GOVERNOR'S CONFERENCE
ON
COLORADO'S PROBLEMS RELATING TO THE AGED AND AGING, MENTALLY ILL, MENTALLY RETARDED, AND MENTAL DEFECTIVES

STATE HOUSE OF REPRESENTATIVES
STATE CAPITOL, DENVER, COLORADO
January 4 and 5, 1954

SECTION III
THE AGED AND AGING

PREPARED BY STAFF OF
THE COLORADO STATE PLANNING COMMISSION
130 STATE OFFICE BUILDING
DENVER, COLORADO

F O R E W O R D

This report, entitled, "SECTION III, THE AGED AND AGING", is the third and final report on the Governor's Conference of January 4 and 5, 1954. This report covers the Tuesday morning session held January 5, 1954. Included is a Summary of the session and the full transcript of the meeting as prepared and edited by the staff of the State Planning Commission.

Due to the pressing demands of other duties, it has been determined that this shall be the final report of that very important State-wide Conference. This decision is influenced by the fact that the Recommendations of the Conference, which were developed at the Final Session, were distributed to Conference members soon after the Conference ended.

Therefore, this third report includes (1) a reprint of the Recommendations adopted; (2) a list of the fine group of Coloradoans who contributed two days of constructive effort to the deliberations, and (3) a reprint of the membership of the Resolutions Committee.

It is hoped that this and the two reports previously distributed will make a valuable contribution towards the solution of problems confronting all Coloradoans in the mental health field.

If additional copies of this or the other reports are desired, they may be secured from the State Planning Commission, 130 State Office Building, Denver.

* * * * * * * * *

* * * * * * * *

* * * * * * *

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

* * * * * * * * * * *

PROGRAM FOR THE
GOVERNOR'S CONFERENCE
ON COLORADO'S PROBLEMS RELATING TO THE AGED,
THE MENTALLY ILL AND MENTAL DEFECTIVES

STATE HOUSE OF REPRESENTATIVES, CAPITOL BUILDING
DENVER, COLORADO
January 4 and 5, 1954

JANUARY 5: TUESDAY MORNING SESSION

9:00 a.m.: Conference Called to Order by General Chairman George M. Kirk

Invocation: Rev. Dale Dargitz, Executive Secretary, Denver Council of Churches

SUBJECT: THE AGING, THE SENILE AGED, AND THE CHRONICALLY ILL

Moderator of the Session: Wm. F. McGlone, President, Colorado State Board of Health

Definitions: What We Are Talking About -- By Dr. Charles A. Rymer, Psychiatrist; Associate Clinical Professor of Psychiatry and former Acting Director, University of Colorado School of Medicine

I. Report on the Work of the Legislative Interim Committee on the Needy Aged

Senator Frank L. (Ted) Gill, Chairman of the Committee; Majority Leader, Colorado State Senate

II. Report on the Program of the Colorado State Health Department's Advisory Committee on Chronic Illness, Aging, and Rehabilitation

Walter Lockwood, Director of the Committee Program

III. Discussion Panel: The Care and Treatment of the Chronically Ill and Senile Aged

Panel Participants:

Dr. Bradford Murphey, Denver Psychiatrist; Past President, Denver Area Welfare Council
Lawrence Martin, Associate Editor, THE DENVER POST
Dr. Emma A. Kent, Director, Mental Health Services, Department of Health and Hospitals, City and County of Denver
J. P. Tatum, Manager, Myron Stratton Home, Colorado Springs
Dr. Heber R. Harper, Retired; formerly Regional Director, Federal Security Agency; Former Chancellor, University of Denver
Dr. Frank J. Weber, Regional Medical Director, U. S. Public Health Service, Department of Health, Education and Welfare
Dr. F. H. Zimmerman, Superintendent, Colorado State Hospital
Dr. Byron Johnson, Associate Professor of Economics, University of Denver
Rocco Santarelli, Chairman, Committee on Mental Health, Colorado State Planning Commission, Sapinero

IV. What the State Is Spending on the Operation of Its Three Institutions for the Care of the Mentally Ill and Mental Defectives

J. Price Briscoe, Director of Public Institutions

Discussion from the floor Summary of the Session

12:20 p.m.: Recess for Luncheon

GOVERNOR'S CONFERENCE
ON
COLORADO'S PROBLEMS RELATING TO THE AGING,
THE MENTALLY ILL, THE MENTALLY RETARDED AND MENTAL DEFECTIVES

* * * * * * * * * * *

SUMMARY OF SESSION
ON
THE AGING, THE SENILE AGED AND THE CHRONICALLY ILL

* * * * * * * * * * *

DR. CHARLES A. RYMER, Denver Psychiatrist and Associate Clinical Professor of Psychiatry, University of Colorado School of Medicine: Life expectancy has increased by 20 years in the past half-century and although the Nation's population has doubled in that time, the number of people past 65 years of age has quadrupled..... Aging is a natural process, but it is not uniform in either the physical or mental spheres or in different organs in the same body..... Aging is only the completion of a physiologic process at work within the human organism. ..... Due to variations in the aging process among individuals, it is fallacious to regard an arbitrary chronologic age, such as the 65th year, as the time for an individual to retire..... When the process of aging results in mild senile mental deterioration, common evidences of such deterioration are the following: Definite memory failure; markedly restricted mental activity; aberration of talk; loquacity; rambling; slowing and poverty of speech; loss of interest and desire for occupation; morbid dislike of new things and new ideas; diminished capacity for self-care and neglect of personal appearance; pathological emotional reactions under stress; asocial behavior outbursts. None of these disturbances in less severe form must lead inevitably to commitment to an institution but they do require changes in living conditions which will permit the person to live with safety and without harm to others. Commitment should be considered only as a last resort.... CHRONIC ILLNESS is an impairment in health that requires an extended period of medical supervision. This may involve ambulatory, home, hospital or institutional care or various combinations of these. It may or may not be manifestly disabling. It may be progressive or stationary..... Chronic disease is the great medical problem facing physicians and the community today. More than two out of three deaths are caused by chronic illness. The most important of the chronic diseases are: Heart disease; arteriosclerosis; hypertension; nervous and mental diseases; arthritis; diseases of the kidney; tuberculosis; cancer; diabetes and asthma. Chronic or long-term illness is not hopeless. Chronic disease and old age are not synonymous -- 75 percent of chronic diseases occur between the ages of 15 and 64.

SENATOR FRANK "TED" GILL, Chairman, Legislative Interim Committee on the Needy Aged: This Committee was formed in 1952 to study the problem of overcrowding at the State Hospital in Pueblo and to try to find a solution. The Committee recommends homes for the senile aged where they could go voluntarily. On the recommendation of the Committee the Legislature, in 1953, created a State Board of Control of seven members to be in charge of such Homes for the Aged when they are built. The Legislature also authorized construction of the first home at Trinidad when funds are made available for construction. The Legislature created

SENATOR FRANK "TED" GILL (continued): Class "C" pensions in 1953, which provides that those on old age pensions who go voluntarily to a home for the aged, such as is planned at Trinidad, will continue to receive their full Federal and State Pension (currently $85.00 per month). Their pension is expected to pay for their board and room at the home and possibly help pay for the cost of building the home. The Committee feels that legislation should be passed which would authorize the State to issue up to $1,000,000 in anticipation warrants to finance construction of the home at Trinidad. The warrants would be paid off from the income paid by patients. If the income is insufficient, perhaps a State appropriation will be necessary. This is an experiment and if it doesn't work out advantageously to the State, no more homes would be authorized by the Legislature. The Committee does feel that such homes can be built at about half the cost of the building recently completed at the State Hospital at Pueblo for the senile aged and which cost $5,000 per bed.

MR. WALTER LOCKWOOD, Director of the Program of the Colorado State Department of Public Health's Advisory Committee on Chronic Illness, Aging and Rehabilitation: The Advisory Committee is composed of 24 members representing all fields of activities and was selected by the State Board of Health to formulate research programs financed by the Kellogg Foundation. The programs deal primarily with studies of the problems of chronic illness and aging. The programs are being set up in cooperation with local community groups who are interested. Two studies are now set up, the first in Grand Junction and Mesa County and the second in Greeley and Weld County. These studies are intended to help formulate overall policies for dealing with the problems of chronic illness and aging.

DR. BRADFORD MURPHEY, Denver Psychiatrist, Past President of the Denver Area Welfare Council: The problem of the aging is increasing year by year. Much research and social experimentation is necessary, therefore, to develop a specific program that will be adequate and that will also be sound economically and tax-wise..... The problems of the aged can not be solved by pressure politics..... Suggested remedial programs include: (1) The establishment of community social centers for the aged with facilities for appropriate social intercourse, recreation, creative activity and remunerative work; (2) Establishment of Old Age Guidance Centers and psychiatric Clinics for the aged; (3) Establishment of infirmaries for the aged; (4) Establishment of geriatric units in public hospitals such as Denver General Hospital, in private general hospitals, in State mental hospitals and in private mental hospitals..... Much research is needed before we can develop long-range plans. Existing facilities should always be used wherever and whenever possible..... Until we develop a sound and flexible program of adequate education, adequate training and adequate care for the aged, the pressure for political solutions will continue, and that pressure will increasingly put us all in a tax straight-jacket.

DR. EMMA A. KENT, Director, Mental Health Services, Department of Health and Hospitals, City and County of Denver: Denver General Hospital is the site of perhaps the greatest congregation of elderly people needing care of one sort or another in the State of Colorado..... They are unable to take care of themselves ..... Do they need care in the State Hospital in Pueblo? Possibly not, but Denver does not have a border-line facility to take care of these people..... Most of our aged should be kept in their own community where the relatives can see them, where they are used to being, where they don't have to give up all contact with community affairs. A small facility is needed, probably, in most communities. Dr. Bradford Murphey's idea of community centers is good. Any facility

DR. EMMA A. KENT (continued): that houses a group of aged is going to run into severe medical and psychiatric problems. They need medical and nursing care. They must be attended by people with a gift of taking care of old people. Each community must do its part in this problem.

MR. J. P. TATUM, Manager of the Myron Stratton Home, Colorado Springs: This Home was established and is permanently endowed by the will of Winfield Scott Stratton, who made millions in gold mining in Cripple Creek and left his fortune in 1902 to operate and maintain a home for elderly people and for boys and girls. Aged applicants, to be considered, must be citizens of the United States, residents of Colorado for the past 10 years, and preferably residents of El Paso County the past five years. The Home serves those who are worthy, without means of support and, due to age, youth or infirmity, are unable to care for themselves. No charge is made to any applicant accepted into the Home. The Home has 100 elderly people and 87 boys and girls. The age range runs from five years to 99. Forty percent of the older persons are in their seventies or older, and the average age is over 80. Cost of running the Home averages $120 per month per person. Many problems are encountered daily in caring for the aged and satisfying their needs. The infirmary is now jammed with the more elderly people. Most of the elderly applicants are on old age pensions and when the Home accepts them, that much burden is taken off of the State of Colorado. If the State establishes homes for the aged, facilities for medical care and hospitalization must also be provided.

DR. HEBER R. HARPER, Retired, formerly, Regional Director, Federal Security Agency: The aging problem will assume staggering proportions in the next 25 years. As one of our greatest elderly statesmen has said, this problem will have more significant social, economic and political implications for us in the rest of this century than the creation of atomic energy and the new means of communication and transportation. ..... Fifteen States have established State commissions on Aging and Colorado needs to do the same. Such a commission can stimulate the creation of local commissions that can help to provide the facilities needed to meet this challenge of the aged. ..... Day Centers have proved beneficial wherever they have been established in communities in other States, chiefly through the efforts of State and local commissions..... A State commission can carry on the necessary research in the overall field of aging to appraise the problem and needs and on resources to cope with the problem..... America always has been and still is a wonderful country in which to be young, but if we are to fulfill the promise of democracy, America must become just as wonderful a country in which to grow old and be old..... Colorado urgently needs to create an overall commission on the problems of the aging.

DR. FRANK J. WEBER, Regional Medical Director, U. S. Public Health Service, Department of Health, Education and Welfare: These comments are made particularly from the public health administrator's point of view, first, as to the problems in aging and, second, as to the problems of the chronically ill..... In seeking the answers to the problems resulting from aging, a goodly number of misconceptions concerning the older person must be examined, as for example: that a person is old because of his number of years; that the attainment of a certain age means a decline in physical and mental abilities right across the board; that inadequate behavior patterns seen in advanced years are always the result of organic change; and that personality deterioration is an inevitable part of the aging process. These are all misconceptions. There are wide variations. Therefore, in adopting remedies, individualization of each older person is indicated..... Suggested answers to the problem of providing for the older persons include: A revised concept of the status and needs of the older person; an effort to keep the older person active and

DR. FRANK J. WEBER (continued): active in productive work, if possible; better integration in neighborhood activities; improved institutional care and use, where possible, of the so-called boarding home; finally, a sound community mental hygiene program..... Chronic illness might be more appropriately termed "prolonged illness." The problem is not exclusive to any one age group -- chronic illness strikes younger persons as well as the older. The attack on chronic illness, or prolonged illness, needs to be on a broad front -- political and administrative, as well as medical. All groups can participate..... The program should include: Adequate financial and community auspices which would: (1) Strengthen the general hospital and the secondary institutions; (2) Establish good programs of prevention at the one end and rehabilitation at the other; (3) Better community planning in regard to factors fostering prolonged illness, such as, poverty and housing.

DR. F. H. ZIMMERMAN, Superintendent, Colorado State Hospital, Pueblo: Out of 1,139 admissions to the State Hospital in the past year, 263 were diagnosed as senile psychosis, and of the 5,412 resident patients, 628 were diagnosed as senile psychosis. To deal with this problem of caring for the senile aged, we made careful studies to develop the most economical housing units, both from the standpoint of construction and maintenance. We now have a six-story unit with 24 wards of 30 beds each or a total of 720 beds. Each ward has six 4-bed dormitories and six single rooms -- the latter for those individuals who can't live with other people. Facilities include a theatre with 168 seats -- for picture shows daily -- occupational therapy units, beauty parlors for women and barber shops for men. Between every two wards is a cafeteria unit. We also have chapel services. These new buildings have already paid dividends -- a good many of these people go home..... All of this came of necessity, because of the increasing number of commitments to the State Hospital (by County Judges) from throughout the State. There are many things we can do for the elderly people if we have the trained personnel needed. That is a big factor.

