Hygiene to administer the new program under the Short-Doyle Act. Special, additional staff for this purpose is provided, not only to furnish accounting, statistical, and clerical help in administering the act, but also to offer consultation in the field wherever advice and guidance are sought by local planning and governing bodies.

Community Organization

The structure of the state-local organization that is prescribed by the act is shown by Chart II in the Appendix. The Local Mental Health Advisory Board, however, should have access to existing data on community resources, needs, and the priorities of unmet needs. Such data are usually available from local health and welfare planning organizations. Where planning bodies do not exist, however, the professions and agencies possessing the desired information may be brought together to form a sort of local mental health coordinating committee, although this is not required by the act. Such a group, representative of all the community's organizations and facilities concerned with mental health, would have the general functions of:

1. Assembling, organizing, and making available the facts already in the member's possession with respect to mental health resources and unmet needs;
2. Formulating an integrated plan or blueprint for the orderly, step-by-step development of supportive services, such as guidance and counseling programs in schools and other agencies, as well as the special mental health services provided under the Short-Doyle Act;
3. Enlisting the participation of community leadership by communicating the data pertinent to the local situation, and by exploring the readiness of the community to support the development of a well-planned program for mental health; and
4. Answering questions pertinent to the official actions and decisions to be taken before any city or county can make use of the act.

The public agencies such as schools, health department, probation offices, welfare departments, and recreation commissions have access to consultants from their corresponding state departments, and to special advice on community organization from their statewide association, the California Conference of Social Work. Private agencies such as family services and mental health societies may turn to their own organizations for guidance in community planning and organization.

Steps in Implementing the Act

1. The first step is to decide which governing body, the city or the county, or a combination of cities and counties, will be the local mental health authority in a given locality. The act provides that any city, or combination of cities, with over 50,000 population may establish municipal mental health services. However, should the county in which such cities are located also establish mental health services, the residents of the city would pay double taxes; the act does not permit cities to stay out of their county's program. On the other hand, the act provides for the establishment of a joint city and county mental health program and, consequently, duplication of either services or taxation can be avoided.
2. The second step is the appointment by the governing body of the Local Mental Health Advisory Board, as provided in the act.
3. The third step is for the governing body to exercise one of the three choices regarding the administration of the community mental health services; that is, to appoint a local director of mental health services as the administrator of the new program, or to appoint the local health officer or the medical administrator of the county hospital to be the administrative officer.
4. The fourth step is the preparation of a plan and a budget for submission to the Department of Mental Hygiene. It should be borne in mind that existing mental health services, similar to those in the act and already operated by the governing body, as well as existing services operating under voluntary auspices, may be included in the plan. The full report entitled "Distribution of Patients by County of Origin," may be procured

from the Department of Mental Hygiene as an aid in estimating caseloads.

5. At any time before, during, or after the preparation of the local plan, consultation may be requested from the Division of Community Services of the State Department of Mental Hygiene. The regulations, which include standards both for the operation of services and for personnel, should be reviewed and understood before the local plan is submitted. Forms to accompany the application for the state reimbursement should also be procured from the Department of Mental Hygiene.

REFERENCES

(1) National Committee Against Mental Illness, Inc.: What are the facts about mental illness? Washington, D. C., 1957.

(2) Department of Mental Hygiene: Statistical report for the year ending June 30, 1955. Sacramento, 1957.

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(5) State Mental Health Co-ordinating Committee: One problem. Department of Mental Hygiene, Sacramento, 1954.

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APPENDIX

THE SHORT-DOYLE ACT OF 1957

Senate Bill No. 244

CHAPTER 1989

An act to add Division 8 to the Welfare and Institutions Code, relating to community mental health services

[Approved by Governor July 6, 1957. Filed with Secretary of State July 10, 1957.]

The people of the State of California do enact as follows:

SECTION 1. Division 8 is added to the Welfare and Institutions Code, to read:

DIVISION 8. COMMUNITY MENTAL HEALTH SERVICES

CHAPTER 1. GENERAL PROVISIONS

9000. This division shall be known and may be cited as the Short-Doyle Act. This division is designed to encourage and to assist financially local governments in the establishment and development of mental health services, including services to the mentally retarded, through locally administered and locally controlled community mental health programs. It is furthermore designed to augment and promote the improvement and, if necessary, the expansion of already existing psychiatric services in general hospitals or clinics that help to conserve the mental health of the people of California.

It is the intent of this act that services to individuals shall be rendered only upon voluntary application.

9001. As used in this division:

(a) "Governing body" means, in the case of a county, the county board of supervisors, or, in the case of a city, the city council, and in the case of a local health district, the board of trustees thereof.

(b) "Community mental health services" and "local mental health services" include city mental health services, county mental health services, local health district mental health services, and joint mental health services.

(c) "Population" means population as determined by the most recent estimate of the Department of Finance.

9002. Any city or combination of cities having an aggregate population of more than 50,000 may by ordinance or resolution of each city involved establish a community mental health service.

9003. Any county board of supervisors may by ordinance or resolution, or in the case of local health district, the board of trustees thereof, may establish a community mental health service to cover the entire area of the county or local health district as the case may be.

9004. The governing body of any county or city may by agreement with the governing bodies of any other city or county or cities or counties establish a joint mental health service. Two or more cities which desire to establish a joint mental health service pursuant to this division may do so only if the aggregate population of such cities exceeds 50,000.

9006. Each community mental health service shall have an advisory board of seven members appointed by the governing body. Three members of the advisory board, shall be physicians engaged in private practice of medicine, and one-third of the physician members, when available, shall be specialists in psychiatry. One member shall be the chairman of the local governing body, one member shall be a superior court judge selected by the judges of the county, and two members shall be persons representative of the public interest in mental health. The term of each member of the board shall be for three years; provided, however, that of the members first appointed, approximately one-third shall be appointed for one year, one-third for a term of two years, and one-third for a term of three years.

9007. The expenses incurred under the provisions of this division shall be a charge against the city, county or counties, or local health district, as the case may be, and shall be audited, levied, collected, and paid in the same manner as other charges.

9008. The local mental health advisory board shall:

(a) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(b) Advise the governing body as to a program of community mental health services and facilities, and, when requested by such governing body, may make recommendations regarding the appointment of a local director of mental health services.

(c) After adoption of a program, continue to act in an advisory capacity to the local director of mental health services.

9009. The local mental health services shall be administered, either by a local director of mental health services, by the local health officer, or by the medical administrator of the county hospital, to be appointed by the governing body. In any case, he shall be a physician and surgeon licensed under the provisions of Chapter 5 of Division 2 of the Business and Professions Code, and, in the case of the local director of

mental health services, he shall meet such standards of training and experience as the Department of Mental Hygiene, by regulation, shall require. Applicants for such positions need not be residents of the city, county, or State, and may be employed on a full- or part-time basis.

