With prevention of mental illness a goal and psychiatric time limited, this health department assigns supportive roles to nurses and consultive roles to psychiatrists. Cooperation with schools, official and voluntary agencies, and State mental hospitals aids in progress toward the goal.

A Health Department's Activities in Mental Health

H. L. BLUM, M.D., M.P.H., and W. A. KETTERER, M.D., M.P.H.

NEITHER a psychiatrist nor a psychiatric clinic was available in Contra Costa County, Calif., 10 years ago to handle the problems of emotional illness encountered by the Contra Costa County Health Department. During these years, we have sought to increase the staff's understanding of emotional illness, to promote better interpersonal relationships among members of the health department and other related groups, and to find the optimum use of psychiatrists and nurses in consultive and supportive roles. In addition, we have engaged in many community activities, such as family life education, to promote better mental health.

Contra Costa County, located east of San Francisco Bay, grew 300 percent between 1940 and 1950 to a total population of 299,000. By 1957, with growth continuing at a much slower rate, the population had reached 375,000. The health department was modest in size until 1950 when it began to expand, with services shaped to the community's needs. A decentralized working staff of sanitarians and nurses serve and represent the health department in specific geographic areas. In the county pattern schools provide their own nurses, while the health department provides medical, dental, nursing, health education, sanitation, and other consultive services to any school desiring them.

Dr. Blum is health officer and Dr. Ketterer is assistant health officer of the Contra Costa County Health Department, Martinez, Calif.

Although the health department provides extensive clinic services, increasing industrialization and the spread of medical care insurance have somewhat decreased the problems of providing medical care. And, with health department emphasis on preventive rather than therapeutic medicine and encouragement of "whole care" in public and private practice, the actual ratio of population to clinic use has declined significantly in the past few years.

Initial Planning in Mental Health

In 1948, it became apparent that some of our persistently vexing problems in public health centered upon emotional illness. Three other county agencies felt similarly about many of their problems, and an informal meeting was arranged for representatives of the Contra Costa County welfare, school, probation, and health departments to consider creating a psychiatric or child guidance clinic. With our very limited means, it soon became clear that a clinic seeing so few patients would rapidly become saturated and its use to us would be minimal.

Thus, a concept developed that mental health activities in the county would have to be more than a series of therapeutic situations between the psychiatrist and individual patients. We felt that a consultant psychiatrist could assist certain groups of professionally trained workers with mental health problems. The training of professional workers would result in the availability of many mental health services throughout the community on a scale quite impossible if the same limited psychiatric time were available only in a clinic situation. Therefore, arrangements were made for each agency to receive psychiatric consultation for one-half day a month. It was agreed to keep this experimental approach open to modification.

Development of the original scheme resulted in the inclusion of more county agencies in the psychiatric consultation program and the formation of the Mental Health Coordinating Committee of county agencies. Today, this committee comprises the department heads of nine different county agencies with whom a psychiatrist meets monthly. This body of administrators acts as a steering committee for the entire program, sets policy, plans, coordinates, evaluates, and determines allotment of time and financing. Broad framework is set up, but each agency has freedom in how it uses its share of psychiatric time. The total program involving all county agencies concerned in 1948 originally commanded 3 hours weekly from one psychiatrist. In 1958, there are 68 hours available from 9 psychiatrists.

In the beginning, after a few sessions of the health department with the psychiatrist we saw that we needed to learn how to deal with mental health problems and how they affected us personally. Staff members' personal problems relating to their job success called for consideration and understanding. For certain of our personnel, difficulties in work situations and interpersonal office relationships had to be remedied for more effective functioning within the staff, with other agencies, and with clients. It also became apparent that the staff members did not clearly understand their responsibilities or the goals they were trying to achieve.

Thus, through 1954, the psychiatrist served primarily as a consultant on administrative problems at various levels. The purpose here was to ease interpersonal relations and to improve our understanding of emotional problems.