DR. BYRON JOHNSON, Associate Professor of Economics, University of Denver: Our church (in Denver) became interested in this problem of the aging when our Board learned that some 60 to 75 of our older members were in desperate need of better housing conditions. We are interested in providing homes for these people, in Denver, and we feel that this will be true throughout the entire State. We want to preserve the independence of the aged to the fullest extent possible. We are interested and depressed by the failure of the building industry to provide any special housing facilities for the aged. The building industry neglects this for a good reason..... We believe that the churches, fraternal organizations, lodges, labor unions, veterans organizations and so forth, as well as city and county governments should all be concerned in providing facilities for their elder members whom I like to think of as "senior citizens"..... We feel that a central organization is needed, that a State authority or a State corporation should be created by the Legislature which would help to provide answers to the problems of planning, of site selection, of site purchase, of financing and construction. If various groups could work together adequate sites and facilities can be provided. This would reduce the load on the State Hospital..... Under this plan, local sponsoring groups over the State would set up non-profit organizations which would raise 10 percent of the funds needed for the home project and 90 percent would be borrowed on a 40-year mortgage insured by the Federal Housing Administration, or, if the State created a revolving fund set up from some of its trust funds the revolving fund could issue mortgages on such homes. Over a period of years, this revolving fund could finance a number of homes, and under the plan, all borrowed money from the revolving fund would be paid back with interest. For example,

DR. BYRON JOHNSON (continued): a 2-million dollar fund might eventually build 20 or 30 million dollars of facilities. The residents of the homes should pay the entire cost of the operation without a State subsidy.....

MR. J. PRICE BRISCOE, State Director of Public Institutions: The cost of operating the State Hospital in the 1952-53 year was approximately $5,100,000, or $86 per month -- approximately $1,032 per year, per patient. After Class "C" pensions were created by the Legislature in 1953, we raised the cost to the patient at the State Hospital from $30 to $84 per month. It was thought that the "C" pension payments would bring in about $1,200,000 annually and reduce the cost of care that much. Actually the amount collected through November totaled $904,000. ..... The State Hospital has 1,609 employes or a ratio of one employe for every 3.32 patients..... At Ridge (State Home and Training School) there are 369 people, more or less. There are 106 employees or one for every 3.48 people there. The cost last year was $458,000, more or less, and that amounts to $1,244 a year to maintain a child at the Ridge Home..... At the Home at Ridge, we are building the first part of a unit at a cost of $500,000. It will have a new kitchen, new receiving wards, an infirmary and beds for 100 children -- 50 boys and 50 girls. We hope the Legislature will complete the job and give us another 100 beds and an auditorium..... The State Home at Grand Junction has 153 employees and slightly over 600 infirmed students there. The cost last year was $694,000 or approximately $1,156 per pupil. We have one employee for every 3.92 patients at Grand Junction and one for every 3.48 at Ridge..... At the Grand Junction Home, we are building a new dining hall and kitchen that will cost, fully equipped, somewhere around $500,000, financed from the mill levy fund.

MR. WILLIAM F. McGLONE, President, Colorado State Board of Health and Chairman of the Tuesday Morning Session: Very briefly, it seems to me that there is common agreement that insofar as the aging and senile aged and the chronically ill are concerned, this is a growing problem that must be tackled by our civilization, or it is one that is going to completely overwhelm us. Many organizations are trying to cope with this problem and, as Dr. Harper suggested, there is need for some proper coordination, at the State level, for all of these activities..... Also, there is general agreement that much can be done on the preventive side of this problem, and this would reduce the need for custodial care or hospitalization. ..... There seems to be a definite wave for tax economy, no matter what the cost. ..... I think we have to re-orient our perspective insofar as tax dollars are concerned, and I think we have to re-define government economy insofar as tax spending is concerned. It is essential, I think, that we look upon a fine, economically operating government as a government which spends dollars wisely, gets a dollar's worth of value for every dollar spent, and does not waste a single penny. We have to take the lead and re-orient the thinking from the dollar itself into the dollar wisely spent and no money wasted.

* * * * * * * * *

POPULATION, TOTAL EXPENDITURES, EXCLUSIVE OF BUILDING FUNDS, AND PER PATIENT COST OF COLORADO'S THREE STATE MENTAL INSTITUTIONS BY SELECTED FISCAL YEARS ENDING JUNE 30

(Source: State Auditor and Division of Accounts and Control)

COLORADO STATE HOSPITAL

Year	Population, June 30	Expenditures July 1--June 30	Annual Cost Per Patient
1953	5,412	$5,462,208	$1,009.28
1952	5,255	5,289,676	1,006.60
1951	5,225	4,968,410	950.89
1950	5,202	4,197,632	806.93
1945	4,255	1,743,995	409.87
1940	4,485	980,819	218.69
1935	3,729	705,184	189.11
1930	2,944	660,869	224.48

* * * * * * *

STATE HOMES AND TRAINING SCHOOLS

	GRAND JUNCTION			RIDGE		
Year	Population June 30	Expenditures, July 1 - June 30	Cost Per Inmate	Population June 30	Expenditures, July 1 - June 30	Cost Per Inmate
1953	600	$627,769	$1,046.28	361	$405,380	$1,122.94
1952	613	500,004	815.67	350	332,757	950.73
1951	624	406,828	651.96	351	263,452	750.57
1950	541	309,621	572.31	340	240,790	708.21
1945	446	151,002	338.56	337	123,097	365.27
1940	403	99,865	247.80	310	76,474	246.69
1930	263	103,269	392.66	148	42,760	288.92

* * * * * * *

The extent to which post-war inflation has affected the cost of operating the State's institutions is emphasized by a study of the table above. Building costs have risen proportionately, thereby adding to the State's problems of providing adequate facilities, treatment and care for its wards in various institutions.

GOVERNOR'S CONFERENCE
ON
COLORADO'S PROBLEMS RELATING TO THE AGING,
THE MENTALLY ILL, THE MENTALLY RETARDED AND MENTAL DEFECTIVES

* * * * * * * * * * *

SECTION III: TUESDAY MORNING SESSION, JANUARY 5, 1954

SUBJECT: THE AGED AND AGING

... The Tuesday Morning Session of the Governor's Conference on Colorado's Problems Relating to the Aged, the Mentally Ill and Mental Defectives convened in the House of Representatives Chamber, State Capitol Building, Denver, Colorado, at nine o'clock a.m., January 5, 1954, General Chairman George M. Kirk, presiding...

... Chairman Kirk made opening remarks, followed by the benediction by Reverend Dale Dargitz, Executive Secretary, Denver Council of Churches ...

... Chairman Kirk then introduced Mr. William F. McGlone, President of the Colorado State Board of Health, as Chairman of the Morning Session, and in turn, Mr. McGlone introduced the members of the panel, leading off with Dr. Charles A. Rymer, Associate Clinical Professor of Psychiatry and former Acting Director, University of Colorado School of Medicine, to give the Conference definitions of the terms "Aging, Senile and Chronically Ill." ...

Dr. Rymer Defines the Terms, "Aging, Senile and Chronically Ill"

DR. CHARLES A. RYMER: NORMAL AGING PROCESSES. It is difficult to understand and accept that aging is a natural process and that like many phenomena it is not uniform in either the physical or mental spheres or in different organs in the same body. The advances of involution and the wear and tear of living result in structural and functional changes. With advancing years the general regulation of the body is less exact and reserve capacity is impaired. Old people are capable of less persistent activity in every sphere. They fatigue more easily and need more daily rest than they did in their younger years.

STATISTICS. With the life expectancy of man increased by a score of years within the space of a half century, America finds itself today with a population of 13 million individuals 65 years of age or older. Statisticians' figures further show that every day 2,700 individuals in this country reach their 65th birthday. Though the population has doubled itself during the past 50 years, the number of inhabitants past 65 has actually quadrupled. Authorities believe that, with improved standards of living as well as of medical care, the present trend toward longevity will not only be maintained but will continue to increase. Although the term geriatrics was introduced into our language 40 years ago, it has only been within the past few years that this field has attracted public interest. The acre of the aged and aging is daily becoming a matter of great concern not only to those engaged in the practice of geriatric medicine but also to society in general.

PHYSICAL CHANGES. The study of the aging process, points out the fact that, though some systems of the individual's body may be growing old while other systems are simultaneously functioning properly, there is inevitably a weakening of

DR. CHARLES A. RYMER (continued): the physical organism. As disintegration and involution gradually make their inroads, various alterations are effected in the individual. Some of these include diminution of stature and of lung capacity, atrophy of specific tissue elements, alteration of the lenses, thinning and whitening of the hair, desiccation of the organs, alteration and deterioration of the blood vessels, drying of the skin, alterations in sex organs, vocal changes, loss of calcium from the bones, disappearance of certain nerve cells of the brain, digestive disturbances and a general fatiguing of the organism, as well as other symptomatology. Thus it is that as other foci of infections distribute their toxins throughout the body parts, the organism gradually assumes an increasing defenselessness against injury and disease. Physical fatigue of the organism is accompanied by mental fatigue which likewise effects specific alterations in the personality. These include impairment of memory for recent events, lessened capacity for mental work, diminution in speed and accuracy of thinking, disinclination toward innovations, lack of initiative, aversion to the outside world, intolerance, irritability, and so on. Such psychical symptoms of aging are not characteristic of all oldsters, however, comparatively few show psychopathology resulting in necessary hospitalization. However, the aged and aging often are committed to mental institutions because of only mild confusion, memory impairment and physical infirmity. It should further be noted that even in a healthy senescence (of which only a few cases are known), it is inevitable that atrophy and a decreased vitality will be evidenced, for involution is as truly normal as is evolution; hence againg is only the completion of a physiologic process at work within the human organism. Geriatricians today are consequently concerned not with the arrest of aging but rather with the over-all problem of modifying the physiologic and psychiatric disorders of those in their later maturity, and of effectively adapting the social environment to their needs and interests to the end that they might enjoy a more satisfying, more useful and happier existence. It should be remembered that aged people today often become emotionally ill because of many problems beyond their control.

AGING. Since bodily alterations in the senescent individual are twice as frequent as are psychologic changes, it is not surprising to note that among the already mentioned 13 million persons 65 years or older today, only 3 million are working, two-fifths of this number being self-employed. One-half of these are to be found on farms. Seven in 10 of the total number of senescents reside in their own homes, while two in ten live with relatives. Seven hundred thousand are in institutions, hotels or large rooming houses. Older people experience not only a defenselessness against disability, the inroads of numerous diseases and deprivation of their jobs, but they also have less money with which to pay for medical care (only one aged person out of four has hospitalization insurance at present). Three-fourths of these people have a cash income less than $1,000 a year, while 15 percent of them have less than $500 annually. Many senescents are forced to retire before they should. It has often been proved that many are still fully capable of executing skills and, if employed, can render additional years of valuable services. It is indeed fallacious to regard an arbitrary chronologic age such as the 65th year as the time for an individual to retire. Though many should in reality retire before this age, others are just as productive as younger people and their occupation means for them prestige, sustenance, and opportunity for social contacts, as well as an insurance against loneliness and idleness. Regular employment is preferable to the small monetary benefit paid under the present system of Social Security.

Many older people who seem obnoxious to their families are sent to state hospitals which are already understaffed and overcrowded. There they are frequently allowed to vegetate in bed, whereas they should be engaged in activities commensurate with their capacities and be allowed only an optimum amount of

DR. CHARLES A. RYMER (continued): sleep and rest in bed. Many become emotionally ill because of loneliness, forced idleness or a feeling of insecurity and rejection. Many, because of their lack of agility, fatigue and defects of sight and hearing, are unable to cope with the unparalleled pace of a highly mechanized, commercial age. These people, feeling that their days of usefullness are over, are in great need of encouragement and help. Proper consideration of their desires and utilization of their potentialities will prove an incalculably precious asset in many instances. If, however, such help and consolation are not given, if the unhappy, dependent, aged person in the home is already suffering degenerative changes, a psychotic episode may be precipitated by a sudden unfortunate incident. Frequently paranoid reactions, especially of the arteriosclerotic group, are denunciations and suspicions hurled against those who should seem nearest and dearest.

PSYCHIATRIC ASPECTS OF AGING. There are some special conditions accompanying advanced age which predispose to psychogenic disorders of varying degrees. The most important are (1) concern over health, whether actual or exaggerated; (2) worry over finances and fear of losing security; (3) loneliness and fear of not being wanted; (4) feelings of having outlived one's usefullness; and (5) fear of losing the place formerly enjoyed in the community. The more common external precipitating factors of illness in the aged are (1) death of husband or wife; (2) threatened disability from real physical disorders; (3) and, less frequently, problems resulting from financial loss, retirement, breaking up the home, and the necessity of moving into a new and strange environment.

EARLY ORGANIC MENTAL CHANGES. Even when the personality changes of age are accentuated as the result of early organic alteration, the capacity of the individual to adjust is more directly related to his complex cultural, economic, and family problems than to the demonstrable pathologic changes. Very frequently the cerebral impairment is the least important factor requiring psychiatric treatment. It is the reaction patterns of the individual's life which offers the greater challenge to therapy. It has been aptly stated by Lawson, some of the ostensible mental deterioration of older persons is simply the cumulative effect of poor work habits. A review of the personality changes found in mild senile mental deterioration reveals clearly the importance of the emotional reactions in determining which of these patients can safely continue to live in the community. Following are some of the more common evidences of simple deterioration:

1. Definite memory failure, with confabulation.
2. Markedly restricted mental activity, with a tendency toward apathy.
3. Aberration of talk; loquacity; rambling, slowing, and poverty of speech.
4. Loss of interest and desire for occupation.
5. Morbid dislike of new things and new ideas (misoneism).
6. Diminished capacity for self-care and neglect of personal appearance.
7. Pathological emotional reactions under stress.
8. Asocial behavior outbursts.

With the possible exception of the last item, none of these disturbances in less severe form must lead inevitably to commitment, but they do require modification of the social and environmental conditions which will permit the aged patient to live with safety and without harm to others. Commitment should be considered only as a last resort for those patients who show destructiveness, aggressive tendencies, combativeness, marked depression, persistent noisiness,

DR. CHARLES A. RYMER (continued): resistiveness, and disturbing bewilderment, delusions, and hallucinations.

LONG TERM ILLNESS: CHRONIC DISEASE. Chronic disease is the great medical problem facing physicians and the community today. More than two out of every three deaths are caused by chronic illness. In a hospital system that represents eight billion dollars of capital outlay, three of every four beds are occupied by the chronically ill, including patients with tuberculosis and mental disease. This is not only a grave medical problem, but a grave economic problem as well.

WHAT IS CHRONIC ILLNESS? A chronic illness is an impairment in health that requires an extended period of medical supervision. This may involve ambulatory, home, hospital or other institutional care, or various combinations of these. It may or may not be manifestly disabling. It may be progressive or stationary. The progression of the disorder and the degree of disability are not necessarily parallel. Disability results from an impairment of the biological, physiological or social efficiency of the individual and prevents him from pursuing normal or usual activities. The most important of the chronic diseases are: heart disease, arteriosclerosis, hypertension, nervous and mental diseases, arthritis, diseases of the kidney, tuberculosis, cancer, diabetes and asthma.