9010. The local administrator of mental health services shall have the following powers and duties:

(a) He shall serve as chief executive officer of the community mental health service responsible to the governing body;

(b) He shall exercise general supervision over mental health services and facilities furnished, operated or supported;

(c) He shall recommend to the governing body, after consultation with the advisory board, the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable to accomplish the purposes of this division;

(d) He shall submit an annual report to the governing body reporting all activities of the program, including a financial accounting of expenditures and a forecast of anticipated needs for the ensuing year;

(e) He shall carry on such studies as may be appropriate for the discharge of his duties, including the control and prevention of psychiatric disorders.

9011. Any agreement between two or more cities or counties for the establishment of a joint mental health service shall provide:

(a) That each city or county shall bear its proportionate share on the basis of population served of the cost of joint mental health services provided;

(b) That the treasurer of one participating city or county shall be the custodian of moneys made available for the purposes of such joint services, and that the treasurer may make payments from such moneys upon audit of the appropriate auditing officer or body of the city or county for which he is treasurer.

9012. Such agreement may also provide:

(a) For the joint provision or operation of services and facilities or for the provision or operation of services and facilities by one participating city or county under contract for the other participating counties.

(b) For appointments of members of the local mental health advisory board between or among particpating cities or counties.

(c) That for specified purposes, officers and employees of a joint mental health service shall be considered to be officers and employees of one participating city or county only.

(d) For such other matters as are necessary or proper to effectuate the purposes of this division.

9013. Unless otherwise expressly provided or required by context, the provisions of this division relating to community mental health service, and the appointment of local mental health advisory boards and directors, shall apply to joint mental health services.

9014. A community mental health service may contract for services and facilities with any hospital, clinic, laboratory, or other similar institution. Any such contract may be entered into notwithstanding that the director of community mental health service is a member of the medical or consultant staff of such hospital, clinic, laboratory or institution.

Chapter 2. Eligibility of Cities and Counties For State Reimbursement

9030. Community mental health expenditures made by cities, counties, and local health districts, pursuant to this division shall be reimbursed by the State pursuant to the provisions of this chapter.

9031. The community mental health services provided herein shall consist of:

(a) Out-patient psychiatric clinics for those who are unable to obtain private care, including referrals by physicians and surgeons.

(b) In-patient psychiatric services in general hospitals and in nonprofit psychiatric hospitals which are affiliated as the psychiatric division of or with a general hospital for those who are unable to obtain private care, including referrals by physicians and surgeons.

(c) Rehabilitation services for patients with psychiatric illnesses for those who are unable to obtain private care, including referrals by physicians and surgeons.

(d) Informational services to the general public and educational services furnished by qualified mental health personnel to schools, courts, health and welfare agencies, probation departments, and other appropriate, public or private agencies or groups authorized in the approved plan for community mental health services.

(e) Psychiatric consultant services to public or private agencies for the promotion and coordination of services that preserve mental health and for the early recognition and management of conditions that might develop into psychiatric illnesses.

To be eligible for reimbursement, a city, county, local health district, or in the case of a joint community mental health service two or more counties, shall first have established two or more of the facilities or services provided for herein.

Such inservice training as may be necessary in providing the foregoing services shall be proper items of expenditure in connection therewith.

9032. To be eligible for reimbursement, a city, county, local health district, or, in the case of a joint community mental health service two or more such entities, shall first submit to the Director of Mental Hygiene annually a plan for proposed expenditures. The director shall review such plan to determine compliance with the standards established in this division and pursuant to Sections 9054 and 9055, and fix the amount subject to state reimbursement. Existing services may qualify, pursuant to the provisions of this chapter, for reimbursement upon determination by the local governing body that such services shall be subject to and administered under the provisions of this division.

9033. Expenditures incurred for the items specified in Section 9031 shall, in accordance with the regulations of the Director of Mental Hygiene, be subject to reimbursement whether incurred by direct or joint operation of such facilities and services, by provisions therefore through contract, or by other arrangement pursuant to the provisions of this division. The Director of Mental Hygiene may make investigations and audits of such expenditures as he may deem necessary.

9034. Subject to appropriation therefor, there shall be paid to each city or county on account of expenditures subject to reimbursement by the State pursuant to Section 9030, 50 percent of the net amount expended from local funds, and for the purpose of determining said net amount, there shall be deducted from the cost of services any fees received from patients, and any other revenues received, save and excepting that funds received from the Federal Government under the National Mental Health Act and the Health Amendments Act of 1956 shall not be deducted from the cost of services. Where, however, such funds received from the Federal Government under the National Mental Health Act and the Health Amendments Act of 1956 for any fiscal year exceed 50 percent of the net amount expended from the local funds during such fiscal year, as such net amount is computed in accordance with the provisions here contained, then the amount of state reimbursement provided for herein shall be reduced by such excess. Reimbursement shall be made on a quarterly basis, upon submission to the Director of Mental Hygiene of such information as he may require.

9035. With respect to cities or counties which have established joint mental health services, expenditures subject to reimbursement shall mean the pro-rated expenditures of such cities or counties as provided by the agreement establishing the joint service.

9036. Expenditures subject to reimbursement shall include expenditures for the items specified in Section 9031; salaries of personnel; approved facilities and services provided through contract; operation, maintenance and service costs; expenses incurred under this act by members of the California Conference of Local Health Officers or members of the Conference of Local Directors of Mental Health Services for attendance at regular meetings of such conferences; and such other expenditures as may be approved by the Director of Mental Hygiene. It shall not include expenditures for capital improvements; the purchase or construction of buildings; compensation to members of a local mental health advisory board (except actual and necessary expenses incurred in the performance of official duties); or expenditures for a purpose for which state reimbursement is claimed under any other provision of law.

9037. Reimbursement shall not be made for expenditures for treatment services furnished to patients who are able to obtain private care, and, for the purposes of reimbursement, there shall be deducted from the cost of services any fees received from patients and any other revenue received.

9038. Reimbursement shall not be made for costs and expenditures incurred by reason of court procedures under this or any other code, nor shall reimbursement be made for the cost of confinement of any person in excess of 90 days.

9039. Reimbursement shall not be made to any city, county, or local health district, which, with respect to a local mental health service, employs a physician who is not a citizen of the United States.

9040. Claims for state reimbursement shall be made in such form, in such manner, at such times, and for such periods as the Director of Mental Hygiene shall determine.

9041. When certified by the Director of Mental Hygiene, claims for state reimbursement shall be presented to the State Controller for payment. The State Controller shall make such audit as he deems necessary, before or after disbursement, for the purpose of determining that such reimbursement is for expenditures made for the purposes and under the conditions authorized under this division. All claims shall be payable from appropriations made for the fiscal year in which the claims are filed, regardless of the time at which the expenses upon which the claims are based are incurred.

Chapter 3. Operation and Administration

9050. Fees shall be charged in accordance with the ability to pay for mental health services rendered pursuant to an approved local plan, but not in excess of actual cost.