Nurses Assigned Patients

During 1954, the health department's opinion crystallized into the belief that the real need for psychiatric consultation lay in providing the nursing staff with the specific management techniques and didactic materials that would enable them to help their patients.

The health officer decided, without much group support and with some misgivings of the staff and the psychiatrists, that the majority of psychiatric time should be used to supervise, directly or indirectly, nurses who would be assigned emotionally disturbed patients. It was reasoned that the nurses would develop a better understanding of psychological procedures if they were confronted with a specific patient who had an acknowledged need for mental health guidance. Responsibility for an emotionally disturbed patient would plunge the nurse into actual work in this field. It was also reasoned that individual casework would provide good material for lectures and group discussions of the problems encountered.

Opponents reasoned that the plan would precipitate personnel into an assignment they were not prepared for. The health officer interpreted this argument as being almost a restatement of his own feelings that the years of discussions were simply postponing and probably encouraging avoidance of dealing with emotional problems.

The issue was resolved by the inception of our present system of public health nurse followup. In order to make such an extensive approach feasible, the department created the position of mental health nursing consultant and employed a public health nurse with special training.

Cases are chosen from among clients who come to the county hospital psychiatric unit, or from those found by the public health nurse among her district clients, and whose diagnosis indicates no frank psychosis or outstanding need for hospitalization. The patients chosen are often unable or unwilling to come to a psychiatrist, but can be visited in their homes or they can visit the public health nurse in her

district office. Assignments are made according to the client's place of residence; our public health nurses are generalized and have geographic districts. Each patient determined to be psychiatrically suitable is invited to a discharge conference attended by the field public health nurse and her supervisor, our mental health consultant, the psychiatrist, and the chief nurse of the hospital's psychiatric unit. After a professional discussion, the psychiatrist asks the patient to join the conference, introduces him, and holds a short interview for the benefit of the nurse. The patient then retires and the group completes its discussion.

This conference establishes a working diagnosis, explains the personality of the patient, indicates his past and expected behavior, and presents social, home, cultural, and economic factors. The nurse receives suggestions and recommendations regarding her relationship to the patient and the patient's environment, and has an opportunity to express her own feelings about the particular patient, whether they be inadequacy, fears, or conflicts. The psychiatrist can help the nurse understand her feelings. The conference enables the supervisor to understand the case and the feelings of the nurse, and to see how they are handled by the psychiatrist. It provides an opportunity for the supervisor to ask questions pertaining to her own role, the field nurse's plan for assistance, and related matters. The patient is given a chance to meet the nurse through the psychiatrist and to make an appointment for nursing visits.

If the public health nurse has additional problems during home or office followup, she returns to her supervisor for consultation. If the supervisor feels unable to assist, both turn to the mental health consultant, who spends approximately one-half of her time assisting the field staff and their supervisors with such cases. If necessary, the mental health consultant arranges for further interviews with the psychiatrist, who occasionally reevaluates the case. The mental health consultant also has 1½ hours a month for individual consultation with the psychiatrist.

The psychiatrist is also available every other month for a 1-hour meeting with each group of nurses and their supervisors in the six districts and the mental health consultant. In addition, 2 hours are available monthly for the entire supervisory group and the nurse consultant. This time may be used to discuss cases presented from the field, whether previously seen by a psychiatrist or not, or to have the psychiatrist fulfill specific requests for lectures and discussion materials.

In 2 years, 1955 and 1956, approximately 250 cases were the subject of psychiatric consultation. Service ranged from a single visit to a series of 60 regular nursing home visits over the 2-year period. Although we are impressed with the results of extending the psychiatrist's services beyond direct contact with patients, we realize that only a small part of the total mental health problem is being touched with our field services.

As a result of this program, the public health nurses are generally satisfied that they are beginning to understand dynamic psychiatry and are putting it to use in their own actions and relationships to patients. Generally, it seems that acknowledging responsibility for services to emotionally disturbed persons is a marvelous learning experience. Prior to actual assignment of cases, didactic information and discussion had not really stimulated the nurses to positive action in dealing with cases of emotional disturbance that are inevitably part of their caseload. Some nurses, however, are not yet able to work with such cases or certain kinds of cases.