WHAT IT IS NOT: Chronic or long-term illness is not hopeless. On the basis of past experience, diseases which appear uncontrollable can be expected, through new discoveries, to be prevented or ameliorated. Chronic disease and old age are not synonymous. More than 75 percent of all chronic disease occurs in the productive years of life, between ages 15 and 64. Chronic diseases are not accurately described as degenerative disease. Arteriosclerosis for example is very likely a metabolic disorder. It occurs in the young as well as the old, and new developments in relation to blood lipids hold out hope that the underlying disease process may be understood and treatment instituted.

"DEFINITION". It is necessary to define what is meant by chronic illness and chronic invalidism. In the Second Interim Report of the Commission of the Care of Chronically Ill Persons, concerning care of the chronically ill in Illinois, issued in June, 1947, the following definition is given: The acute or short-term illness is one which, when recovery is completed after a relatively short period of time, does not result in change of normal adjustments and ways of living which prevailed for the individual before the onset of the disease. The chronic or long-term illness, in contrast to the acute, requires an adjustment for the remainder of his life or for a very long period after the chronic disease attacks. A chronic invalid is a patient whose chronic illness is of such severity that his condition requires at least the availability of others when need arises; occasional or seasonal care from others is generally needed; and from such minimum degree of affliction the need for care progresses to the point where constant attention needs to be available either from others in the patient's home by supplementation to home care by visiting housekeeper or visiting nurse service and in most advanced stages by care in special nursing homes or institutions. It is estimated that between 1.25 percent and 1.50 percent of the total population are chronic invalids. From the same report it is noted that chronic illness is not a problem of the aged alone. It strikes most devastatingly in the middle years when persons should be at their prime in terms of contribution to the economic and social welfare.

CHAIRMAN McGLONE: Thank you, Dr. Rymer. I think you performed an excellent task in defining the words we are going to use here this morning, and also in setting a pattern for the general discussion.

CHAIRMAN McGLONE (continued): Next on our program for this meeting is a report of the Legislative Interim Committee on the Needy and Aged. I think that it is certainly a show of advancement that such a committee is in existence and that such a committee is ready to report. The Chairman of that committee is Senator Frank Gill, better known as "Ted" Gill, majority leader of the Colorado Senate. Senator Gill.

Senator Gill Reports on Objectives of His Committee

SENATOR FRANK GILL: Thank you, Mr. Chairman. Ladies and Gentlemen: I am rather at a disadvantage here today. The last speaker was able to read his speech, and did a mighty fine job of it. Unfortunately, the school I graduated from -- many of the cow camps in eastern Colorado -- didn't teach us to read and write, so this is off the cuff. If any of you have any questions that you want to raise at any time, butt right in because you are not going to embarrass me. I have been embarrassed by the Republican and Democratic parties for years, and it doesn't bother me any more.

To start off with, some three years ago our committee was formed to look into the situation that had to do with the overcrowding down in Pueblo. That institution -- and this is probably the only nice thing I will say about it, and I want Dr. Zimmerman to hear it -- it is probably one of the outstanding institutions of its kind in the United States from the standpoint of good management and doing a good job with what they have there to do with.

However, they do have an institution that is built for about 4,700 people, and I imagine that at this time there are about 5,400 in there, and they have spent all of their money from their building fund up through the year 1957. There is no other money coming from the building fund in sight to work with, and we have an obvious problem there.

One answer that we could come to would be to go ahead and get some money and build at Pueblo, build more room because we have to have more room. You can't just keep accepting people without space to put them in. That would be one obvious answer.

However, the committee looked the situation over, and we think we possibly have come up with another answer that might do equally as well or better.

Primary Interest of Committee is in the Aged

We are primarily interested, of course, in the aged people because they are the ones that seem to be making the excess load at the State Hospital. Some of those people, I believe, to get them accepted there, are committed as insane, when in reality they are merely senile. We don't believe that's a very good setup. Our committee recommended that we try another angle to it, and build something in the nature of homes for the aged that they could go to voluntarily. This would not necessarily be for pensioners, but we do feel that it should be undertaken on the basis of a price that the lower income brackets of elderly people could pay, and we would say the pensioners are in the lower income brackets, and on that basis, if this place would be almost or totally self-supporting, we feel that we would be doing a fine job.

Board of Control for Homes for the Aged Created

Up to date, we have passed legislation creating a Board of Control over the type of institution we have in mind known as The Home for the Aged. The Governor

SENATOR FRANK GILL (continued): has appointed some good men on that committee, and I think it's a very representative group. There is automatically the head of your State Welfare Department and the head of your State Health Department written into the bill as members of the committee. Then later there was also written into the bill that somebody with known interest in the pension cause be on the committee. The Governor appointed Mr. Bloedorn who I believe is a very good member. Then it was decided to take one individual from each Congressional District, which wasn't entirely adhered to because of the fact that already there had been three from the First Congressional District, including Mr. Briscoe, who is custodian of all institutions. Therefore, the appointment of one from the First Congressional District was ignored. From the Second Congressional District, the Governor appointed Frank Allen from Akron, who is an outstanding attorney out in that district. Down in the Third Congressional District, he appointed a man by the name of Mr. Rippen from Trinidad who is an outstanding man there, and over in the Fourth District, a man was appointed by the name of Mr. Archie Maine from Walden.

In 1953, the Legislature authorized the building of a home at Trinidad, Colorado, but they didn't produce any money to build it with. Now, the thought of our Committee is that we would like to see this home built and see if we have the answer. There isn't any sense in building them all over the State unless the are workable propositions.

Class "C" Pensions Established by Legislature

I am going to transgress over onto the pension proposition a little bit. When this came up, there was no such thing as the Class "C" pension, and a person going to Pueblo at that time was automatically taken off the pension rolls, and would have no income and would be entirely dependent on the State. We felt if they could go voluntarily into a home of this kind, they could stay on as a Class "A" pensioner and use their income towards paying their way. Since then, also in 1953, legislation was enacted that creates the Class "C" pension, and it is now tied up in court. Assuming it does stand, the Class "C" pension would entitle a person going to the State Hospital to draw his State pension, and also entitle the State to charge him for his fee there.*

That Class "C" pension is only eligible on a State basis by itself. That is, the State pays all the Class "C" pensions, and comparatively speaking, if the person were sent to Pueblo and another one sent to a home for the aged, voluntarily, the one for the home for the aged would be able to participate in the Federal grant of $35.00 a month where the one going to the institution at Pueblo would not, and the over-all picture on the pensions would amount to about $35,000 a month for every 1,000 people that were put on the Class "C" pension as against being on a Class "A" pension, and that would make a sizable sum in itself that in my opinion might go toward helping to build these homes or something of the kind.

We passed that legislation in the 1953 session of the Legislature. Since then, our committee has gone all over the State, and we have the feeling that these people would be much better off if they were kept closer to home rather than sent down to Pueblo. Pueblo is a long way from certain parts of the State, and the thought is, if we could create enough of these homes, if the first one was justified, that would take care of the situation on a home level or a closer

---

*Editor's Note: On February 13, 1954, the State Supreme Court held that the Class "C" pension legislation is constitutional.

SENATOR FRANK GILL (continued): level to their home, and I think that would be a mighty good thing, and it would put people closer to their own people.

Many of you will say, well, perhaps you are returning to the county poor farm idea. Perhaps it might be in a certain respect. Yet, at the same time, these people would not be there as a matter of charity. They would be there as a matter of paying their own way, an individual who went there because he wanted to, not because he was forced to, and the individual could move away from there at any time.

Various Homes Now Operating Throughout the State

There is quite a backlog over the State of various homes, private and public, that are on the border of being unsatisfactory, to say the least, and there is quite a group of these people that are now in that type of institution; also, there's quite a number of them who are scattered around in hospitals and such as that over the State who are using up space and beds that probably should be reserved for more acute cases. They are chronically ill and not acutely ill, and we have worked the problem out to the extent I have told you.

I don't think there is much use in going further in the way of authorizing other homes until we provide some money for the one that has now been authorized and see whether it will work or not. If we don't have the answer, there is no sense in wasting a lot of the State's money in something that is impractical.

To that end, there are two or three different ideas as to how it ought to be financed. Perhaps the General Fund of the State would be a nice way to finance it if you had the money, but I am told the boys are a little short this year, and a million bucks would be about what we would anticipate to start off with to inaugurate the one at Trinidad, and therefore, we have a piece of legislation up that may or may not pass, authorizing the issuance of anticipation revenue warrants.

Hospital Care to be Charged Back to Counties

We are anticipating we would have about five hundred patients, and if we charge them $75.00 a month for their room and board there, they would still be a private individual and operating on their own, paying for what they got. If they needed hospitalization or anything of that nature, they would get it on their own, or if they didn't have enough to pay for it on their own, we calculate that they should retain their residence in the county they came from, and if there is a welfare problem other than what they could meet themselves, it would revert back to the county they came from, and not go to the county in which the institution is located.

We feel if it is set up on that basis, it would probably be able to support itself and might even come out a little ahead. We anticipate a little revenue from it to pay off the building. If it didn't entirely support itself, it would be a question of an appropriation; otherwise, you would have to contribute something to keep them at Pueblo because that is also a state institution that is on the tax roll, and it is on an appropriation basis. Therefore, an appropriation might be necessary for the operation of one of these homes. Doubtless the first homes that were built would draw the most severe cases. In other words, they would draw the people that were in bad shape, probably many of them unable to walk, and they probably would not be as near a paying proposition as later ones which might come along.

SENATOR FRANK GILL (continued): We also run into the proposition that there are other things entering into the picture all the time. We feel that one of the principal reasons for people breaking up is because of their feeling of insecurity and so on, and the thought occurs that perhaps if they were a little better provided for in the way of living quarters and so on, and if a little more security were set up for them, maybe some of them wouldn't ever get to the point where they would have to go to an infirmary of any kind, and that enters the picture.

Right along with that we have another novel idea that Dr. Byron Johnson from Denver University came up with, and I think it is a very good financial plan. His plan of financing would be to take care of people who are able and can wait on themselves. It would be to reach the group before they reach the stage where they require infirmary care, and I think it is certainly worth a lot of consideration, and I think it's very sound.

The whole situation is that we have to do something about it. Now, we've either got to build more at the State Hospital at Pueblo or build somewhere else because you just can't put people where there isn't space for them.

I don't know that there is anything else particularly. Most of the members of my committee are here, and I will be glad to have them needle me a little or any of you people if there is anything that you think I ought to cover that I haven't already done. I don't want to take a lot of your time because most of the things that I have told you either have been in a written report or will be, and I am sure you can get the information in full.

Committee Has Covered the State Looking at Sites for Homes

In closing, I might say that this last year we went pretty much over the State. We found a lot of mighty fine places where an institution of this kind would be very practical and would work out very nicely if we have the answer, and if we don't have the answer, it may be that we would have to go to a larger institution to be financially sound. It may be that a smaller one would do the job, but there are a great many places that you could coordinate these over the State so I don't believe anybody would have to travel more than 75 or 100 miles to get to see an elderly person who was dear to them. With a great many of those old people, their best friends, the ones they think the most of are old people who can't stand a long drive, and as a result, when they are sent to a centralized place or centrally located place, be it Pueblo or wherever it is, they are more or less isolated from what they hold dear.

There is another thing we ran into. We feel that those institutions, if we find they are practical, should be located at a place where they have most of the facilities immediately available that the people need to live with such as water, power, hospitalization, churches, and things that they could get to to make their lives happier for them.

I don't believe there is anything unsound about our proposition in any way, shape, or manner, and I do believe it is a proposition that Colorado has got to answer one way or the other.

Are there any questions you wish to ask?

REPRESENTATIVE ERNEST WEINLAND: You might mention the construction costs.

SENATOR FRANK GILL: We find the construction at Pueblo has been a multiple story proposition, and I believe the last buildings that were built there were

SENATOR FRANK GILL (continued): running in the neighborhood of $5,000 a bed, and we believe that you could operate on a one-story affair which would cost materially less. We believe it could be cut almost in half so you could get two beds for $5,000 rather than the one, and if you continue to build at Pueblo the same type of structure that you have there now, I believe it would be more expensive than it would be to build what we have in mind.

Anything else? Thank you very much.

CHAIRMAN McGLONE: Thank you, Senator Gill, for bringing to us the thinking of your Committee, and again, it is encouraging to those of us who do not participate directly in government to see that those of you who do are interested in these problems which also interest us and which mean so much to the welfare and happiness of the State at large.

Sometime ago, the Department of Public Health of the State of Colorado, noticed that throughout the State and throughout the years, there have been many movements blossoming for the improvement of the condition of those people suffering from chronic illness and from aging, and in need of rehabilitation. Many of these movements are going at cross purposes, one with the other, and with that background, it was thought well to appoint an advisory committee to the Department of Public Health which at least would form a central sounding board for the various movements of this type throughout our State.

Mr. Walter Lockwood has been appointed Director of the Committee Program, and is here today to report to us on behalf of that program. Mr. Lockwood.

Mr. Lockwood Discusses Community Studies of Mental Health Problems

MR. WALTER LOCKWOOD: Mr. McGlone and Ladies and Gentlemen: It is a pleasure to be with you folks as we work together to join our hands to walk through the fields of the many, many problems which we have in the field of human frailties.

Mr. McGlone has given you a brief summary regarding the appointment of the Advisory Committee. This Advisory Committee is composed of 24 volunteers throughout the State representing education, welfare, health, religious activities, economics, employment problems, retirement problems, and the many, many different groups which are working on these problems which we face.

Community Studies Financed by a Grant from Kellogg Foundation

This Advisory Committee was selected this past July after the Kellogg Foundation had provided money -- $43,000 for three years -- in Colorado for the State Health Department to assist those communities which have an interest in making such studies.

I should like very briefly to tell you what we hope the studies will be, who will make the studies, how they will be accomplished, where they will be accomplished, and when they will be accomplished.

Since the studies will be made in individual communities, we are hoping that the community committee comprised of individuals in the community who have organized a study committee will be able to establish their own scope of study. We are suggesting that the scope of the studies include the problems of the chronically ill and aged in the fields of education, welfare, health, which will include medical care, dental care, and nursing care; housing problems, employment problems, public health problems, and in the case of the aged, the problem of retirement

MR. WALTER LOCKWOOD (continued): since that is one of the many, many major problems in aging today. People are often forced to retire or are put out of business before they are ready to go to the rocking chair.

The State Health Department will assist the communities in making these studies, both on a counseling basis and on a direct service basis. We have formed not only the State Advisory Committee of volunteer citizens throughout the State, but a staff committee whose regular health programs are most directly related to the problems of chronic illness and the aged. These doctors and other professional people will be available to work with me in the communities on problems which we have recommended be the scope of the study.

Studies Center on Problems of Chronic Illness and the Aging

We are suggesting that the communities divide the studies into the problems of chronic illness and then the problems of aging. We all know that chronic illness is a direct relationship to aging, but we have many chronic illnesses which are not directly related to aging and they are also community problems.