9053. There is hereby established the California Conference of Local Mental Health Directors, with which the Director of Mental Hygiene shall consult in establishing standards, rules, and regulations pursuant to this division. Until 12 community mental health services have been established, the membership of the California Conference of Local Mental Health Directors shall consist of and be identical with the membership of the California Conference of Local Health Officers in addition to the local mental health directors appointed under this division.

The California Conference of Local Mental Health Directors shall consist of all regularly appointed directors of community mental health services. It shall organize and shall annually elect a president, a vice president, and a secretary, who shall serve as the executive committee of the conference. The president of the conference, after consultation with the Director of Mental Hygiene, may appoint, for the purpose of advising the director, such other committees of the conference as may from time to time be necessary.

Meetings of the conference for the purposes of this division shall be called by the Director of Mental Hygiene, who shall give the members at least 10 days' notice of such meetings. At official sessions of meetings of the conference the Director of Mental Hygiene shall preside; provided, however, that the conference may hold additional sessions as may be determined upon by the executive committee of the conference at which the president or other members of the conference shall preside. Those members present at official sessions shall be considered as making up a quorum.

Actual and necessary expenses incurred by a member as incident to his attendance at not more than three meetings per year of the conference shall be a legal charge against the local government unit which he represents. Actual and necessary expenses incurred by members of the conference incident to attendance at special meetings of the committees of the conference called by the Director of Mental Hygiene shall be a local charge against any funds available for administration of this division.

9054. The State Department of Mental Hygiene shall administer this division and shall adopt standards for approval of local mental health services, rules and regulations necessary thereto; provided, however, that such standards, rules and regulations shall be adopted only after consultation with and approval by the California Conference of Local Mental Health Directors. Approval of such standards, rules and regulations shall be by majority vote of those present at an official session.

9055. The State Director of Mental Hygiene, after consultation with and approval by the California Conference of Local Mental Health Directors, shall by regulations establish standards of education and experience for professional and technical personnel employed in local mental health services and for the organization and operation of local mental health services. Such standards may include the maintenance of records of services, finances and expenditures, which shall be reported to the State Department of Mental Hygiene in a manner and at such times as it may specify.

The regulations shall be adopted in accordance with the Administrative Procedure Act, commencing with Section 11370 of the Government Code.

9056. The State Department of Mental Hygiene, after consultation with and approval by the California Conference of Local Mental Health Directors, may provide for consultant and advisory services and for the training of technical and professional personnel in educational institutions and field training centers approved by the department, and for the establishment and maintenance of field training centers in local mental health services.

9057. The president of the California Conference of Local Mental Health Directors, for the purposes of this division, may, after consultation with the Director of Mental Hygiene, appoint such psychiatric and such other consultants as may be deemed necessary who shall serve without pay but who shall receive actual and necessary travel and other expenses incurred.

9058. The Director of Mental Hygiene may withold state reimbursement, after consultation with the California Conference of Local Mental Health Directors, in whole or in part, from any city or county in the event of the failure of such city or county to comply with the provisions of this division or regulations made pursuant thereto relating to community mental health services or the administration thereof.

TITLE 9—INSTITUTIONS

SUBCHAPTER 3. COMMUNITY MENTAL HEALTH SERVICES

Article 1. Application

500. Application of Subchapter. Subchapter 3 shall apply to community mental health services and local mental health services as defined in and for which state reimbursement is claimed under the provisions of Division 8 of the Welfare and Institutions Code.

NOTE: Authority cited for Subchapter 3: Div. 8 (§§ 9000-9058), Welfare and Institutions Code. Authority cited for Article 1: §§ 9054-9055, Welfare and Institutions Code.

History: 1. New subchapter filed 10-31-57; effective thirtieth day thereafter (Register 57, No. 19).

501. Section Headings. Section headings contained herein shall not be deemed to govern, limit or modify the provisions of any section.

Article 2. Definitions

510. Act. "Act" means Division 8 of the Welfare and Institutions Code.

NOTE: Authority cited for Article 2: §§ 9054-9055, Welfare and Institutions Code.

511. Local Director. "Local director" means the administrator or director of the local mental health services appointed by the governing body.

512. Department. "Department" means the Department of Mental Hygiene of the State of California.

513. Nonprofit. "Nonprofit" means a corporation or association, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual, or a facility owned or operated by a public entity or agency in this State.

514. Unable to Obtain Private Care. "Unable to obtain private care" refers to persons who are financially unable to pay for private care or for whom no private care is available within a reasonable distance of the person's residence.

515. Qualified Mental Health Personnel. "Qualified mental health personnel" shall mean psychiatrists, clinical psychologists, social workers, and other personnel working under their direction.

Article 3. General Provisions

520. Establishment of Local Services. Prior to the submission of any plan for approval, the governing body shall appoint a local mental health advisory board and shall, by resolution or ordinance, provide for or indicate its intention to provide for at least two of the facilities or services, in accordance with the act.

NOTE: Authority cited: §§ 9006-9031, Welfare and Institutions Code.

521. Supervision by Local Director. The local director shall maintain general supervision over all local mental health services

through direct operation of the services or by written arrangement with the person or agency providing the service. Such arrangement shall permit the local director to supervise and specify the kind, quality and amount of the services and criteria for determining the persons to be served.

NOTE: Authority cited: § 9010, Welfare and Institutions Code.

522. Contracts for Service. All arrangements for service to be furnished by other than the governing bodies establishing the service shall be through written contract. All such contracts must be approved by the department prior to any reimbursement for such service.

NOTE: Authority cited: § 9014, Welfare and Institutions Code.

523. Fee Schedules. Fees for service to individuals shall be charged in accordance with ability of the patient or those legally responsible for his care to pay therefor. Each community mental health service shall adopt a local plan relative to fees, subject to the approval by the department.

NOTE: Authority cited: § 9050, Welfare and Institutions Code.

524. Auxiliary Personnel. Each local service shall have sufficient clerical personnel, and such accounting and statistical assistance as may be necessary to maintain adequate records.

NOTE: Authority cited: § 9054, Welfare and Institutions Code.

Article 4. Services and Facilities Subject to State Reimbursement

540. Reimbursement Conditions. Subject to the provisions of the act and of these regulations, state reimbursement will be made for expenditures for the services and facilities described in this article.

NOTE: Authority cited for Article 4: §§ 9031-9055, Welfare and Institutions Code.

541. Outpatient Psychiatric Clinics. Outpatient psychiatric clinics shall mean mental hygiene clinics established and maintained by either public or private agencies for the examination, diagnosis, care or treatment, on an outpatient basis, of persons suffering from mental illness, mental retardation, or behavior or emotional disorders, subject to the following conditions:

(a) The minimum professional staff shall include a psychiatrist, clinical psychologist and social worker, except that under special circumstances the department may authorize the operation of a clinic with less personnel.