The district supervisors without case experience and the higher echelon of nursing supervision now desire the same opportunity. Five out of eight have requested and have been assigned disturbed persons. For theoretical and administrative reasons the supervisory groups should not lag behind the field personnel in understanding, and they also confer with the mental health consultant. It may well be that the top administrative ranks, including health officers, will wish to be assigned disturbed persons, serving what might be called psychiatric internships.

Responsibility for Program

At the same time that nurses were given the direct responsibility for assisting selected emotionally disturbed patients, the assistant health

officer in charge of venereal disease control was given responsibility for the mental health program. This physician is not a psychiatrist, but he has participated in the evolving programs during most of the 10 years and recently worked briefly on the psychiatric staff of a State hospital. In addition, he has been assigned to represent the department's non-nursing activities in community mental health. Under his direction a manual has been developed outlining the plans under way in each division of the health department and the role that each employee plays in the mental health program. We believe that official assignation adds prestige to the activities and provides a tangible means of direction, continuity, and evaluation.

Community Activities

In addition to the public health nursing activity in the emotionally disturbed cases, we are concurrently engaged in several community activities to promote mental health. We have augmented the maternal and child health programs, encouraged family life education courses, worked with voluntary agencies, and have developed a cooperative arrangement with the California State Department of Mental Hygiene, the agency responsible for the rehabilitation of county residents discharged from the State mental hospital.

Family Life Education

The foundation for mental health, much like the foundation for physical health, is laid early in childhood. Preventing mental ill health and creating a sound family life through family life education in the school are activities that take into account future generations. Many maintain that this is the responsibility of parents, but too few parents are adequately informed. Many are hesitant; others are unhappily married or do not have the time or the desire to provide this training. On the other hand, the careful integration of courses in family living, from kindergarten through college, can help in the creation of responsible parents whose children will be healthier mentally and more stable emotionally.

In 1953, a survey of all county schools revealed courses in family living were largely absent, particularly in grade schools. Since that time, the health department has attempted to stimulate school administrators, parents groups, church groups, and others to plan family life education courses in schools. This is done by such means as teaching and assisting with films and reference materials. To expedite school and community acceptance of courses on human development, venereal disease, and similar topics, a professional person is sometimes needed. Thus, the assistant health officer in charge of mental health or persons chosen by him may be the initial lecturer. We regard the arranging of curriculum and teaching as a job for trained school personnel. No attempt is made to tell the school personnel how to give the course, nor do we teach, except as explained above. However, the assistant health officer offers guidance in areas to be covered. Whenever it appears that a particular school district has some interest in the topic, whether in elementary or secondary schools, the health department adds its weight to the movement.

Maternal and Child Health

Special mental health problems seem to cluster about certain groups in the population, many well known to the health department. Pregnant women constitute one of the major groups. In the maternal and child health program, both the clinic services and home calls to pregnancy cases are geared to a consideration of the special problems, particularly those of unwed mothers.

Another area of tremendous scope is our program for the newborn, the infant, and the preschooler. Here, the nurse through her home visits and the clinicians in well-child conferences have opportunities to work with special risk groups in allaying fears, offering advice, understanding parental anxieties, and paving the way for a more normal childhood. Our specialist director of maternal and child health supervises the clinicians. We have at times paid for and provided courses on growth, development, and emotional needs for these physicians. Rather than have a full-time specialist staff, we prefer employing part-time clinicians who are general practitioners in the community. Our objective has been to spread more of the mental health "know-how" among

the doctors through special training. We hope they will provide more preventive care to families in their own practices through their increased awareness and interest in foresighted guidance.

Other major programs are currently geared to consideration of the mental health aspects likely to be associated with the primary conditions for which the program was created.