On the "how" of the studies, we expect to utilize in the community and in the State as a whole the many, many previous studies, the volumes of material which are already available, and to begin our studies by bringing together that material. We also hope to accomplish surveys through a medium to be established by the community committee and obtain the additional facts that are needed. Aft the community committee has met together and worked from five to seven months wi us, we hope that a report will result which will show what the existing programs are, and how they can be coordinated; what the total problem is; and that the co mittee will make some very definite and positive recommendations to help not onl their own community, but to help the other communities in the State and other co munities in the Nation.

Two Studies Under Way -- at Grand Junction and Greeley

When will these studies be made? We are starting two studies in Colorado this month. The first will begin in Grand Junction where a committee is already formally organized. The second will begin in Greeley where the committee is now being formed. We will provide a part-time paid person to help the local committee. I will work in each community as much as possible during the five to seven-month period to help them with direct service in counseling.

Additional communities that are interested in making studies should contact Dr. Roy L. Cleere (Director), or me, at the State Health Department. If they will send their problems and their interest to us, we will arrange to work with them, to meet with them on preliminary studies and to advise them as to how soon it might be possible to give the direct assistance.

When the W. K. Kellogg Foundation, which has interests in financing these many worth-while studies in the country, provides money to a State or to a group, they do not require that you have a definite result, that you guarantee certain action. It is their hope that the results of all such studies will be beneficial not only to the community and the State where the money is granted, but to the Nation as a whole. (Applause)

CHAIRMAN McGLONE: Thank you, Mr. Lockwood, for acquainting us with the plans and workings of the committee which you represent.

CHAIRMAN McGLONE (continued): We are now going to proceed with the discussion panel, the subject being the care and treatment of the chronically ill and senile aged. I am not going to spend a great deal of time in introducing the various panel participants. Each is a person well versed in one or several fields related to the general topic under discussion, and each has generously given of his or her time so that this panel discussion may be a success.

Our first panel participant is Dr. Bradford Murphey, Past President of the Denver Area Welfare Council and one of Colorado's most prominent psychiatrists. Dr. Murphey.

Dr. Murphey Outlines Proposals to Deal With the Problem

DR. BRADFORD MURPHEY: Mr. McGlone and Members of the Conference: As you all know, because of improved public health measures widely established throughout this Nation, and especially because of improved medical care for the total population in the United States, our population is increasingly made up of aged people. They are growing older with each succeeding decade. By 1970, it is estimated that there will be 16,500,000 persons in this country 65 years of age or older.

It is interesting to note that at the present time the life expectancy of the individual who is 65 years of age is a little better than 13 years. Now, at the present time, we do not know what percentage of those who are 65 years of age or older are in need, actually in need of private or public physical or psychiatric care; nor do we have accurate data which will permit us to predict what percentage of those individuals will have to have such care before they die. Much research and social experimentation will have to be done before we can develop a specific program for the care of the aged, a program that will be adequate, but at the same time, a program that will be sound economically and tax-wise.

While the rate of admission of aged persons to hospitals for mental disease is increasing rapidly, it may well be that a substantial part of this increase is due to the sociologic fact that sick people today of all ages are being cared for in hospitals rather than their own homes. Whether this is true or not, it is a fact that all hospitals for chronic diseases are increasingly crowded.

At this point in history, whenever an aged person finds it hard to care for himself, and has no one who can or will care for him, most of us seem to think he should be shipped off to a State hospital for the mentally ill, although he may show nothing more significant than memory impairment, some confusion and various physical infirmities. From all this it seems evident that many aged people who are sent to mental hospitals today are sent there for sociologic reasons.

This is a situation that needs correction in Colorado, not only because it puts a burden on our State Hospital and is unfair to aged people, but also because it has helped to create another sociologic problem; for example, a pressure group determined to solve the problems of the aged by pressure politics. This is a situation that needs correction.

"Establish Community Social Centers and Psychiatric Clinics"

With this in mind, we would like to offer the following suggestions:

One, the establishment of community social centers for the aged with facilities for appropriate social intercourse and recreation. Wherever possible, such centers should provide facilities for useful and remunerative work and creative activity. Wherever possible, such centers should be developed in conjunction with

DR. BRADFORD MURPHEY (continued): or as an extension of already existing social agencies -- preferably private agencies. Certainly the development of such centers should be a matter of great interest to all churches of all denominations.

Two, the establishment of Old Age Guidance Centers and psychiatric clinics for the aged. And here, too, such centers should be developed whenever possible in conjunction with already existing mental hygiene clinics and psychiatric hospitals. Such centers should provide medical, social, case-work, psychiatric, and psychological services as well as such x-ray and laboratory facilities as might be needed for diagnosis and treatment.

An example of how one such organization handles its aged is illustrated by the work of the Benjamin Rose Institute in Cleveland, planned for the benefit of cultured and educated elderly people. When needed, the institute offers pensions which average $52.00 per month. In a case load of 290, over 65 percent live independently, and the rest in nursing or boarding homes. They are supervised by seven social case workers. Each individual accepted for care is given a thorough physical examination. Medical care is continued through treatment in the doctor's office or at home when necessary. Hospitalization under the agency is available, if needed. Model boarding homes are used, caring for 10 persons, each of whom has his own room and may carry on his own business if he is capable of doing so. The incidence of psychiatric illness has been very low. Within the past 10 years, only two or three patients have required commitment to a public mental hospital. The average case load ranges from 250 to 300. Intensive case work keeps the patients working, active and out of the hospital. Several psychiatrists attend case conferences in an advisory capacity. The institute is building a sixty-bed hospital in connection with the University for research purposes.

"Establish Infirmaries for Aged;
Also Geriatric Units in All Hospitals"

Three, the establishment of infirmaries for the aged. It is suggested that each community of sufficient size should establish such units in conjunction with the community hospital for the care of aged individuals who are physically infirm. Wherever possible, facilities should be available for elderly couples.

The first place I know of west of the Mississippi where an attempt was made to take care of elderly people as a family rather than separating them as is so often cruelly done is at the Myron Stratton Home in Colorado Springs.

A fourth suggestion: geriatric units in public hospitals such as Denver General Hospital. I will not dwell on that. It is something that one of our panel associates will probably discuss when she speaks, Dr. Kent, the present head of the psychiatric services at Denver General Hospital.

Number five: geriatric units in private general hospitals. I think we have reached a time when hospitals like St. Luke's, St. Joseph's, Presbyterian, General Rose, and all well run general hospitals must develop geriatric units especially designed to take care of the special problems of aging people.

Number six: geriatric units in state mental hospitals. Colorado has already taken the lead and has developed one of the finest geriatric units in the United States.

And then seven, geriatric units in private mental hospitals. We have quite a ways to go yet in Colorado before we get to that, but we should see it as part

DR. BRADFORD MURPHEY (continued): of our total vision for the care of, the education of, and the maintaining of the respect of aging people.

Some Major Points Are Stressed

In conclusion, let me just emphasize five or six points:

1. There is need for social recognition of the many problems presented by our aging population, and above all, recognition of the complexity of all these problems.

2. Much research needs to be done before we can develop long-range plans. We simply do not know enough about this subject yet to begin with an elaborate plan.

3. Existing facilities should always be used wherever and whenever possible.

4. Unitl we know more about the needs of the aged and the possible uses we can make of existing facilities, we should avoid or at least postpone any program that seeks a solution through building state homes for the aged.

5. An educational program directed towards helping all of our people of all ages to prepare for their own care when they reach retirement age.

And finally, until we do develop a sound and flexible program of adequate education, adequate training and adequate care for the aged, the pressure for political solutions will continue, and that pressure will increasingly put us all in a tax straight jacket. (Applause)

CHAIRMAN McGLONE: Thank you, Dr. Murphey, for your very interesting remarks to which I am sure you gave a lot of thought before presenting them to us, and of course, bespeak your own personal experience in a very broad field as related to the problem of the aged and the chronically ill.

We will now hear from Dr. Emma A. Kent, Director, Mental Health Services, Department of Health and Hospitals, City and County of Denver. Dr. Kent.

Dr. Kent States the Problems and Suggests Some Remedies

DR. EMMA A. KENT: Mr. McGlone and Ladies and Gentlemen: I speak with rather specialized interest because of the nature of my work in a large city hospital. Perhaps Denver General Hospital is the site of the greatest congregation of elderly people needing care of one sort or another in the State of Colorado. It falls to my lot to see about 200 patients from the hospital a year who are problems in the community because of mental symptoms. About 150 of these eventually go to the State Hospital in Pueblo through the process of adjudication as insane and commitment through Judge Brofman's Court. The remainder go back into the community into private nursing homes or to their own families.

These patients come into the hospital for one of two reasons: One, because of progressive mental symptoms which make it impossible for them to remain either in their own families or in their own boarding houses or in the convalescent homes in which they have been residing. The others come to the hospital, not having made an adequate adjustment from some physical illness; a fractured hip, perhaps pneumonia or something of that sort has broken down their adjustment and proves to be a little too much for them to recover from completely, handicapped as they are by the natural aging processes, and we know that a number of patients that are

DR. EMMA A. KENT (continued): admitted to the medical and surgical wards of the hospital will show progressive mental symptoms and will not be able to return to the community.

What about the patients that we send to the State Hospital in Pueblo? As Dr. Hopple remarked yesterday, and as Dr. Rymer has said today, it is a little difficult to define the exact extent of mental illness in the aged. At what point does an aged person with the normal loss of memory, decrease of interest, easy fatigue-ability, emotional upsets become psychotic? It's pretty difficult to say. None of us like to think of Aunt Sally or Uncle Willie being psychotic or insane. They are part of the family that we have known all our life, very fine people who have made a great contribution in their day, and we certainly don't want to call them insane. Well, we leave it to Judge Brofman to call them insane.

The problem is, however, from a practical standpoint that they are unable to take care of themselves. They are unable to be at large in the community without the possibility of danger to themselves. They are a problem in their families, a problem to their children, particularly in relation to how their children take care of their grandchildren. They are not able to get along in this complex society that we have set up for ourselves, so perhaps they are incompetent. Maybe they don't have delusions or hallucinations; maybe they do know what is going on most of the time, but they need special care.

To the State Hospital or Where?

Do they need State Hospital care? Possibly not, but we do not have a borderline facility that takes care of these people. For example, many of these people have to be locked up. Now, don't misunderstand me there. I mean that one of the symptoms that is so frequently distressing in elderly people is their tendency to wander. They get out on the street and start out to see their sister-in-law, dead these many years perhaps. They are a hazard in traffic. It is necessary to restrain them in some physical way to prevent them from harming themselves.

Another common symptom is a tendency of an elderly woman to wander into the kitchen and turn on the gas stove with some vague idea of doing some cooking perhaps, but not quite understanding what is involved in escaping gas. Such an individual has to be protected from those hazards, and so, in many instances, some restraint is necessary.

Other physical precautions are necessary. Elderly people are prone to fall downstairs. They lose their way going to the bathroom perhaps, fall downstairs and are subject to fractures and all sorts of injuries. So, we do need special precautions and special facilities for this group of elderly people.

At this point, the State Hospital is the only facility, with perhaps a few exceptions, that makes such provisions. Our convalescent homes are able to take a great many elderly people, but they are not allowed to lock patients up. They are not allowed to bar the stairways because of fire prevention restrictions. They are not allowed to lock their front gates so that patients can't get out into the street.

I think then that we should think a little bit about the nature of the facility that we need for the care of the aged. I question a little bit how useful a facility such as has been described as a home for the aged would be. I am very much in favor of the aged of our community doing what they want to do, going voluntarily to a facility if they wish to, but we know that the aged do not like to leave home. They are resistant to change. They want to stay in their family community.

DR. EMMA A. KENT (continued): I share Senator Gill's concern about sending people so far out of their communities as is often the case when they go to the State Hospital at Pueblo. However, to my way of thinking, 75 miles or a hundred miles is far too far. Most of our aged should be kept in their own community where the relatives can see them frequently, where they are used to being, where they don't have to give up all contact with community affairs.

A Small Facility in Most Communities is Proposed

A small facility is needed probably in most communities. I think it is important to keep the facilities very small. I think the people who are able to take care of themselves should be encouraged to remain at home even in their own boarding houses if they like. Some of these people have lived for a long time in a boarding house, and it's home to them. Then with Dr. Murphey's idea of the community centers, their interests can be expanded and what productivity they have can be used to everyone's advantage.

Any facility that houses a group of aged is going to run into severe medical and psychiatric problems. Elderly people cannot take care of themselves. They need a great deal of medical care and nursing care. As Dr. Rymer said, they are more subject to illnesses and injuries than younger people, and things must be available to help them when they need it, and the mental symptoms will inevitably become a problem.

It isn't necessary to have a highly developed professional staff, I think, for many small facilities. Many of our convalescent homes do an awfully good job with perhaps one registered nurse and some attendants who have the facility for taking care of old people. There is something of a gift in the facility of taking care of old people. Some people can do it and some people can't.

One of our best facilities, I think, for elderly people, including those of rather severe mental symptoms, is in Boulder, a small convalescent home. They just have a knack of taking care of old people. They tolerate their peculiarities and patients there do very well. This is the sort of thing that individual communities can develop themselves, using their own resources, finding the people who can take care of old people, who can put up with some difficulties, because lots of times these symptoms are very aggravating. That is one of the reasons they are such problems in our own homes, and it seems to me that before we think in terms of a large State institution where the elderly patient is lost, just one of a group, that we should think in terms of individual problems, and what can the patient's own community do to help him with them. (Applause)

CHAIRMAN McGLONE: Thank you, Dr. Kent. If we lay people stay here long enough and listen to enough Dr. Kents and Dr. Murpheys, we are going to be educated on the problem of the chronically ill and aged. I think you all deserve a great deal of credit here on the panel for what you are giving to us.

While Dr. Kent was speaking, I happened to look around and I saw Judge Brofman, and to me, that is one of the encouraging aspects of this meeting. So many of the people who in one way or another have to do with this problem are showing an interest in the methods proposed for the solution of this problem. Judge Brofman, by law, being the County Judge in the City and County of Denver, is given not only the right but the duty at times to incarcerate some aged and senile people. He knows, and I think it bespeaks of good citizenship, he knows as well as any of us there are certain things about the present system and the workings of the present system that should be rectified, and I think he is just representative of all of the many of you who in one way or another have to meet

CHAIRMAN McGLONE (continued): this problem in your daily lives and want to find a proper solution for it.

I was stimulated to hear Dr. Murphey state that one of our institutions here in the West was one of the pioneer institutions in a most humane way of handling the problem of the aging and chronically ill, and that is the Myron Stratton Home in Colorado Springs, and we have to speak to us today, Mr. J. P. Tatum, Manager of the Myron Stratton Home. Mr. Tatum.