(b) A psychiatrist shall be responsible for the diagnosis and treatment of the patients and must be present at the clinic at least half of the time during which the clinic is operated.

(c) The services of the various professional disciplines shall be integrated through regular staff meetings and other conferences for the joint planning and evaluation of treatment.

(d) Psychiatric clinics must be licensed under the provisions of Division 2 of the Health and Safety Code, or if legally exempted from licensure, must be otherwise eligible for a license.

(e) Individual records shall be kept on each case, and shall include all diagnostic studies and a record of services provided by the various

professional disciplines. Such records should provide sufficient detail of factors of background and symptomatology, diagnostic formulation and course of treatment to make possible an evaluation of services.

(f) Such statistical data shall be kept as may be required by the department.

(g) Outpatient psychiatric clinics operated as a part of the psychiatric service of a general or psychiatric hospital shall be subject to the requirements for outpatient psychiatric clinics.

542. Inpatient Psychiatric Services in General Hospitals and in Nonprofit Psychiatric Hospitals. A general hospital shall mean a hospital in which many different types of patients are cared for on an inpatient basis and shall consist of various departments such as medicine, surgery and pediatrics. It must conform to applicable state and local laws and regulations. A nonprofit psychiatric hospital shall mean a hospital in which psychiatric patients are cared for on an inpatient basis and which is operated as part of, or is affiliated with, a general hospital.

(a) The inpatient psychiatric service shall be for the observation, diagnosis, care and treatment of persons with mental illness, mental retardation, or behavior or emotional disorders and shall not be limited to referrals from other departments or services of the hospital.

(b) The psychiatric service shall provide for a psychiatrist to direct the service and assume medical responsibility for the patients. The service must provide for an adequate staff to carry out its responsibilities.

(c) Case records shall be kept, including all diagnostic studies and a record of services, in sufficient detail to make possible an evaluation of service.

(d) Such statistical data shall be kept as may be required by the department.

543. Rehabilitation Services. Rehabilitation services shall be services rendered to persons with mental illness, mental retardation, or behavior or emotional disorders and shall be under the general direction of a psychiatrist. The services shall consist of the application of appropriate social techniques, vocational guidance and training, or other measures directed at the prevention of, compensation for, or correction of the handicapping effects of a psychiatric disorder.

544. Informational and Educational Services. For the purpose of this program, informational and educational services shall mean those activities carried out under the general direction of a psychiatrist by qualified mental health personnel to communicate their special knowledge regarding the problems of human personality and behavior to the general public and to professional workers who have special responsibilities for the health and welfare of other persons.

545. Psychiatric Consultant Services. Psychiatric consultant services shall consist of consultative services, under the general direction of a psychiatrist, by qualified mental health personnel to the professional staffs of schools, health and welfare agencies, courts and

probation offices, law enforcement agencies, recreation commissions or departments, group work agencies, family counseling services and such others as the local director may find appropriate.

Article 5. Limitations on Reimbursements

560. Outpatient Psychiatric Clinics. Outpatient psychiatric clinics shall be limited to psychiatric diagnosis, care and treatment, including the prescribing or furnishing of necessary drugs but excluding other medical care or treatment.

NOTE: Authority cited for Article 5: § 9036, Welfare and Institutions Code.

561. Inpatient Psychiatric Services. Inpatient psychiatric services shall be limited to psychiatric diagnosis, care and treatment, including the prescribing or furnishing of necessary drugs, together with such general medical and surgical procedures as are necessary in the treatment of the psychiatric condition, but excluding other medical treatment or other surgery.

Article 6. Submission of Plans for Approval

580. Forms and Limitations. Plans shall cover the fiscal year, beginning on July 1st running through June 30th of the following year, or remaining part thereof. All plans for proposed expenditures (original and four copies) for the Fiscal Year 1957-58 shall be submitted on forms provided by the department, at least 30 days prior to the commencement of the period for which reimbursement is claimed. Plans for subsequent fiscal years shall be submitted at least 60 days prior to the commencement of the period for which reimbursement is claimed.

NOTE: Authority cited for Article 6: § 9032, Welfare and Institutions Code.

581. Contents of Initial Proposals. Each initial proposal shall be accompanied by:

(a) A description of the proposed plan and program.

(b) A proposed budget which identifies each service and facility and shows in detail the sum to be expended for each.

(c) Copies of any local ordinances and resolutions pertaining to community mental health services.

(d) Copies of all existing contracts pertaining to joint mental health services.

(e) Copies of all existing or proposed contracts for furnishing service by other than direct operation of the entity making the application.

(f) Such other information as may be required by the department to insure compliance with these regulations and the act.

582. Contents of Subsequent Proposals. Plans for proposed expenditures in succeeding fiscal years shall contain the information provided by subdivisions (a), (b) and (f) of Section 581, together with any changes in the items mentioned in subdivisions (c), (d) and (e) of said section.

Article 7. Claims for Reimbursement

600. Forms and Information. Claims for reimbursement shall be submitted quarterly (orginal and four copies) to the Director of Mental Hygiene, with such information as he may require and on forms provided by the department.

NOTE: Authority cited for Article 7: §§ 9032-9040, Welfare and Institutions Code.

601. Limitation on Reimbursements. Reimbursement for any fiscal year shall be limited to the amount fixed by the Director of Mental Hygiene when the plan is approved, unless additional expenditure is authorized after filing of a supplementary application. Expenditures incurred prior to approval of a plan by the Director of Mental Hygiene or for costs or expenditures not included in the approved plan shall not be subject to reimbursement. Actual and necessary expenses incurred by members of the California Conference of Local Mental Health Directors for attendance at meetings, pursuant to Section 9053 of the act, prior to approval of local plans, shall be subject to reimbursement in accordance with the act.

Article 8. Qualifications of Personnel

620. Director of Local Mental Health Services. Where the local director is other than the local health officer or medical administrator of the county hospital, he shall be a physician and surgeon licensed as such in the State of California and show evidence of having completed three years graduate training in psychiatry, in a program approved by the American Medical Association or the American Osteopathic Association, to be supplemented by an additional period of two years of training or practice limited to the field of psychiatry. Possession of a valid certificate in psychiatry issued by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry or a written statement from the secretary of either board showing eligibility for examination for such a certificate shall be evidence of the completion of three years graduate training and the two years supplemental training or practice. In addition, he shall have had at least one year of administrative experience in a medical program.

NOTE: Authority cited for Article 8: § 9055, Welfare and Institutions Code.

621. Program Chief. Each local mental health program shall provide for a program chief, unless the program is administered by a local director who meets the qualifications specified in Section 620. The program chief shall have the qualifications mentioned in said section, except that one year of administrative experience in a medical program shall not be required.

622. Requirements for Professional Personnel. Wherever in these regulations the employment of a particular professional person is required, the minimum qualifications for that person shall be as hereinafter specified in this article. It is intended that these minimum qualifications shall apply to the head or chief of a particular service

or professional discipline but not necessarily to subordinate employees of the same profession.