Our crippled children's services offer opportunities for dealing not only with handicapped children but also with parents who experience rejection, guilt, inadequacy, unwillingness to go ahead, and related difficulties. Our tuberculosis and venereal disease programs particularly offer many challenges. Here again fears, guilt feelings, domestic problems, and potential socioeconomic losses are expected to engender or worsen emotional disturbances. In these, our nursing services in particular (to a lesser extent our clinic services) can be of great help. In many instances we have been of fundamental assistance to our clients in their emotional problems.

Assisting Voluntary Agencies

Nationwide, a great need is recognized for public education and support in mental health. Voluntary citizens groups and associations are major means of realizing these goals. Recognizing this, our health department stimulates and assists many organizations dealing broadly with mental health or various facets of it. Responsibility for this endeavor rests largely with the assistant health officer in charge of the mental health program. It has also been shared by the health officer and by the assistant health officers (particularly those in charge of maternal and child health, crippled children's services, and school health), health educators, and the public health nursing staff.

Characteristically, the organizations dealing with mental health have been small, with limited budgets, personnel, and activities. The health department participates in organizing, developing programs, and forming policy. Clerical assistance, health education materials, and press releases are provided during crises, especially in the early development of a voluntary agency. Usually the department does not provide "legwork" for voluntary agencies, since we feel they can promote their cause better when their services are carried out by participating volunteers.

Members of the health department's staff are often members of the board of directors or committees of an agency and frequently are on the speaker's bureau. However, staff members do not accept executive positions such as president or chairman of a voluntary agency or its committees. We believe community voluntary workers should formulate a truly community program and avoid the possibility of being dominated by official agencies or of becoming an "arm" of the health department.

Since we must spread ourselves thin by participating in many voluntary agencies, we are constantly aware of the importance of assessing the value and goals of each agency in relation to the mental health and the total health picture. We attempt to devote our limited time to programs in which the most can be accomplished, preferably with the smallest investment of time and money. An example is our extensive participation in the Contra Costa-Alameda Epilepsy League. In our area, epilepsy is still neglected medically and shunned socially, and epileptics are rejected by schools and employers. The condition is comparatively easy and inexpensive to control, but does not receive a fraction of the attention justified compared with poliomyelitis or cerebral palsy, each of which it outnumbers sixfold.

Cooperating With the State

In the sphere of rehabilitation, we now work with the psychiatric social worker from the California State Department of Mental Hygiene, who has the legal responsibility for followup and rehabilitation of county residents discharged from the State mental hospital system. Our health department's role is primarily one of nurse cooperation. The nurse has a supportive relationship with some families and assists with the material needs of the discharged patient and his family.

The distances of the State hospitals from Contra Costa County have precluded a more direct relationship to date. However, our mental health consultant has established mutually helpful relationships with the nearby Berkeley outpatient clinic of the State Department of

Mental Hygiene. Previously, the health department and other agencies of the community referred cases there but immediately lost contact. We neither profited from the therapeutic experiences nor did we contribute in any way. Now we are able to furnish a more pertinent summary of findings and background on the patient and his family when we refer patients. In turn, the outpatient clinic provides the health department with pertinent information on these patients. The clinic, which has no home visiting services, has the benefit of our psychiatrically oriented staff.

Discussion

Certain basic tenets were assumed in determining the framework of the original mental health program.

1. Emotionally disturbed persons brought to an agency's attention are often in a phase of exacerbation and have passed through a prior phase in which the illness was less severe or fixed, but nevertheless under way (*1*).

2. It should be easier to reach such persons therapeutically at a time when their illness is less fixed, when they and others in their environment are less pessimistic in attitude. Presumably, at this time they can be assisted with a lesser expenditure of limited psychiatric resources (*2*).