The Myron Stratton Home for Elderly People and Children

MR. J. P. TATUM: We certainly want to thank you for this opportunity to talk to you for a moment this morning. Many of you may not be familiar with the Myron Stratton Home which is just three miles south of Colorado Springs. It was founded by Winfield Scott Stratton and named in memory of his father. Winfield Scott Stratton was a carpenter and earned about three dollars a day, and in his fifties he struck it rich in Cripple Creek, sold his Independence Mine for 10 million dollars, and got a start in life. He died in 1902 and left his fortune to endow a home for elderly people and for boys and girls. That possibly was a mistake. A home for elderly people or a home for children is a full-time job in itself, and we have two.

The Myron Stratton Home is run by three trustees, a superintendent, and some 63 employees who care for some 100 old people and 87 boys and girls. It is, therefore, really two homes on a 98-acre campus, and we have some 40 buildings.

Aged applicants to be considered must be citizens of the United States, residents of Colorado for the last ten years, and preferably residents of El Paso County for the last five years. We have no age limit for elderly people. The home serves those, who according to Winfield Stratton's will, are worthy, without means of support, and due to age, youth or infirmity, are unable to care for themselves. Our age range at the Myron Stratton Home runs from five to 99. The older people's ages run from 38 to 99, and as Mr. Chamberlain, one of our trustees, says, "Everthing happens to us."

Forty Percent are 70 and Older

About 40 percent of our older residents are in their seventies and over. We have a "90-Club" for the older folks and we usually have a birthday cake and a little celebration for the 90-year old celebrities. These 90-year olds either eat at the cafeteria and walk from their cottages, or their meals are brought to them at their cottages. One 95-year old lady is in the infirmary and one was 99 on December 29. She fusses a good bit of the time.

The Myron Stratton Home doesn't keep separate cost figures for the aged and children. We have personal ledgers for each individual, and so, I can't give you a good estimate there. I presume many of you might be interested in that, but at present our average monthly maintenance runs about $120 a month. Our total operational costs in 1942 were $159,274 and in 1952 our costs had risen to $262,000, and they will be a little bit higher than that this year.

Altogether, the Home has some 5,500 acres of property around Colorado Springs and in Denver, and the income from our farms and mines and the South Suburban Power and Water Company and the real estate go to support the Home. On the basis of one person, the Home has rendered six thousand years of service up to 1951.

MR. J. P. TATUM (continued): As I mentioned before, our Home serves about 100 old people ordinarily, 87 boys and girls without charge. The Myron Stratton Home has about six to eight boys and girls that we send to college each year.

Let me give you a rather quick picture of the Home and some of our services. On our campus we have in our facilities for the aged housing in 26 cottages and our infirmary. Eleven of our cottages are housekeeping cottages, and we serve there a man and wife, maybe a mother and daughter or sisters. In our experience we find that the least trouble is encountered with the man and his wife. Sisters, and mothers and daughters give us a lot more trouble. In general, there is less trouble in the housekeeping cottages than there are in the 16 cottages we maintain for our older people. In the other 16 cottages we house either four old ladies or four old men.

One of the greatest difficulties is fighting over the bathroom. We have one bathroom for our old people, and if they all want to go at once or even if two of them want to go at once, sometimes trouble comes up.

A friend of mine came from Tulsa who wants to endow a home, leave several million dollars for a home down there for old people, and after talking to us, he decided that he would like to have a separate bathroom for each old person if he had a cottage plan.

People Are Living Longer and Problems Now Are Greater

There are some disadvantages to the cottage plan which I want to point out in a minute. We have a lot of money invested in plant there, and we are wondering what we ought to do about it. We do have an infirmary which is a 24-bed infirmary. Our trustees were thinking about putting another wing on because people are living longer, and with better medical facilities, they will live longer. People are now staying out on the pension until they are 85 or 86 or 87 and the minute they need hospitalization or infirmary care, they call us and want to come to the Home.

There are some people who are staying out a long time and taking the pension. For instance, we went over near Manitou and interviewed a lady, and she was 92, and she said she was feeling pretty well, that she was getting the pension, and was going to wait a while before she came into the Home.

We have expanded the infirmary and have added three beds. Our infirmary now is jammed. Twenty years ago it wasn't. Many of the people trying to get in the Home were in their sixties. Many of the folks coming in now are 85 and 86. In the last fifty cases, they were all well above 80, so it means the kind of resident we are going to get is a resident pretty feeble, maybe a mental case, and one requiring a lot of care, which, of course, also present innumerable problems to us.

In these 16 cottages that we have of maybe either four men or four women, they have a common living room and the bathroom. They walk to the cafeteria, and we try to provide entertainment and that kind of thing.

About 50 or 60 of them eat in the cafeteria and they should be able to walk from the cottages to the cafeteria. We have the cottages arranged in a circular arrangement so that the cottages won't be too far from the cafeteria, and that works out pretty well.

MR. J. P. TATUM (continued): It's amazing how, with good medical care, these elderly people can get along without a special diet and can walk to their meals and enjoy them. Many of them want to eat in their cottages, which constitutes a problem. We don't like to have the cottages littered with food. Many of them eat two meals a day. Many of them are feeble and inactive and three meals a day are almost too much for some of them.

Our actual food cost runs us, not including the salary, 60 to 65 cents a day. Part of this is due to the fact that the Home has its own beef. We have about 400 beef. We have our own pork and our own milk from 100 dairy registered cattle.

The Stratton Home assumes responsibility for complete care without charge. We take care of the matters of housing, food, medical care, psychiatric care, glasses, dental plates, x-rays, operations. We don't operate at our infirmary. The patients go to the city hospitals for that. We also take care of transportation, education, recreation, entertainment, and innumerable other expenses, even including funeral expense. We have the Stratton Home Memorial at Evergreen Cemetery, and hold fine funerals for these folks if they haven't made previous arrangements.

As far as our applicants are concerned, we don't take them in if they have over a thousand dollars. If they have a thousand dollars or a little less, we take them in. That amount was smaller in past years, but due to inflation, it's been raised by the trustees to a little under a thousand. Applicants who wish to come to the Home may not leave money to the Home as a condition for their entrance. We take a lot of people in the Home who would like to pay for their board and room there, but we are bound, we are aided and handicapped by Mr. Stratton's will in some ways, and we have to take them without charge.

Most of Applicants Are on State Pension

Most of our applicants, I think I can probably say, these days are on the State pension, and are taken off the pension rolls when they enter the Home, thus taking some of the burden off the State of Colorado. Maybe that is good news to some of you because Colorado has financial problems, even as we do. Some of the residents coming in have Social Security and we allow them to have that, and they buy some of their own clothes and have a little more independence than they would if they had no money at all. The Home gives them gifts of money and other things, and yet, if they have a little money of their own, it's a nice thing.

I think that the point that was made here this morning was a good one. If people can pay their own way, it establishes a kind of independence that is a very good thing. Many people, of course, hate to have to be dependent, and I know they hate to be dependent on the Stratton Home or any charitable institution.

We have a third of a million dollars a year to make them happy and make them like it, and it's a real problem.

A point was made earlier about keeping people happy at places like this. We have a residence payroll for the older folks and children that ranges from $416 to $600 a month. Our old folks are paid small sums for doing odd jobs -- watering the lawn, cafeteria work, some work a little bit in the infirmary. The main idea is to give them a little bit of spending money and to keep them busy, and some of our happiest residents do some work in town. They feel useful. They feel needed. One old gentlemen has some flowers that he wants to take care of, and he's out there at five o'clock watering them. He feels useful, and is happier, I am sure.

MR. J. P. TATUM (continued):

More Care Needed for the Elderly

I think maybe one thing that might be of paramount interest to you is the fact that the picture of the Stratton Home has changed greatly in the last 20 years. Twenty years ago many of the applicants were in their fifties and sixties, were stronger and in better health, mentally and physically. Today, as I mentioned before, the applicants are older. The phone rings when they feel they need infirmary care or hospital care, and so, in some ways, we think that we might be better off almost with a giant nursing home or hospital or infirmary instead of having money tied up in these cottages. The cottage system is a fine system if the people can walk around, but if we have to carry meals to the cottages for six weeks, it means we have to have more help and can't give them quite the medical service in the cottage that you can in the infirmary.

Our average age of elderly folks in the Stratton Home is now well over 80. Our infirmary facilities, as I have indicated, are frequently jammed. For a long time they tossed the question around about enlarging our infirmary and it may be done someday. We have added three beds, as I mentioned before.

Infirmary and Mental Health Costs Have Soared

We have noted this: that with the increase in the average age and with senile applicants, with applicants who are hospital cases, our infirmary and mental health costs have soared in the last 10 years. Our cost of drugs, operations, doctors' fees, psychiatrists' fees, not counting our infirmary salaries and our infirmary costs, come to $1,000 to $1,600 a month. Our Home furnishes dental plates, x-rays, eye glasses, and our bill for eye glasses may run us a hundred dollars a month, so those costs can really get out of hand, and of course, if the State of Colorado decided to assume those, then you would also put yourself in a position where you will be criticized when human wants are rather unlimited.

I have a lady who feels she needs an operation, and she will not be happy until she can be operated on. She is not a good surgical risk, and we cannot satisfy her because we won't operate, and that's what she wants.

We have been forced to increase our infirmary staff. Our trustees think that with the cottage plan, we may have to have more maids and more nurses to visit the cottages if we are going to have to sort of have an out-patient setup in our cottages. We have to carry quite a few meals to the cottages because our infirmary is jammed and we can't take people to the infirmary that we ordinarily take there.

We have some border-line seniles living in our group. Sometimes these folks require custodial care which is difficult for us to supply. We have some big problems dealing with children and old people in finding enough money to run the place and to care for these dependents on the charitable basis and make them feel happy and wanted and useful.

Where we supply everything, as we do, we place ourselves in the position where people are trying to impose on us, many people. Pop Meisenheimer is 93 years of age and works eight hours a day. They try to out-figure you. They want you to give them the dollar and a quarter if they don't have their hair cut. A lady comes in and says, "I would like to buy a hearing aid because I haven't had any expensive operations lately."

MR. J. P. TATUM (continued): So, I believe maybe from this brief description you can well imagine some of the problems that we encounter with our age range of five to 99. We never have a dull moment at the Myron Stratton Home. Things are popping all the time. In these homes you are going to have some difficult people. We have run onto some, and they can be pretty difficult sometimes. We have the lady who was at the home, and her daughter came and told me, "Mr. Tatum, we can't get along with her. We don't know how you do." We run into some severe problems that we have to solve.

Just in passing, maybe I should mention this: that in general with the women, the old women are more trouble than the men are. Probably the married couples are about the nicest to deal with.

Now, I might re-emphasize that I think if you had a setup where people paid for their own way a little bit, it does give them, I think, a better attitude. I think it's a good idea, and it does give them some independence that I think is very valuable. We can't do that with Mr. Stratton's will. In the same way, we have to operate without charge, and we are wide open for criticism because some of our people want to make a lot of demands. If you get into the business of medical care and hospitalization, for instance, people are going to fall down and break a hip or a leg, and what are you going to do about it? You take them to Memorial Hospital and it costs $200 to have the fractured hip set. You have those costs and others and the doctor's bill, and it costs around $700 or $800. That's a problem for State homes, too.

If the State furnishes medical care, why then, of course, you are wide open for criticism, and the demands, I presume, could easily be unlimited.

If any of you have any questions or would like to know more about our Home, or if there is anything we can do to help, we will be glad to do it. (Applause)

CHAIRMAN McGLONE: Thank you very much, Mr. Tatum. We are going to go right along and are hopeful we will have time for the general discussion from the floor.

I notice on the program they refer to our next participant as retired. I wish Dr. Rymer had given us the proper definition of retired because I don't think it would be applicable to this gentlemen, Dr. Heber R. Harper. He is the Former Chancellor of the University of Denver, and formerly the Regional Director of the Federal Security Agency. Dr. Harper.

Dr. Harper Urges Establishment of State Commission on Aging

DR. HEBER R. HARPER: Mr. Chairman and Ladies and Gentlemen: I find that since I have been so-called "retired," I have been busier than I ever was before I was retired.

I have just one specific proposal to suggest to this Conference, and I want to do it as briefly as possible, but in order to make the suggestion effective, I really must give a little of the background information out of which this proposal has developed.

It seemed to me that Governor Thornton in opening the Conference revealed in very telling fashion the magnitude of the problems that concern this Conference as agreed upon by all the governors at their Seattle Conference. Of course, the appalling thing is that in the next 25 years these problems are bound to be greater rather than less, and that is true because the aging problems as a whole

DR. HEBER R. HARPER (continued): will assume staggering proportions in the next 25 years.

Dr. Rymer has reminded us of the fact that we now have between 12 and 13 million people in this country over 65 years of age. Also, we have 43 million over 45 years of age. When it's difficult for people in this age bracket to get work, the beginning of emotional disturbances sets in.

But, the thing that we need to remember is that on the basis of conservative estimates, we will have 20 million people over 65 years of age between 1975 and 1980, and 60 million over 45 years of age. That will constitute a vast nation within a nation, a nation bigger than Germany was before the Second World War.

Population of Oldsters Has Quadrupled in 50 Years

The total population of our country in the last 50 years has about doubled, but the population over 65 years has quadrupled in the same time, and it is this relative increase in the size of this older age group more than its absolute increase that constitutes what our population experts call our demographic revolution. This revolution with considerable justification can be said to be the greatest social problem that confronts our society, second only to the prevention of war.

As a matter of fact, one of our greatest elder statesmen has said that this problem that we are confronted with today, particularly in its over-all aspects, the problem of aging will have more significant social, economic, and political implications for us in the rest of this century than the creation of atomic energy and the new means of communication and transportation.

So, I begin on this sober fact, that difficult as the problem seems now, we who are partly responsible for what happens in the next 25 years are going to be confronted with it in still greater magnitude.

Now, the very magnitude of this problem and its increasing magnitude that's eminent during the rest of the century demand, it seems to me, that the maximum attention by conferences of this kind should be paid to certain suggestions that have already been offered in this Conference; namely, the implications of other aspects of the aged problem and that which is the specific concern of this Conference, that of mental health and the senile aged.

We are aware, of course, of the importance to mental health of employment, and particularly of re-employment after the age of 45, and of occupational rehabilitation, of housing, and living arrangements, as has been indicated; of the problem of providing adequate creative opportunities, as Dr. Murphey has indicated, for the older people who are not employed particularly, and for the new types of adult education.

But these are only some of the aspects of the overall problem of aging with which the new science of gerontology is concerned, but I want to say just briefly that it seems to me that whenever we do anything constructive in any of the nine or ten major aspects of the aging problem that are not of particular concern of this Conference, whenever we do anything constructive in those fields, we almost invariably do preventive work as related to the field of mental health, and usually slow down the advent of senility. But what we lack in many instances and in many sections of this country and in this State is an over-all coordinating body that can accurately tell us the total needs and resources in all these aspects of the field of aging, and they can assist in developing them to their

DR. HEBER R. HARPER (continued): fullest potential, not only for their own usefulness, but their assistance in the solution of the problems that concern this Conference.