623. Psychiatrist. A psychiatrist shall have a license as a physician and surgeon in this State and show evidence of having completed three years graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association. Possession of a valid certificate in psychiatry issued by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry or a written statement from the secretary of either board showing eligibility for examination for such a certificate shall be evidence of the completion of such training.

624. Clinical Psychologist. A clinical psychologist shall have a Ph.D. degree in clinical psychology from a school approved by the American Psychological Association for training of clinical psychologists.

625. Social Worker. A social worker shall have completed a two-year graduate curriculum in social work in a recognized school of social work and, in addition, shall have had the equivalent of two years of full-time supervised experience in social work, in a psychiatric setting, at least one year of which shall have been in a supervisory, administrative or consultant capacity.

626. Exceptions for Limited Periods. Where persons with the qualifications specified in this article cannot be obtained, the department may make exceptions to the provisions in this article for limited periods.

Article 9. Accounting and Records

640. Financial Records. Records shall be kept so that they clearly reflect the cost of each type of service for which reimbursement is claimed. Where apportionment of costs is necessary, such as for inpatient psychiatric service in a general hospital, such apportionment shall be made according to accepted accounting principles in order to reflect the true cost of the services rendered.

NOTE: Authority cited for Article 9: § 9055, Welfare and Institutions Code.

641. Patients' Records. Individual records shall be kept on each case, and shall include diagnostic studies and a record of services provided by the various professional disciplines in sufficient detail to make possible an evaluation of services.

642. Mental Health Education and Consultation Services. Records concerning informational, educational and consultation services shall be kept in sufficient detail to show the extent of each of these services and to make an evaluation thereof possible.

643. Statistical Data. Statistical data shall be kept and reports made as required by the department. Reports shall be made on forms provided by the department.

REPORT ON

CLINIC FEES

Community Services Program

California State Department of Mental Hygiene

in collaboration with

the Heller Committee for

Research in Social Economics

University of California

July, 1953

(Revised February, 1958)

REPORT OF THE CLINIC FEE COMMITTEE
(Revised February 1958)

INTRODUCTION

In July, 1953, the first report of the Outpatient Fee Committee proposed policies regarding fees and a payment schedule for psychiatric care in the department's seven State Mental Hygiene Clinics and in the Outpatient Department of the Langley Porter Clinic. The State Legislature, in 1953, officially authorized the State Department of Mental Hygiene to determine fees and to arrange for collection of fees for services rendered by the State Mental Hygiene Clinics. The precedent to charge outpatient fees began at the Langley Porter Clinic which opened in 1943. Its outpatient department has set fees according to the financial ability of patients and responsible relatives.

Appointment of a departmental committee to study fee setting for outpatients was recommended at a meeting of the supervising psychiatric social workers in the department in April, 1952. The committee was formed in November of that year and consisted of two psychiatrists and two psychiatric social workers. Its function was to consider theoretical concepts and practicalities of fee setting and to recommend general policies regarding outpatient fees to the Department of Mental Hygiene.

Miss Emily Huntington, University of California, Chairman of the Heller Committee for Research in Social Economics, met with the fee committee in two of its early meetings. She acted as a consultant to the fee committee, explained the work of the Heller Committee in estimating family budgets, and assembled data for the basic allowance used in the fee schedule.

The committee also considered the practice of other outpatient psychiatric clinics throughout the United States in fixing fee schedules. A study by Barhash and coworkers, "The Organization and Function of the Community Psychiatric Clinic," published in 1952, provided considerable material. The National Association for Mental Health furnished compilations of fee schedules currently used in various parts of the Country and these were studied by the committee. Clinics, in general, have charged low fees. At present the trend is toward higher fees, scaled to the individual patient's ability to pay for service.

The committee considered several general factors relative to the justification of the state clinics charging fees. Despite the many claims for the therapeutic value of fees, the committee found no convincing evidence that the collection of fees materially advances therapy in the majority of cases. It is always therapeutic, however, to consider carefully the patient's ability or inability to pay. Since money symbolizes value in our culture, failure to charge fees commensurate with the ability to the patient to pay may lower the worth of psychiatric care in the eyes of some patients and perhaps of some staff members and trainees.

The collection of fees can help pay the cost of operation of the clinics. Even though in California the fees do not go to the individual state clinic where they are collected, they contribute to the overall state governmental

funds from which the operational costs of the clinics are budgeted. Persons making use of the clinics thus indirectly share more in the expense of the operation of the clinics than does the public at large.

Some standardization of outpatient fees in the state clinics from one case to another and from one clinic to another is desirable even though flexibility in using the fee schedule is a necessity. General statements of policy can be made to cover the common questions and a simple sliding fee scale to fit varying incomes can be devised. This policy and this scale support the fee-setters and help them become aware of their own individual attitudes about fees.

THE GUIDE (FEE SCHEDULE)

The guide can be used as it is or with variations suited to a given community.

A basic allowance for current living expenses is derived, with provision for adapting it to families of varying sizes. The handling of variable items not included in the basic allowance is discussed. A basis for considering savings and health insurance is included. A sample computation is made for determining the amount available per month for fee in a given instance. A table establishes the amount of fee per weekly visit relative to the budgetary surplus.

The Basic Allowance. The basic allowance is the amount considered necessary for current living expenses. Only the income above this amount is available for fee. The stable items for a family of four, as priced in the "Wage Earner Budget" of the Heller Committee, September, 1957,[1] is used as a starting point:

Stable Items for a Family of Four

	Annual	*Monthly*
Food	$1,699.88	$141.66
Clothing	475.03	39.59
House operation	218.78	18.23
Furnishings	217.12	18.09
Automobile	513.02	42.75
Care of person	109.38	9.12
Recreation	247.35	20.61
Carfare	17.42	1.45
Tobacco	101.40	8.45
Gifts	46.80	3.90
Association dues	56.48	4.71
Student body dues	6.63	.55
Contributions to church and charity	39.50	3.29
Incidentals	15.50	1.29
Total stable items for family of four	$3,764.29	$313.69

[1] The items included are in general based on the spending habits of families living in the San Francisco Bay area that are in the wage earner socioeconomic group. An article is considered typical of the expenditure pattern if it is purchased by more than 50 percent of the families studied.

The Heller Committee's budget studies are published annually. (The original report of the Fee Committee used the September, 1952, pricings.) For further elaboration see *Quantity and Cost Budgets for Two Income Levels, Prices for the San Francisco Bay Area,* September, 1957. Issued by the Heller Committee for Research in Social Economics. Obtainable ASUC Store, Berkeley, California. Price $1.90.

The sum of $313.69 per month for a family of four does not include items which will vary greatly from family to family, such as rent, life insurance, medical and dental bills, extra transportation for clinic visits, installment payments, and back debts. The committee added one of these variable items, life insurance, to form the total basic allowance.