3. It should be possible to provide many persons in the early stages of their disturbances with a supportive relationship through their contact with workers who are not psychiatrists but are employed by agencies whose work unveils emotional implications. If these workers are well indoctrinated in psychiatric principles and can work with psychiatric guidance, they should be able to accomplish a great deal. A. D. Schwartz, in an unpublished paper, calls them "caretaker persons" and points out that they may exist in or out of agencies or organizations. Those in agencies should be easier to mobilize.

4. It should be possible to utilize the services of a high proportion of professional people such as school guidance workers, probation caseworkers, social welfare workers, medical social workers, public health nurses, teachers, and others. This group numbers about 1 percent of the general population and 2 percent of the adult population and has a large number of public contacts as well as some psychological orientation.

5. It might be possible to transmit continuously a significant amount of psychiatric understanding and working know-how from the psychiatrist to these field workers. This would probably be most successful if the information were mediated by another small but strategically placed group of workers who are equipped with significant psychiatric skills. These are the psychologists, psychiatric public health nurses, and psychiatric social workers.

Restated, the field worker in a supportive relationship with many disturbed persons would work closely with skilled intermediaries who in turn would deal directly with the psychiatrist. In this way the limited services of a psychiatrist could be extended through many professional workers or "caretakers" to a great number of their contacts. We have called this the "trickle down" approach.

The team headed by a psychiatrist has to develop an appreciation of community problems, socioeconomic groups, cultural patterns, organizations, and governmental agencies. Through an extensive training program (which we think should include closely supervised work with a limited number of clients), the psychiatrist helps train several echelons of mental health workers. The more psychiatrically skilled of these (in the health department, this would be the nurse mental health consultant) would primarily assist him by acting as consultants to the field workers. The field workers promote mental health concepts through the use of specific preventive techniques geared to the various groups of their "at risk clients." The field workers learn early to recognize emotional problems near their inception. The workers handle cases when they feel capable and refer more difficult ones to higher echelons. When a nurse assists in rehabilitating a posthospital or clinic patient referred to her, she receives instructions from the psychiatrist in order to achieve optimal family and community adjustment and acceptance for the patient.

Field personnel have many contacts with personal health problems and defects revealed by screening procedures or law enforcement activities. If clients are approached suitably, the

agency's goals are more likely to be achieved, and anxiety-producing situations are minimized. The worker's growth and increased skills in interpersonal relations enable him to avoid recalcitrancy, and possibly enable him to prevent violations of the law that result in legal prosecution with its antisocial and mental health consequences for the individual and his family.

Appreciation by the oriented worker of the need to define choices clearly for the potential law violator or victim of disease can be the stimulus for healthy decisions and the patient's moral growth. Our health department has seen successful contacts alter the attitude of fairly well-confirmed antisocial persons and apparently help reincorporate them into the community. By contrast, we have maneuvered persons into becoming hostile recalcitrants, even though they have really never before come afoul of basic community requirements.

Among the benefits that were foreseen in well-planned, psychiatric indoctrination was the clarification of administrative relationships. The very necessary administrative hierarchy is automatically an imposition in a democracy and resentments, always difficult to overcome, block communications and lead to misunderstandings (*3*). Any improvements in the field worker's understanding and acceptance of the proper exercise of authority and worker-supervisor relationships should result in less ambivalent feelings at the field level about law enforcement and the functions to be accomplished with clients. In strengthening the worker's ability to win the client's cooperation, the accomplishment is much more gratifying. Well-established communication lines that permit the worker to transmit his thoughts about his client help the agency do its job.

We also find more understanding between agencies. Frequently dealing with the same families, agencies often follow upon one another's footsteps and interfere with one another's attempts to assist a client. An appreciation of another agency worker's policies, legal limitations, and problems is therefore essential. Each affects the client whose welfare and peace of mind, if properly promoted, can lead to the amelioration of his status or his dismissal from the category of "client." By mutual agreement, basic work with a family can be assigned to the one agency worker most concerned. Success in this area involves extensive free-flowing communications. It is our feeling that our mental health program has paid for itself by keeping administration and worker lines of communication open.