That, it seems to me, is our greatest single lack, the existence or the lack of the existence of an over-all coordinating body that can assist us in all these fields.

Fifteen States Have Commissions on Aging

Now, recognizing the seriousness of this problem to their future well-being, 15 states have created such over-all coordinating bodies called State Commissions on Aging, or State Councils on Aging that assume as their responsibility activities in all the fields with which gerontology is concerned. Notable among these states are New York, California, Illinois, Michigan, North Carolina, Rhode Island, and Florida.

New York State particularly has achieved remarkable results in the solution of many of its problems, and as they have found solutions in some of these other fields that I have indicated, they have stressed their value toward the prevention of the onslaught of mental illness in its various forms.

I would like to talk for a moment about what New York State has done through its State Commission on Aging in the legislative field. I will only mention the fact that last year they succeeded in having a bill passed that five percent of all public housing must be devised for and occupied by aged people. That is an achievement in itself, but I want to illustrate achievements of this New York State Commission on Aging, the first that was created and perhaps the most successful of all the State Commissions on Aging, in two other fields: One, the field of employment, and second, the field of providing creative activities for people not employed, the field Dr. Murphey mentioned.

Local Bodies Formed to Help Solve Problems

One of the greatest activities of the New York State Commission is the stimulation of the creation of local commissions on aging, local bodies that can help to provide the facilities that have been discussed in so many different aspects at this Conference.

In Schenectady, they succeeded in setting up a commission that had a large part in succeeding in developing employment opportunities for people over 45. In Schenectady there was a group of retired engineers, who had organized their own very successful consulting engineering firm and were very successful. They were retired from the General Electric Company. They became greatly concerned about a group of older people who were retired or unemployed and could not find employment. These engineers organized a local committee of fine, strong citizens and with the cooperation of the State Employment Agency, they began to see what they could do about helping older people to become employed, many of whom had become emotionally disturbed. They began in January, 1951, when only nine percent of people over 45 employable for jobs were being employed. By April first, they succeeded in placing 17 percent. In ten months, by November first, they were placing 32 percent, almost one out of three. I need not labor the point of what this meant in the way of added financial security and mental and emotional security to this added 23 percent of Schenectady's older population, but I want to move on to the activities of another local commission in New York that has been assisted by the State Commission.

DR. HEBER R. HARPER (continued): In the City of New York there are 12 day centers for aged people that are similar to the community centers, it seems to me, which Dr. Murphey referred to. They are called substitutes for the working day, an opportunity for older people to be occupied constructively for eight hours even though they are unable to be employed for one reason or another. I do not have time to describe these centers in detail except to say I saw there the happiest group of old people I have seen anywhere in this country. They are people who are being provided opportunities not merely for recreation in the ordinary sense of social activities as we think of them, but opportunities for creative activities in the arts and crafts, and I want to quote something about the value of these centers in the field of mental health. Dr. Rusk, the great, remarkable rehabilitation specialist in New York City, has said that in any group of the size of the membership of these centers, but without such activities, between 30 and 40 would go each year to institutions for the mentally ill. At the time he wrote, not one from the membership of the day centers had gone to such institutions from these day centers. I am, therefore, simply trying to emphasize particularly the value of one of these suggestions that Dr. Murphey made.

Day Centers Have Proved Beneficial

As a matter of fact, Mr. Levine, who is the inspiration for the creation of these centers said they not only do a great thing for the old people themselves from the standpoint of their mental and emotional health and well-being, but the talents they have revealed and developed are such that if such centers were established all over the country, they would bring about a renaissance of American folk arts and crafts.

I want to quote one more appraisal. A Pulitzer Prize Winning Reporter wrote a series of articles in the New York papers in which he said, "These are the brightest things in the City of New York," and then he went on to quote the fact that they cost the City of New York about 19 cents a day per member, whereas the estimated cost for those who go to mental institutions is $12.00 per day.

Well, you see what I am trying to indicate is that the stimulation of the creation of these local commissions is one of the most valuable things that an over-all state commission can do, and it has been one of the prime interests and the prime activities of the great State Commission in New York.

But in addition, however, there is a certain amount of research work that can be done only on the state level in this over-all field of aging to know exactly what our problem is, what our needs and resources are in all these fields. There is a certain amount of information gathering and dissemination for public education that can only be done by a State Commission, with a primary function or certainly one of the primary functions of assisting in the coordination of the activities of all the public and private agencies that are working in any of these fields of aging, and assisting them in achieving their objectives.

I might say that it seems to me that no state could more successfully utilize the services of such a state commission composed of citizens representing every major interest of this community, all the public professional people, the leaders of industry and of labor, of all the social agencies.

Now, I just want to say in conclusion that it seems to me that while most of the problems of aging perhaps will be solved at the grassroot level by individual initiative, there are times when there are situations beyond the control of the individual, as was the case of certain of these workers in Schenectady, when the

DR. HEBER R. HARPER (continued): assistance of local and state commissions or similar bodies is necessary. We have, it seems to me, created many difficulties for our older people. In the process of transforming from an agricultural economy to an industrial economy, from a rural society to an urban society, we have really treated many of our older people very ruthlessly. As a matter of fact, the Kansas City Study on Middle Age and Aging, which is one of the most significant that I know of being conducted in this country by a very able group of experts, says there is perhaps a greater fear of aging in the United States than in any country of the western world.

Professor Hall of the Harvard School of Business Administration has indicated the kind of unhappiness and mental disturbance that comes even to people in the top economic brackets. He has recently in the last two years made a study of retired executives only in the upper brackets, $25,000 and above, I believe, or more, and he has just published those findings in a book called "Executive Retirement," and among the other remarkable statements he makes, he said that 60 percent of these retired executives admitted they were unhappy in retirement, not for any reason of financial insecurity, but that indicates the beginning of emotional disturbances among a group of people like that.

Dr. Barbato said yesterday that as a follow-up to the White House Conference on Children and Youth, a great Colorado Citizens' Committee was created to implement the findings of that great White House Conference. Isn't that typically American? No society, I suppose, in all history has done more for its children and youth than has America, and following these successive White House Conferences, we appoint citizens committees to carry them out.

Now, it seems to me that America, of course, always has been and still is a wonderful country in which to be young, but if we are to fulfill the promise of democracy, America must become just as wonderful a country in which to grow old and to be old.

It has been my lot in the past three years to go to every major region of this country studying certain aspects of this problem of aging, and therefore, perhaps you will permit me to express the conviction that much as we may need the kind of citizens' committee that Dr. Barbato has referred to, in my judgment all the other 33 states, including Colorado, need to do what the other 15 states have done -- they need to create an over-all commission on the problems of aging and pretty nearly all their activities of a constructive character will bear upon these problems in preventive fashion.

I believe that we are a dynamic enough society, a creative enough society, a society rich enough in potential resources of all kinds that we can achieve through such commissions, state and local, the objective of making America the greatest country in the world in which to grow old. (Applause)

CHAIRMAN McGLONE: Thank you very much, Dr. Harper. We certainly appreciate your participation in this discussion and the benefits, of course, which came from it.

Our next speaker is Dr. Frank J. Weber, Regional Medical Director of the U. S. Public Health Service, Department of Health, Education and Welfare. Dr. Weber.

Dr. Weber Discusses Aging and Chronic Illness

DR. FRANK J. WEBER: Thank you, Mr. McGlone, and Members of the Conference: I might say that in introducing this subject it seems to me that a speaker appearing at this point of the Conference, particularly after that inspiring address of Dr. Harper, runs the risk of repeating much of what already has been said. However, too, I believe that the position is not without its advantages because through re-emphasis of certain points, I feel that the participants can get a better idea of the areas of common agreement, and this speaker, if his free association capacity functioned reasonably well, has had the opportunity to prepare a more intelligent commentary on points already made, but open to further elaboration.

Some of these points, I feel, can undergo endless elaboration. At any rate, I shall attempt to indulge in this commentary particularly from the public health administrator's point of view, and from the point of view of a public health administrator who stands in need of advice from the various experts assembled here, advice as to the proper courses of action indicated for solution of these puzzling health problems.

I would like now to comment on the two main aspects in order: The problems in aging, and the problems of the chronically ill.

In taking up the first, that is to say, the problems of the aged and the senile aged, I am reminded of what someone once said: "The only way to avoid old age is to die young." Since hardly anyone wants to die young, the problem is automatically made for us. What are we to do about it? In tackling the question, I am again reminded that this conference, and also this particular session, began with a consideration of definitions of terms used. I shall start off by saying that I don't like the terms, "aging," or "aged," or again "the senile aged." Each of these terms beg the question. Since aging begins at birth, if not before, when can one be called aged? I feel a better term would be something like "older persons." In my own way of looking at it, this refers to the usually accepted point of 65 years and over.

As we have heard, each year a greater proportion of the populations enters this age range. As this happens, we find that more problems have been created than should be expected. In one state the admissions to mental hospitals in that group have quadrupled, whereas, the population of people over 65 has not shown a corresponding gain. We find proportionately 30 percent fewer people of that group gainfully employed than was the case back in 1870. Many other evidences point to the increasing seriousness of the problem. The point is, why?

In theorizing on that point, I feel there is a case for the hypothesis that somehow rejection or non-acceptance of the older person by modern society, including their families, is a good part of the answer. Those of us who have had clinical experience with many of these people know it to be a frequent and prominent factor. If we grant this to be a fact, it is permissible to speculate realistically on some of the reasons.

All Persons Not "Old" on Basis of Chronological Age

An answer may be found by examining a goodly number of misconceptions concerning the older person, to name but a few: One: That a person is old because of the number of years that have passed over his head. At best, chronological age is only a rough measure of the capacity to cope adequately with one's environment. There are wide variations. Therefore, in adopting remedies, individuali-

DR. FRANK J. WEBER (continued): zation of each older person is indicated.

Two: That the attainment of a certain age means a decline in physical and mental abilities right across the board. This is not so. While the capacity to learn in certain areas is often impaired, little diminution is seen in other areas. Indeed such complex mental functions as those involved in judgment may further develop during maturity. In our complicated civilization, however, it may be that knowledge gathered over the years so soon becomes obsolete in one or more ways, there is not the need for the services of the sage. In that sense, our civilization may be penalizing the older person unduly.

Three: Another common belief, even in sophisticated circles, is that inadequate behavior patterns seen in advanced years are always the result of organic change. Any pathologist will tell you that there is no hard and fast correlation of that sort revealed by autoptic studies. Therefore, while organic factors undoubtedly play some part, they are not the whole story, and when they exist, can often be relieved by adequate medical remedies.

Four: Another mistaken belief, a corollary of the preceding, is that personality deterioration is an inevitable part of the aging process. The truth is that many of the causes of personality deterioration, when it occurs, might be sought for elsewhere rather than in the mere fact of a man's years. Too often an eccentricity in behavior that has its origin in these other factors is seized upon as an excuse to hospitalize the patient merely because he stands in the way of the pursuit of the family's activities and interests. This may be part of the reason why 28 percent of first admissions to mental hospitals now come from this age group. It is an interesting clinical phenomenon that the personality may improve with age as old conflicts are left behind and new perspectives are gained. The well known philosopher, George Santayana, who wrote his first novel, "The Last Puritan," a best-seller, after he reached his sixties, had this to say of his old age -- which then was eighty:

"Never have I enjoyed youth so thoroughly as I have in my old age. In writing 'Dialogues in Limbo,' 'The Last Puritan,' and now all these descriptions of the friends of my youth and the young friends of my middle age, I have drunk the pleasures of life more pure, more joyful, than it ever was when mingled with all the hidden anxieties and little annoyances of actual living. Old places and old persons in their turn, when spirit dwells in them have an intrinsic vitality of which youth is incapable; precisely the balance and wisdom that comes from long perspectives and broad foundations -- old age, having less intensity at the center, has more clearness at the circumference."

Well Developed Program Includes Several Approaches

After this quick look at some of the phases of the problem on the part of myself and others, I would like to outline a few suggestions as to how we might proceed in this matter:

One: Work through all of our information media toward a revised concept of the status and needs of the older person.

Two: Strive to keep the older person active within the social framework of our society. In doing that, we can consider some of the following areas of activity:

First, employment in productive work. Most individuals anchor themselves in the social structure through their jobs. Retirement from them, especially of the

DR. FRANK J. WEBER (continued): potentially productive person, is frequently a severe blow because of the attendant ego-involvement. Retirement Boards in industry furnish a ready example of one of the better devices that might be employed in this undertaking. Job placement agencies for the older citizen has an obvious place. Such an agency in Toronto was able to secure employment for 300 of 550 applicants, most of whom had been seeking employment unsuccessfully for many months.

Secondly, better integration in neighborhood activities. The Hudson Street Center in New York is an example of such a facility which is able to operate a full activities program at a cost of 20 to 40 dollars per year per person.

Thirdly, improved institutional care. Geriatrics should rank with pediatrics medically. Therefore, good general hospital care, when necessary, is a "must." The same is true of mental hospital care, when necessary. I am told that close to 90 percent of mental depressions in this group are successfully treated by electro shock therapy. Pre frontal lobotomies should be available for selected cases.

There is also a place for the so-called boarding home, but with the understanding that this is not a substitute for the hospital. It is really a substitute for the patient's home. It is designed to give no more than infirmary type medical care, and planning for them must be conducted with such facts in mind.

Finally, a sound community mental hygiene program has much to offer to many segments of this problem. One of the strengths of that program rests in the knowledgeability of its practitioners regarding the origins and course of human development as well as an understanding of the various biological and environmental stresses, and the variety of adjustments to them that must be effected. A good part of its work consists both in preparing for these events and in being available for relief when they happen. In that way anticipatory guidance and the other techniques designed to preserve healthy mental functioning have a useful place in averting the severe maladjustments we have discussed during these past two days.

The discussion of the next topic, "The Chronically Ill," finds me with very little time. Therefore, I shall say only a few words with a good part of them taking the form of questions.

Chronic Illness Not Exclusive to Any Age Group

Here again, we are confronted with the matter of definition. Since one of the principal distinctions would seem to be that of time, perhaps the term "prolonged illness" would be more appropriate. Furthermore, the problem is not one that is exclusive to any age group although it is true enough that it is a more common problem in older persons. That it strikes younger groups as well was borne out in a study of one of the New York studies which showed that one-half of its chronic case load was in patients under forty and one-third in youngsters under sixteen.

In any examination of such a problem, as we are doing here, there is a need to address ourselves to a number of questions, and in the field under discussion there are many.