Life Insurance. Inquiry was made of a large insurance company about the average amount of life insurance carried by the wage earner. Though unwilling to make recommendations, the company representative agreed that life insurance coverage in an amount equal to the annual family income could be considered appropriate. An annual income of $6,000 would approximate our basic allowance for a family of four plus rent and other necessary expenses. Therefore, we added to the annual basic allowance $143.52 ($11.96 monthly), the amount of the premium for an available whole life policy which would yield $6,000 upon death of the insured.

Other necessary types of insurance were included under "Stable Items." For example, automobile collision and accident insurance were included under "Automobile."

Total Basic Allowance for Family of Four

	Annual	*Monthly*
Stable items	$3,764.29	$313.69
Life insurance	143.52	11.96
	$3,907.81	$325.65
	(or for ease in calculating)	
	$3,900.00	$325.00

The calculation of the basic allowance for families of other than four members is determined by the following guide.[2] The amount allowed varies, not in arithmetical proportion to the size of the family, but according to a percentage based on calculations allowing for expenses relatively greater, the smaller the family.

Family size	*Percent of four*	*Amount of $325 base*
1	46%	$150 *
2	65%	210
3	84%	275
4	100%	325
5	114%	370
6	128%	415
7	141%	460
8	154%	500
9	167%	545
10	179%	580

* Considered an unreliable estimate.

Other Variable Items

Rent or Home Ownership. Housing costs vary greatly from one family to another. Often a family can do little to control the cost of its housing.

[2] Based on estimates made by the United States Department of Labor, Bureau of Labor Statistics, "Budget Levels for Families of Different Sizes," *Monthly Labor Review*, February, 1948, p. 181.

Therefore separate computation in each case is necessary. Exorbitant expenditures for housing which is obviously unnecessary should be handled in an individual manner.

Medical and Dental Expenses. In previous editions of this report, a small arbitrary sum was added to the basic allowance for medical and dental expenses, but all studies of these costs emphasize their unequal incidence.

The unpredictibility of medical and dental expenses applies not only to different families, but to the same family in different years. Insurance and prepayment plans offer no basis for making a consistent allowance because of their wide variation in costs and coverage.

Therefore we recommend that medical and dental expense allowance be determined individually for each patient. The fee-setter can consider such questions as:

What were last year's medical and dental expenses? Were they representative of previous years?

What are the established routine preventive measures taken in the family; for instance, routine pediatric care, immunizations, general physical, dental or eye examinations?

What are the continuing medical problems?

Are expensive procedures, such as operations, or fitting of prostheses contemplated? (Allow for these only at the time they are actually done.)

What is the coverage by prepayment and insurance plans? What are the cost of these?

The amount allowed for medical and dental expenses should represent the fee-setter's estimate of actual future expenditures rather than needs. Obviously the estimate can scarcely be more than a guess, and the patient can be requested to propose re-evaluation of the fee if the actual medical and dental expenses differ grossly from the predicted expenses. Psychiatric treatment in itself may influence the amount of other medical care used by a patient.

Transportation. When a patient travels a considerable distance to the clinic, allowance can be made for extra transportation costs. If time lost from work for clinic visits results in loss of salary, it will affect the income available.

Back Debts. These are debts for which there is no definite plan for payment, but for which the person has responsibility. Sometimes the accumulation of debts by careless management may be a part of the expression of emotional problems in the family. There may be large medical bills. The patient may have had to borrow money to cover such expenses as funeral costs of a family member, payment of foster home care, or payment of fines or judgments. A plan for paying the debts over a period of time should be made, setting the payments at a level which permits the clinic to assess a fee. After a stipulated period the clinic fee can be reviewed to determine whether the debts have been sufficiently reduced to justify revision of the clinic fee.

For example, a family of four with a net income monthly of $450 is paying $75 rent, has estimated $15 average monthly medical and dental expenses, and has $180 in back debts. Without the debts there would be $35 available monthly for fee and an $8 clinic fee per weekly visit would be set. An agreement with the patient could be reached whereby he pays $15 monthly on the back debts, leaving $20 per month for clinic fee which would then be set at $5 per weekly visit. If the patient is still in treatment at the end of 12 months the clinic fee would be reviewed and increased to $8 per weekly visit.

Installment Payments. Installment buying is accepted family economy in our culture. Some families have a heavy installment load. Careful review should determine whether a better financing plan can be arranged, and which items do not merit special allowance. Since the basic allowance includes items for both car payments and payments on furnishings, additional allowance for these debts are usually ill-advised unless it is determined that loss of a large equity in a particular item would otherwise result.

Savings. It is recommended that savings and invested capital, over and above the amount necessary for maintenance of the family for one month, be considered as available income. If a family earning $410 has savings totalling $600 and monthly expenses are $400, the difference between savings and expenses, or $200, should be prorated and added to the monthly income of $410.

It is suggested that the prorating be determined on an estimated duration of treatment. Since at the time of application duration of treatment is unknown, a more or less arbitrary estimate of probable duration must be made. In the above example, if duration of treatment is estimated at 10 months, then one-tenth of $200, or $20, would be added each month to the monthly income of $410 and fee would be determined on the total of $430.

Savings of individuals have different meanings for different age groups. A patient in his sixties is much more dependent upon his savings for security than is a younger patient. Therefore, with the older patient much more than a month's maintenance should be allowed in considering savings as available resource.

The committee reached no conclusions regarding real estate holdings and investments in relation to availability of assets for payment of psychiatric clinic fees. Often patients own expensive cars and homes but have no savings and only sufficient income for current expenses. Other families with similar income have savings adequate to justify payment of a full clinic fee, but rent their home and have no car or else an inexpensive one. No helpful precedent could be found, and the committee believes each such case will require consideration on its own merit.

Health Insurance Policy Benefits. Patients sometimes have insurance policies which will pay for outpatient psychiatric care either in part or in full. Inquiry about such policies should be made at the time of fee-setting. Any funds available from insurance should be added to the fee which is still set in terms of available income and savings. If the sum available from insurance plus income and savings is greater than that needed for a maxi-

mum fee, the total insurance funds would be used, adding only that part of income and savings necessary to bring the fee to a maximum. For example, a patient can pay $3 per visit from income and savings, but he has an insurance policy which will pay $5 per visit. An $8 fee (the maximum fee) would be set using the $5 from insurance funds supplemented by $3 from income and savings.

At the time the fee is set initially, the patient may give the information that he has a health insurance policy but he is uncertain as to whether its benefits include payment for outpatient psychiatric visits, or if so, in what amounts the insurance policy will pay. In such a case, the fee is set on the basis of the patient's income and savings pending the clarification of possible payment from the insurance company. If the insurance company then pays for visits retroactively, it may be necessary to make a refund to the patient, depending on whether or not the addition of the insurance payment has brought the total payment per visit to an amount greater than the maximum fee per visit.