For the price of inservice training, it has been possible to expedite the administrative duties and functions of the health department. Fixing responsibilities for our mental health program in addition to the inservice training has succeeded in interesting everyone in the emotional aspects of their services.

We also feel that we can extend the community psychiatric resources through public health nursing services. This has not been inexpensive, but examination of a few apparently successful case histories indicates that for a very few hours and dollars large individual community savings are achieved.

Cost is not the only factor. A clinic cannot serve some of the clients that we do because some persons are not adequately motivated to seek help from a psychiatrist or clinic, nor do they require hospitalization. A nurse's relationship with a patient can be more felicitous; for a patient initially is likely to be less awed by a nurse's presence than a doctor's. A nurse may also be accepted by persons who will not deal with anyone having a psychiatric label. At least in a few cases, it was only after a good many home visits by a nurse that the patient's attitude changed enough to induce him to avail himself of psychiatric services.

Summary and Conclusions

The Contra Costa County Health Department's mental health program, although incomplete and inadequate from the standpoint of the whole problem, has explored and incorporated several projects in prevention of mental illness.

Promotion of mental health is carried out in all our general programs, including those in sanitation. More specifically, our maternal and child health program is geared to this approach in prenatal, parental, and child guidance. Encouragement of family life education in schools is a similar activity.

Limitation of apparent disturbances are also of major concern in these programs and par-

ticularly in our crippled children's, tuberculosis, venereal disease, and chronic disease services.

Direct assistance to the emotionally ill and to those being rehabilitated during or following therapy is a specific activity of our mental health program.

We feel that the health department's limited use of a consulting psychiatrist, extensive use of a nurse mental health consultant, and reliance on field nursing for patient supervision is one successful approach in furthering mental health. Proper indoctrination and training enables our field staff to help with many lesser conditions and to recognize and refer the more severe to the more psychiatrically skilled. Utilization of professional "caretaker" personnel seems to be an economical and feasible way to get mental health services to a great number of persons, particularly when psychiatric services are minimal or absent.

Most of the nursing field staff did not work readily with families or individuals with mental health difficulties until given specific case assignments. Classes and case presentations became of more value once the nurses had specific cases and needs. Heavy turnover of nursing personnel makes it unlikely that usual inservice training or course work can be expected to prepare the staff as successfully as actual case responsibility with good supervision and consultation under overall guidance of psychiatrists.

There was need to formalize our mental health activities into a specific program and to assign an assistant health officer as program director. The program's importance was thereby recognized and responsibility for direction, supervision, and evaluation was established.

Administrative improvements, intra-agency and interagency relationships have been a major consideration with particularly significant gains in the latter.

REFERENCES

(*1*) Schumacher, H. C.: Prevention of emotional and behavioral disturbances. California's Health 13: 121–123, February 1956.

(*2*) Querido, A.: The Amsterdam psychiatric first aid scheme and some proposals for new legislation. Proc. Roy. Soc. Med. 48: 741–748, September 1955.

(*3*) Stanton, A. H., and Schwartz, M. S.: The mental hospital. New York, N. Y., Basic Books, 1954.

Course in Laboratory Methods in TB Diagnosis

A course in laboratory methods in the diagnosis of tuberculosis is offered by the Microbiology Laboratories of the Communicable Disease Center, Public Health Service, Chamblee, Ga., in cooperation with the Service's Division of Special Health Services. The course, scheduled for October 20–31, 1958, and for January 26–February 6, 1959, is open to all grades of employed laboratory personnel who have the approval of their State health officers.

The training includes preparation of culture media, microscopy, cultural procedures, diagnostic use of animals, and testing of drug sensitivity. Students attending will be offered a "student extension service" for a period of 1 year following termination of the course.

No tuition or laboratory fees are charged. Reservations for this course should be made well in advance, since the size of each class is limited to 12.

Application forms may be obtained from the Laboratory Branch, Communicable Disease Center, Public Health Service, P. O. Box 185, Chamblee, Ga.