Naturally, many of the questions relate to the possible types of medical care. Again, the general hospital, the "Community Healing Center" as Dr. Ebaugh expressed it yesterday, is central to the activity. With the control of infec-

DR. FRANK J. WEBER (continued): tious diseases, together with other trends, it would seem that the general hospital will take care of more and more chronic illness cases which comprise about 27 percent of all general hospital admissions. Because of the greater duration of these illnesses plus the high cost of construction and of maintaining adequately staffed and equipped general hospitals, serious problems of financing are encountered. With the growth of the problem, more assistance is needed. The financial side is obvious. Less obvious, but real, is the need for services rendered by auxiliary installations such as out-patient departments, secondary institutions such as boarding and convalescent homes, and even home care. The respective roles and admission policies of these places need to be defined.

Other questions of a related nature must be faced. For example, what about the integration of services for mental patients and tuberculosis patients as well as the so-called senile aged in to the general hospital? Should these people whom we expect to return to society be subjected to prolonged institutional treatment away from that environment?

At this Conference, too, questions have been raised about other matters such as the social and medical pressures created by illness. As an example, Dr. Gaskill mentioned the welcoming by some patients of dependency conferred by the illness. These and many more problems should be part of the re-examination.

It seems to me that we still need and will probably always require continuous study and evaluation of these problems. At the same time there is even more of greater need to go into action in this whole area with its various facets. It appears, too, that we know enough to make a good beginning now, learning more as we go along. The attack needs to be on a broad front -- political and administrative, as well as medical. In this is needed not only the medical and public health agencies, but representatives of the schools, churches, the social sciences, the organs of public opinion, and representatives of citizens' groups.

Three-Point Program Proposed to Deal With Prolonged Illness

In conclusion, I can envision a program with adequate financial and community auspices which would: One, strengthen the general hospital and the secondary institutions to meet the problem of prolonged illness.

Two, establish good programs of prevention at the one end and rehabilitation at the other. Much would be contributed to this program by business and industry along lines already mentioned. Industrial hygiene and occupational health programs constitute good economics and mean less physical disability.

Three, better community planning in regard to factors fostering prolonged illness. Most of these are obvious: Poverty with its vicious circle; poverty fostering disease; disease intensifying or producing poverty. Housing has a special place. Not infrequently increased hospital bed use only reflects the lack of any reasonable facility for medical care at home.

I wish to thank you for your kind attention, and I hope it has been possible to throw a little different point of view on some of these problems we have been discussing. (Applause)

CHAIRMAN McGLONE: Thank you, Dr. Weber. Our next participant in this panel discussion, I am informed, has had some exposure to the problems of the chronically ill and senile aged. Is that right, Dr. Zimmerman?

CHAIRMAN McGLONE (continued): It is always a great pleasure to present to an audience such as this Dr. Zimmerman, Superintendent of the Colorado State Hospital. Dr. Zimmerman.

Dr. Zimmerman Discusses Care of Senile Aged at State Hospital

DR. F. H. ZIMMERMAN: Thank you, Mr. McGlone. I am not going to talk about the plans for the future. I am going to talk about what we have had to do by necessity at the Colorado State Hospital in the last few years and what we have done.

Just to get you straight on a few figures, during this past fiscal year, we had 1,139 admissions. Of that group, 263 were diagnosed as senile psychosis. Also, of our resident population at the end of the year, June 30, 1953, we had 5,412 patients in the hospital. Of that group, 628 were diagnosed as due to senile psychosis.

Now, I want to say something about Senator Gill. I hope he is still here. No, he isn't -- I don't see him.

When we started planning for a separate unit for the aged, we went into the problem of single-story buildings. We felt in our beginning studies that that was the ideal solution. We also felt that the units should be small, not more than thirty patients in a unit. Then we had our preliminary plans made. We were strung out all the way from Pueblo up to the Myron Stratton Home -- that is, if we had used these small units. So then we decided to pile them up a little bit. Our first studies then were for two-story buildings. Well, we found out we would have to have elevators for the two-story buildings. So eventually after piling them up and considering costs and everything, we decided on a six-story unit.

Now, the reason for that was that at the hospital, we have a six-day work week for the attendants, and we sort of figured that if we could take the relief attendant and have this same relief attendant on each one of these wards as he went around his six-day week, he would not cause the confusion and sometimes the actual mental suffering on the part of the aged individual by having a stranger come in, so we decided on a six-story unit. Now I understand we are going to a five-day work week one of these days, so I don't know what we will do with the top story.

In our construction, as I say, we decided upon the six-story unit and small wards. We divide our wards up something like this. We have six four-bed dormitories and six single rooms. The only individuals that get the single room are the individuals who can't get by with three other people. Mr. Tatum mentioned some of the difficulties that he has there with his elderly people, and naturally, we do, too.

In this unit, we have tried to provide a good many facilities that should be given to these people who are sent to us, not because we want them there, not because they want to come there, but because the judges -- like Judge Brofman over here -- are sending these people to us.

In this six-floor unit, each floor has two wards. Between the two wards is a cafeteria unit, and these patients go through the cafeteria unit, serve themselves, select any table they want to sit at. Most of the wheelchair patients are able to select their own food and to manipulate their wheelchairs around, and in that way, we are trying to give them something a little bit better than they used to have.

DR. F. H. ZIMMERMAN (continued):

Elderly People Now Housed in Six-Story, 720-Bed Building

Not too many years ago, our elderly people were scattered all over the institution. As a good many of you know, for a long period of time, we were about 1,600 over capacity. This new unit we constructed has 720 beds in it. That's 24 wards of 30 patients each. Six hundred of these beds are set aside for the aged. 120 beds are set aside for elderly people with diabetes and in need of special diets, long-time cardiac conditions and things like that.

Now, we attempted to do this, too: We attempted to cut down the maintenance cost. By that, I mean eliminating painting and papering and things like that that you have to repeat periodically. So, the finish within the wards is a glazed tile, and we anticipate that there will be no maintenance cost to speak of.

In the facilities, we provided beauty parlors for the women, barber shops with the POLICE GAZETTE for the men, occupational therapy units, a theatre where they can go to the picture shows, and our picture shows are daily. We have a small theatre there with 168 capacity. In planning the seating, we arranged it so the distance between the back of the seat and the front is about eight inches longer than you have in ordinary threatres, feeling that the older person would have and does have more difficulty getting up and sitting down than the younger person.

New Buildings Have Paid Dividends

We have hoped to get into a study, too, of what we can do in the way of rehabilitating these people, and already, as I have told members of the Planning Commission, the new buildings have paid dividends. By having the controlled supervision for sometimes days, sometimes weeks, sometimes several months, and proper diet, and good medical attention, a good many of these people go home. I can think of several bed patients right now who have come to the hospital, and within six months these people who came in as bed patients go back home and into their home environment.

We also have chapel services for our patients. We have a full-time Protestant chaplain, a full-time Catholic chaplain. We want to do more in our occupation therapy and we want to do more to make the individual feel that he is not there for the balance of his life, but that he has a chance of going home and going back into the community and visiting with his friends and neighbors.

Adequate Supply of Trained Personnel an Urgent Need

Now, all of this came of necessity. In the early 1940's, as some of you perhaps remember, there was a marked influx by commitment throughout the State. We had to do something, and I just wanted to tell you something of what we have attempted to do. It is purely experimental at this time. There are so many things we can do if we have the personnel, and trained personnel is a big factor.

To illustrate, in staffing this unit, we screened our employees, because, as one of the speakers has said here, not all employees can take care of elderly people, so we screen our employees. Then we gave them special training as to what we wanted the patients to receive.

So, any of you elderly people -- that includes myself -- come down and see us sometime and see what we are doing. (Applause)

CHAIRMAN McGLONE: Thank you, Dr. Zimmerman. Our next participant is Dr. Byron Johnson, Associate Professor of Economics at the University of Denver. Dr. Johnson.

Dr. Johnson Describes Plan for Providing Facilities by Local Groups

DR. BYRON JOHNSON: Thank you, Mr. McGlone. I think we have had a very fine series of recommendations this morning, and I would like to build a little new brick or two on the structure, on the foundation that has already been laid.

We have been told, for example, that we should stress prevention even more than we have, and stress prevention in order to cut down the amount which must be spent on the cure of these persons. I am certainly happy to hear that some of the ones who are at the State Hospital at Pueblo have a chance to get back home. Certainly, the feeling of fear with which most older persons face institutionalization should lead us to do all we can in that direction.

You might be interested in knowing how I got into this field and why I am up here this morning. I happen to be a member of the Board of Counselors of Plymouth Congregational Church, and our Church Visitor came to our meeting a year ago and told us that in our own church there were 300 persons over 60 years of age, and she told us that 60 to 75 of them were in desperate need of better housing conditions. She felt housing itself was a key to this problem, and she mentioned time and again the feeling of insecurity that the aged person has who faces the possibility of falling or coming down with a chronic illness, being unable to reach anyone, being isolated by reason of being alone in a little room, by lack of decent facilities and no one around who cares.

This feeling of loneliness and this feeling of insecurity, social, personal and medical insecurity, quite independent of the economic consideration, just tore at her heart strings, and also, at the heart strings of the entire Board, and we organized a church committee to investigate the problem of church homes, and I have been working on that issue for the past year, and growing out of our studies, have come to a few suggestions which I think we should share at large.

Elderly People Should be Kept in Their Home Community

We certainly are firm believers in the notion, as Dr. Kent spelled it out, that people should be kept near home. We are interested in providing homes in Denver for people in Denver, and we feel that this will be true throughout the entire State. We also feel that to the fullest extent possible, housing should be provided on the basis of some local initiative, some direct community concern over the thing, and not simply be a gift of the State, even though we who live here in the Denver area, of course, feel that the State is a little closer to us perhaps than people out in the remote counties.

We are firm believers, thirdly, in the notion that we should preserve the independence of the aged to the fullest extent possible. We believe very much that every aged person should be allowed to be employed to the fullest extent of his abilities, that he should make his contribution to the community in whatever way he can. We believe he should manage his own affairs to the fullest extent possible.

Someone once said that old age is like adolescence in reverse. The adolescent moves from dependence to independence, and the aged person may move from independence to dependence. But certainly every effort should be made to preserve that feeling of independence on the part of the aged person, and to postpone the

DR. BYRON JOHNSON (continued): time of dependence as long as possible and the degree of dependence to make it as small as possible.

We are, fourthly, interested and depressed by the failure of the building industry to provide any special housing facilities for the aged. It is very easy to understand why they don't do it, but in view of the tremendous growth in the market, as has been spelled out here by Dr. Harper, it is depressing. For example, one of our own members on the Board had spent some weeks looking for a decent little apartment here in the City of Denver where you would think adequate housing facilities would be available, and she was depressed beyond words at the inadequacy of the facilities that are available to a single person, an old widow or an old maid, perhaps a retired school teacher, trying to find some facility within which she could keep house and attend to her own wants and be near transportation, shopping, recreation, her church, medical care, and be near at least to transportation to get to her friends and they to visit with her. The prices asked are large.

The building industry neglects it for a good reason. There is an excellent market in housing for young married couples and housing for middle aged families, and there are real problems associated with providing housing for the older persons between the landlord and tenant. If they become chronically ill on the landlord's hands, the landlord is likely to be somewhat disturbed about the obligation which he seems to be taking on unless he goes all out and goes into a nursing type of home directly.

Local Groups Should Provide Facilities for "Senior Citizens"

We do believe, as was suggested by Dr. Murphey, that the churches, the fraternal organizations, the lodges, and the labor unions, as well as city and county governments, veterans organizations, and so forth should all be very much concerned to provide facilities for those of their elder members. I don't like the term "aged" or even "older citizens." I like the phrase "senior citizens." That suggests sort of having arrived.

Bear in mind that we are well aware that most -- and by most I mean more than 50 percent of the aged persons -- will probably take care of their own needs within the family and maintain the house in which they raised their children or otherwise, but there will be some for whom the house was too large; some who never owned that house, or possibly for medical reasons need to move, and there will be others who, for economic reasons will be forced to give up the security which they had in middle age, and in their senior years need to find other housing facilities.

It is exactly out of this concern that our own church committee was established. Very shortly after we got into the study of this thing last spring, we realized there were a number of problems that would be very difficult for us to solve as a church. We found that there were special problems of planning the facilities. They must be suited to the peculiar needs of aged persons -- medical, personal, physical needs as well as their social needs.

There are very real problems of financing these facilities although a technique is available which has been little used. In fact, I know of only one use of it, and that is in Boston. It is the use of Federal Housing Section 213 financing, but this is a technique still very much in the experimental stage. The problem of finding a decent site becomes a real problem when you consider the specifications already laid down, and the fact that any such site is already built on. That is, the good sites are gone. This means that very probably land would have to be cleared in order to get what you want.

DR. BYRON JOHNSON (continued): Then, of course, there are the problems of construction, the problems of staffing such a facility when built. I do think that the churches, the lodges, fraternal organizations and unions and so on can very easily or at least with reasonable success operate these facilities, once built.

We felt that because of the unique problems involved and because these problems would be common to all groups such as ours -- and there are a number of them here in the city equally concerned with our own church -- it would be helpful if there were one central organization which could help with these problems of planning, of site selection, of site purchase, of financing, construction, and the whole initial activity involved in creating such a facility.

Plan: A State Authority Would Cooperate With Local Groups

So, working with a number of persons, including some here in this room, Representatives Allen and Palmer Burch and Frank Kendrick, with Louis Wertz and with Speaker Dave Hamil, we drafted a bill, House Bill 476, in the 1953 session of the Legislature that would create a State corporation or State authority which would help to provide these initial planning activities, and then the thought was that the homes, when built, would be turned over, of course, to the sponsoring organizations. In fact, the home would not be built without a sponsor clearly in mind.

We had in mind that multi-family structures and apartments would be built as well as court-type structures and residence halls, and possibly a portion of the units to be devoted to the nursing home type of facility. We felt that while our own needs were perhaps for 60 units, by cooperating with four or five other like-minded groups, we could get 250 or 300 persons housed within an area of a few blocks and share certain mutual overhead facilities that are very essential--the day care centers, for example, that Dr. Murphey spoke of. We had in mind the recreation facilities for creative activity should be provided as a part of the housing facilities that we would create.

We felt, if I may by way of supplementing what Senator Ted Gill said at the outset, that if we could build enough of these facilities, not only ourselves in Denver, but other sponsoring groups throughout the State could build such facilities, that they could provide such attractive housing facilities for older persons, for our senior citizens that there would be a reduced number of such persons who would need the services either of Dr. Zimmerman's Hospital at Pueblo or of other State homes for the senile or for the chronically ill.

In other words, we would be finding something useful and creative for them, giving them a feeling of belonging and a feeling of participation, a feeling that someone cares, and all of this will do more for them than anything else, and the sheer physical plant is an important part of that operation.