The Formula

To set a fee the first step is to secure the following information:

1. Size of family.
2. Rent or payments on home.
3. Estimated medical and dental expenses.
4. Total income after taxes and social security deductions:
   a. Wage and salary income after taxes.
   b. Other income after taxes.
5. Savings.

In some instances it may be necessary to consider such items as:

Gross wages (when there may be deductions other than taxes from wages, such as savings bonds).
Installment payments (not included in basic budget).
Back debts (arrive at a monthly allowance for paying).
Transportation to clinic (if patient comes from a distance).
Health insurance benefits.

The next step is to deduct the allowable expenses from the available resources, to determine the amount per month available for fee.

SAMPLE COMPUTATION

Add Expense Items

Basic allowance (family of four)	$325
Rent or home payment	65
Estimated medical expenses	20
Monthly installments (not car, home or usual house furnishings)	10
Back debts (plan made for patient to pay $5 per month)	5
Clinic transportation (patient lives in town)	0
Current monthly expenses	$425

Add Income Items

Monthly pay after taxes	$435
Other income	none
Prorated savings	20
Total	$455
Deduct total expenses	425
Income available for fee	$30

Fee charged (see guide, below) $6-$7 per weekly visit.

Computation on Savings

Total savings	$625
Deduct monthly expenses	425
Available for fee	$200

Prorated over 10 months probable duration of treatment	$20 per month

The proposed fee is set in terms of the following guide and offered the patient for discussion:

Amount available per month *	*Fee per week*
$0	$0.50–$1.00 (per family)
0–10	2.00
10–15	3.00
15–20	4.00
20–25	5.00
25–30	6.00
30–35	7.00
35 and up	8.00

* Intervals overlap to allow latitude to the fee-setter.

A variation from the fee schedule in setting an individual fee, should be explained on the fee sheet. The written statement permits a quick review of the clinic's policy toward a given patient, facilitates supervision of fee setting, and calls attention to situations in which the guide is not applicable.

STATEMENT RELATIVE TO GENERAL POLICIES

Changing Amount of Fee. The initial fee is agreed upon at the time of the application interview with the social worker since it is an important consideration in the patient's decision to make use of the clinic. When a fee needs to be changed during therapy, preferably the therapist should reach a new agreement with the patient, using, through consultation, the social worker's knowledge of fees as an aid. However, in some clinics this is not possible because of frequent staff changes. In such instances the therapist, after talking in general terms with the patient, may call upon the social worker to reset the fee with the patient.

Minimum and Maximum Fees. If we adhere strictly to the concept of fee setting on an ability to pay basis, when the income and savings do not exceed the amount of the basic allowance plus accepted variable items, no fee would be set. Most budgets have some flexibility, however, and a minimum fee of $1 is suggested unless the family is living on public relief or on the equivalent of the community's relief budget. However, the amount of the minimum fee should be determined by the individual clinic according to the standards of the community in which it operates. In an individual instance, for therapeutic reasons, a fee lower than the minimum set by the clinic may be charged.

The maximum fee per patient visit in the Mental Hygiene Clinics has been set by the Department of Mental Hygiene at $8. The maximum fee is based on the minimum cost of a patient visit in a mental hygiene clinic as determined by cost statistics compiled within the Department of Mental Hygiene.

Payment for Visits. Any visit, whether for psychological testing, social work interviews, group therapy, psychiatric interviews, etc., should be paid for at the same rate.

Since the amount available for clinic fee is computed on a weekly basis, this amount should be collected each week the patient visits the clinic, whether he makes one or more visits. Payment should be collected on a current basis. Statements to patients of accounts due should rarely be necessary.

When more than one member of a family is in treatment, the question arises as to how the fee should be paid. The fee table is set up in such a way that the total family income available for fee is computed. Either a single family fee can be quoted or a separate equal fee for each member attending the clinic can be set.

Whenever the patient fails to pay during the course of therapy, it is first regarded as a therapeutic problem, and only after clarification with the therapist should a possible need for a change in fee be considered.

THE CLINIC FEE COMMITTEE

ETHEL FRAPWELL, P.S.W.
Sacramento State Mental Hygiene Clinic
(Until October, 1956)

MARIETTA HOUSTON, M.D., Chairman
(Since April, 1955)
The Langley Porter Neuropsychiatric Institute

LIDA SCHNEIDER, P.S.W.
The Langley Porter Neuropsychiatric Institute

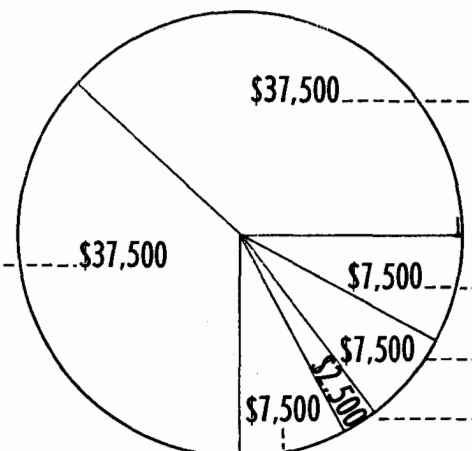
WILLIAM R. SHEEHY, M.D., Chairman
(Until March, 1955)
Berkeley, California

CHART I

THEORETICAL APPORTIONMENT OF FUNDS UNDER THE ACT (for 50,000 population)

Estimated total cost of all services under the act:
$2 per capita per year

E.g. for a population of 50,000:
$50,000 from local government
$50,000 from the State



NOTE: Approximately 350 patients per year per 50,000 population would be served at an estimated average cost of $236 per patient.

NATIONAL MENTAL HEALTH FUNDS

MARSHALL E. PORTER, M.D.
Director of Mental Hygiene

GOODWIN J. KNIGHT
Governor

STATE OF CALIFORNIA
DEPARTMENT OF MENTAL HYGIENE
1320 K Street
SACRAMENTO
February 3, 1958

Please address reply to
2900 Buena Vista Way
Berkeley 8, California

To: Prospective Applicants for National Mental Health Funds

From: California State Mental Health Authority

Subject: Funds for Community Mental Health Programs and for Training Personnel

I. Availability of Funds

In accordance with Public Law 487 of the 79th Congress, the California State Mental Health Authority has available for the Fiscal Year, July 1, 1958, to June 30, 1959, a limited amount of federal funds for the use of local agencies "to aid in the development of more effective methods of prevention, diagnosis, and treatment of such disorders (i.e., mental disease), and for other purposes." Funds available for the next fiscal year to the California State Mental Health Authority may be used primarily for two purposes:

(a) Development and support of community mental health services.

(b) Training of personnel for extramural or outpatient mental health programs.

NOTE: The total amount of Mental Health Act funds to be granted to California in 1958-59 is estimated as $278,900.

II. Principles of Allocation of Funds for Community Services

The California Advisory Committee on Mental Health has adopted a set of principles to guide the State Mental Health Authority in the allocation of funds. These principles were based upon the fact that there is again a relatively small amount of funds available in relation to the large number of requests for use of these funds.

A. Primary consideration will be given to plans for community services based upon comprehensive community planning for mental health. Lesser priority will be given to projects for isolated programs of mental health within communities by one or more agencies.

B. Funds will generally not be allocated to replace local participation. Although, in emergencies, support may be provided to supplement existing services, priority will be given to the development of additional support for new mental health activities.

C. In consideration of the desirability of aiding those projects which promise the soundest development, the Advisory Committee will be influenced by the following factors:

(1) Indication of community readiness to accept and support mental health activities;

(2) Comparative merits of the objectives of projects submitted;

(3) Broad, long-range planning for maximum community benefit;

(4) *Outlines of a plan for the gradual assumption of financial responsibility for the program by the sponsoring agencies. It is a standing policy to gradually reduce these funds granted to local agencies within a definite time schedule;*

(5) Opportunity presented by the agency for training of psychiatric professional groups as well as participation in the education of teachers, nurses, physicians, social workers, probation officers, and others who work in community services affecting the mental health of the entire community.

D. Applicants not receiving grants for 1958-59 and wishing to re-apply for funds the following year should submit new applications a year from now.

III. Method of Application for Funds for Community Services

A. *Community Mental Health Project:*

1. Fill out the application face-sheet provided in *quadruplicate* to accompany each copy of your application. (A fifth face-sheet is being supplied for your file copy.)

2. Agencies desiring funds appropriated under the National Mental Health Act should submit an application in quadruplicate for such funds to Portia Bell Hume, M.D., Deputy Director for Community Services, State Department of Mental Hygiene, 2900 Buena Vista Way, Berkeley 8, California, postmarked prior to midnight, March 10, 1958. Applicants should submit a narrative account of the proposed project, incorporating the following information:

a. Brief description of the project.

b. Official sponsorship and name of individual under whose direction the activities will be conducted.

c. Objectives of the program.

d. Relationship to existing community mental health activities and/or the overall, local mental hygiene program.

e. Time limit for which support is desired. (Although commitments can be made at the present time for support for only one year, if the project is a continuing one, indication should be made at this time of the total period for which it is believed federal funds will be necessary, with a time limit generally not exceeding three years.)

f. Organization chart, showing staff-relationship and depicting affiliations, if any, with other community agencies or organizations.

g. Proposed plan of *evaluation,* including a statement of intention with reference to extension, discontinuation, or incorporation of services at the termination of support by Mental Health Act funds. It is hoped a plan of evaluation will be formulated at the outset.

h. Statement of willingness to provide an annual report of the project and to exchange information and ideas with the State Mental Health Authority (Department of Mental Hygiene).

i. *If funds have been applied for from foundations or other sources for financial support,* and this is not shown in the proposed budget submitted with the application, please list name and address of such organizations. State efforts made to obtain support elsewhere and results of efforts. Also show if formerly budgeted personnel actually worked and for how long.

j. Explanation, elaboration, or clarification of the financial data supplied on the face-sheet.

k. Statement of policies, such as "intake" policies.

l. What will your agency do if National Mental Health funds are *not* received?

B. *Training*

Applications must be made by the agency which intends to employ the trainee upon completion of the training.

Availability of Funds for Training Stipends

Applications for some training stipends will be considered in the next fiscal year. However, training needs should be met, wherever possible, from the national training program. Information may be obtained from the Director, National Institute of Mental Health, U. S. P. H. S., Bethesda, Maryland, and from the approved schools for training.

Closing date for applications is March 10, 1958.

IV. Method of Application for Training Stipends

1. At present applications will be received only for the second year of graduate psychiatric social work training or the second or third year in graduate training in clinical psychology. A graduate year of training in child psychiatry may be financed for certain trainees in psychiatry and pediatrics. Graduate training for certain qualified public health nurses in the mental health field will also be supported from time to time.
2. A legal stipulation where federal grant-in-aid funds are used for training individuals is that the trainee must agree to return to work for an agency contributing to the public health of the community. The usual practice is that for every year of training on these funds, the trainee will work at least a year in the community agency upon completion of training as a salaried member of the staff of the sponsoring agency.
3. Applications for training will be received only by the community agency sponsoring the individual for training. This means that persons desiring training apply to local community agencies to sponsor their training with the understanding that upon completion of the training the trainee returns to the agency as a member of the staff of that agency. The State Mental Health Authority will write contracts with the agency for the funds for training of individuals.
4. There are no formal application blanks. Narrative applications should include:
   (a) Letter from director of agency to which trainee will return upon completion of training with description of use and contribution of trainee to agency upon his completion of training.
   (b) Statement of previous training and experience of trainee.
   (c) Letter indicating acceptance for graduate training in a school approved for such training. In the case of psychiatrists applying for a graduate year of training in child psychiatry, the State Mental Health Authority has approved certain child guidance clinics in California for such training. The names of these clinics and their directors may be obtained by writing the State Mental Health Authority. Applicants should then make arrangements with the directors of these clinics for training.
   (d) Statement as to why the individual desires and needs graduate training at this time.
5. The eligibility for training and the amount of training stipends will, in general, be the same as that offered by the United States Public Health Service for training under the National Mental Health Act.

In general, the stipend levels are as follows:

Psychiatrist, third graduate year	$3,400 per year
Psychiatrist, fourth graduate year	4,000 per year
Clinical psychologist, third graduate year	2,400 per year
Clinical psychologist, fourth graduate year	2,800 per year
Psychiatric social worker, second year, graduate training	2,000 per year
Psychiatric social worker, third year, graduate training	2,800 per year
Public health nurse, final year before B.A.	2,000 per year
Public health nurse, first year graduate	2,400 per year
Public health nurse, second year graduate	2,800 per year

With only limited funds available for training, it should be mentioned that probably relatively few applicants will be able to be trained with these funds.

V. Notification of Applicants of Action by Mental Health Authority

Although the final decision on the applications cannot be made until the State Mental Health Authority has been advised of the exact amount appropriated by the United States Congress (usually done in June or July), applicants will be notified of the preliminary action taken on requests at the earliest date, i.e., by June 1, 1958. Grants will be made through contract with the applying agency, which is requested to submit on the first of each month (starting on August 1, 1958), a signed statement in quadruplicate itemizing the amounts expended during the previous month. Three copies of these statements should be sent to Mr. Robert E. Conahan, Comptroller, State Department of Mental Hygiene, 1320 K Street, Sacramento 14, California. The fourth copy of the monthly statement should be mailed to Portia Bell Hume, M.D., Deputy Director for Community Services, 2900 Buena Vista Way, Berkeley 8, California. Forms for monthly statements are available upon request.

MARSHALL E. PORTER, M.D.
Director of Mental Hygiene and
State Mental Health Authority

CHART II

STRUCTURE OF THE STATE-LOCAL MENTAL HEALTH ORGANIZATION

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