H. B. 476 Passed in 1953 by the House but Not the Senate

I hope that House Bill 476 will be included in the coming session, and if not, that it certainly will be included in the next session. I might add that it passed the House practically unanimously, but it arrived in the Senate during the last week of the session, and in the closing rush, never came to a Senate vote. In the House it had excellent bi-partisan sponsorship and active support throughout the Chamber.

DR. BYRON JOHNSON (continued): We would create a State authority or corporation of five directors, choosing persons particularly knowledgeable in the fields of financing, banking, real estate, and construction, and health and welfare administration, and familiar with the problems of the aged. The corporation will have the powers and duties to serve the needs throughout the State for housing for the aged suitable to their needs.

Secondly, to secure in communities throughout the State, agencies ready, willing and able to sponsor suitable housing facilities in their own communities.

Thirdly, to plan with such sponsors the facilities best adapted to the needs of that community with due consideration to the availability of general hospital facilities and transportation, other utilities, recreation and other facilities. To arrange suitable financing for the facilities to be constructed either by issuing its own mortgage or revenue bonds, or including a mortgage insured by the Federal Housing Administration. Actually, it is my thought that Section 213, financing for a trust type of corporation sponsored by one of these non-profit organizations would be the way you would get actually 90 percent of your money at four and a half percent interest rates with forty years to amortize the loan.

I believe any person on the old age pension could pay an economic rental for such a unit. The economic rental for a unit costing four to five thousand dollars to construct shouldn't run much over $40.00 per month, and that ought to be within the means of the persons, even the old age pensioners. Other persons certainly should be able to get something from their families in order to pay this economic rental, and therefore, no subsidy need be involved in any of these operations. The sponsoring group, it should be noted, would have to raise the other 10 percent by way of either gifts or initial investments on the part of persons who wanted to live in such facilities.

The corporation would acquire land suitable for the facilities by purchase or eminent domain or gift. The corporation would sell, lease or otherwise convey the facilities when built to the appropriate sponsoring organization with proper safeguards. And then the bill provides for the proper staffing of such facilities.

As a means of getting the initial capital in order to get it going, it is suggested that the corporation have the power to borrow money from one of the State trust funds. It has been suggested that we broaden out that power to include both to borrow and to lend in order that the corporation might have greater financial flexibility. We are asking for no appropriation from the General Fund, only for the loan of money at interest from one of the trust funds in order to help go through the planning, site acquisition, and construction stage. We expect the sponsoring organization which takes over the particular project to reimburse the State not only for the State's outlay for land and so on, but actually for the expenses of operating the corporation itself, so the State would, in fact, spend none of its own tax money, but would only lend its money, and more particularly, it would be lending its credit on an FHA insured loan which means the State would be running no particular financial risk.

Revolving Fund Would Finance Numerous Homes Under the Plan

We would create a revolving fund for this purpose. My own belief is that if, say two million dollars were put at the use of this corporation to help start such projects, that two million dollars might ultimately build 20 or 30 million dollars worth of such facilities in loans ranging in size from a small amount to a larger amount. The State would end up having its two million dollars in the treasury with interest in the trust fund from which it was borrowed. More than that, the

DR. BYRON JOHNSON (continued): homes would be owned and operated by non-profit sponsoring groups. There would be no drain upon the general fund of the treasury for annual appropriations to maintain the homes.

More than that, the residents and tenants in the home should pay the entire cost of the operation, so no subsidy would be involved in any way, shape, or form. The State would have helped these non-profit sponsors, many of whom feel the need to do something like that, but seem unable to get over the initial hump of getting a program under way -- actually launched and going.

This program should reduce the intake at the State Hospital and other institutions which already exist, or which might hereafter be created, by providing facilities that will keep these people happy, near home, active in the community, and by providing a direct relationship between someone who cares within their own community through the lodge or fraternal organization, church or other sponsoring group.

This may not seem as if it's directly concerned with the problem of mental illness or the chronically ill or the senile, but our view of it is this: that we are working from the end of the spectrum where the people are, and by providing better facilities for them, we will reduce the total number who will arrive at the other end in the categories with which the other discussants have been concerned.

Therefore, I feel this measure when spelled out, regardless of details, is a very real way of emphasizing prevention in order to cut down the cost of the cure. (Applause)

CHAIRMAN McGLONE: Thank you very much, Dr. Johnson. Now, our next discussant, I am sure, is familiar to all of you. He is Mr. J. Price Briscoe, Director of Public Institutions in the State of Colorado. Mr. Briscoe.

Mr. Briscoe Reports on Cost of Operating the State's Mental Institutions

MR. J. PRICE BRISCOE: Mr. Chairman and Friends: The subject that the committee has given me today to discuss is "What the State is Spending on the Operation of Its Three Institutions for the Care of the Mentally Ill and Mental Defectives." I am not going to try to give you a complicated statement because figures are dry, but I am very sure that if these figures are of interest that the committee later will type them and distribute them to you.

The three institutions that they are talking about are the State Hospital, the Home and Training School for Mental Defectives at Ridge, and Home and Training School for the Mental Defectives at Grand Junction. The State Hospital I will discuss first because it is a little complicated due to the "C" pension, and I am sure you read in the paper or heard over the radio that the District Court held for the State, but the Old Age Pension Group is going to take it up to the Supreme Court. That will tie it up, no doubt, for some time. The "C" pension checks have been coming to the Hospital and are kept practically in their envelopes awaiting the Court's decision.

The Legislature, going back now to 1952-53, in its session which wound up June 30, 1953, appropriated $5,350,000 for the State Hospital. Added to that is about $450,000 from the mill levy for the benefit of the hospital operation, and about $450,000 from patient pay, making $900,000 or a total of $6,200,000 in 1952-53, and that is what they thought they were going to spend to operate the hospital one year.

MR. J. PRICE BRISCOE (continued): They did not get into the buildings that Dr. Zimmerman was telling you about, these fine buildings, and so at the end of June 30th, the first week in July, they turned back to the General Fund of the State, $1,151,000, which left the cost of operating the State Hospital for the year 1952-53 in round figures now, approximately $5,100,000. That $1,151,000 came back to the General Fund. $725,000 of it was appropriated back to the Hospital for the new boiler plant, two new 80,000 pound boilers, because as that institution grows, it must have hot water for cooking, baking, and so forth.

Now, the Legislature that met in 1953 for the fiscal year 1953-54, appropriated $4,000,000 from the General Fund, and there was added to that a raise in the civil service pay formula, and of that $4,000,000 the Legislature put up, $191,000 went to the State Hospital to pay for the increase in salaries. Again we have the $900,000 coming from the mill levy and the patient pay, and that is a slight guess there because we raised the cost to the patient at the State Hospital from $30.00 up to $84.00 per month.

We don't yet know how many people are going to pay the $84.00, but it certainly was unrealistic at $30.00 a month. That left a gap and that was put on the "C" pension. They had thought that the "C" pension would bring in about $1,200,000. Actually it has, up through the month of November, brought in $904,000 so that it looks as if there would be a deficit of $214,000. The whole thing will probably be a deficit if they tie up that money in court, and it will be up to the Legislature coming into session now, it seems to me, to survey that very carefully and see how much money from the General Fund it will take to run the hospital through to June 30, 1954, if they are not allowed the "C" pension checks which are estimated to bring in $904,000.

Those figures are rather dry, perhaps, but if we get all of the money, the cost of operating the hospital this year, now that we are in our new buildings, is about $6,225,000-- very close to what the estimate was a year ago. However, they didn't get the buildings opened, so it cost a million less than estimated a year ago.

Cost of Caring for Patients at State Hospital Was $1,032 Each, Last Year

I think it is rather interesting to learn what it cost per month to get down to what we can understand. The cost per month in 1952-53 was $86.00-plus, per month per patient, in the State Hospital, or approximately $1,032 per year. It looks as if the cost for 1953-54 will be $1,135 per patient per year -- not quite a hundred dollars a month.

As I understand, there are approximately 5,462 patients at the State Hospital, and that number is not static. Some die and some new ones come in. It can be 10 or 15 either way, and there are 1,609 employees, or a ratio of one employee for every 3.32 patients. It would cost the State Hospital considerably more if they did not raise so much produce of their own and also maintain one of the finest dairies at the State Hospital. If they had to go out on the open market and buy this stuff, it would cost them much more. It would also cost them much more if many of the patients were unable to do any work around the institution.

When we talk about mental defectives, don't think that we are talking about babies. They run all the way from babies to 70 years old. When they were speaking of mentally defective children, I thought they were talking about 10 or 15-year old kids or younger. They are not that way.

MR. J. PRICE BRISCOE (continued): The Federal Government in the past few years, and more especially in the last few months, has been making available to the three homes a good deal of Government commodities. Many of you are acquainted with this through the school lunch program, and I don't wish to bore you, but I want to show you at the State Hospital the quantities of food that are made available. I will just use the State Hospital: Butter on hand -- 31,000 pounds of government butter, and using 10,000 pounds a month. 29,000 pounds of cheese, using about 3,000 pounds a month. 64,000 pounds of canned meat and gravy -- that's a new product which we have found to be very good -- and they are using about 7,000 pounds a month. We have about 32,000 pounds of hamburger which we use at the rate of about 13,000 pounds per month. That's protein. That is what happened to some of the cattle from the distress areas. It is very helpful because all people need protein, and our good doctors that run these institutions tell me there is no better package for protein than meat. Enough for the State Hospital.

At Ridge there are 369 people, more or less. I think Jim Hinds told me today that he had 372. There are 106 employees or one employee for every 3.48. Remember, the hospital was one for every 3.32 patients, so it's holding the line. Their appropriation was $410,000. The civil service added $18,000 to it, making a total of $428,000, and they get approximately $30,000 a year from the parents of the children that are there. That makes $458,000 more or less, in round numbers.

Annual Cost Per Inmate at Ridge is $1,244

They are spending $33,000 a month and it's costing $1,244 a year to maintain a child at the Ridge Home with the educational possibilities that we are now supplying, and I might say in passing that none of that money comes from any of the State educational funds, like the school funds, but of course, it doesn't make any difference -- if the General Fund appropriates enough money to run the schools, it's out of the General Fund anyway, so I don't very often get into the argument about whether the mental homes are supported by the public school funds.

The salaries are 70 percent of the total expenditures at Ridge, and at Pueblo they are 72 percent, so they are about alike there. At the Home out at Ridge we are building a first part of a unit, a $500,000 building. It will have a new kitchen, new receiving wards and an infirmary and beds for 100 children -- 50 boys and 50 girls. We hope that at some time the Legislature will complete the job and give us another 100 beds there with the auditorium which we left out of this first building.

Cost at Grand Junction Home is $1,156 Per Inmate

Now we go to Grand Junction. Grand Junction has 153 employees and slightly over 600 infirmed students that are there. It had an appropriation of $640,000 from the Legislature. $24,000 was added by civil service, and approximately $30,000 paid by the patients, which gave them a budget of $694,000 for one year. They are spending approximately $56,000 a month, and it's costing $1,156 per pupil per year.

There is a strange thing at Grand Junction. We are spending more for maintenance and operation than we are at the other institutions. Probably the Grand Junction Home was more run down than any other institution but one. The pipes, the buildings, the painting, the floors, the drapes, the bed coverlets, and so forth were in a very run-down condition.

MR. J. PRICE BRISCOE (continued): The percentage of money spent for pay roll is 60 percent of the total cost at Grand Junction. We have one employee for every 3.92 patients at Grand Junction and one for every 3.48 at Ridge. It is very difficult to find employees on the Western Slope. We have about the average patient load for every attendant. We are doing a lot of work around the place, revivifying the farm and the buildings, making repairs that are necessary. If any of you have been there recently, you probably have noticed quite a change.

We are building over there a new dining hall with kitchens, things that have been very badly needed. That will cost fully equipped somewhere around a half million dollars, and all of that money comes out of the mill levy fund.

Now, that, in brief, is the financial picture at those three institutions. They run along fairly even. The Ridge Home is a little higher in cost than either Grand Junction or Pueblo. There is a reason for that, I think. Any of you who have visited the Ridge Home lately have found, I am sure, that it is very excellently run; it is clean and neat as a pin. The food is excellent. The food is excellent also at the Hospital and at Grand Junction, but there are more visitations to the Ridge Home. I think the management out there realizes that anybody is liable to arrive at any time and it is kept right up to 100 percent at all times, and they do maintain the dairy that is now run at Ridge and also supplies two other institutions -- the Girls' School and the Colorado State Home.

We do invite any one of you to come at any time, day or night, to visit any one of these institutions. I don't know whether Dr. Zimmerman would appreciate your arriving at that great institution at night, but I am sure if you did, you would be welcome to go anywhere with him.

We are getting rather proud of the institutions, and I think if you visited them, you would be proud of them, too. The Legislature has been very kind and very thoughtful in studying the needs of these institutions, and so far, they have come up grand with the money necessary to run them. They are going to have a problem at Ridge in their appropriation because we do not know when we will get into the new building. We hope we will be in by October or November, in which case, if we take on another hundred children, then we would have to multiply on the average to be realistic, and we have to multiply that average of $1,244 by a hundred, and they would have to give us $124,000. However, they may decide to wait until January, 1955 to see whether the building is finished and whether we need the money, and if we need it, I am sure they will give it because they are well aware of the problem of the mentally defective children.

Mr. Chairman, I thank you. (Applause)

Chairman McGlone Summarizes Some Points Covered

CHAIRMAN McGLONE: Thank you, Mr. Briscoe. I am certain that all of us appreciate your being with us and appreciate your statement of the consideration of the Legislature regarding these particular problems, and the fine way they have supported these institutions in the recent past.

We have but very few minutes before we are to be dismissed for lunch, and I am sure those having to do with this afternoon's program are anxious that the program proceed promptly at two o'clock as scheduled, so there will be no time for any lengthy summary of what has transpired today.

CHAIRMAN McGLONE (continued):

The Growing Problem of Aged May Overwhelm Us

Very briefly, it seems to me that there is common agreement that insofar as the aging and senile aged and chronically ill are concerned, this is a growing problem that must be tackled by our civilization, or it is one that is going to completely overwhelm us. It also seems to be brought out and agreed in by everyone that there are many, many organizations trying to cope with this problem, among them being private agencies, churches, fraternal organizations, local communities and State governments. From that, it seems that Dr. Harper's suggestion of some proper coordination between all of these activities is certainly a suggestion very soundly and very well taken.

State Co-ordinating Committee Needed

I think all of us having to do with health and welfare agencies, both in a public and private nature, are agreed that the day is here when these agencies all must let each other know what the other is doing so that each may properly co-ordinate their own efforts with the other, and if that requires a state co-ordinating committee, I think that that is the place to start.

I think also it was generally brought out, and there was general agreement among the speakers and the discussants that much can be done on the preventive side of this problem; that many people who otherwise would need custodial care or hospitalization can be assisted and probably prevented from reaching that stage if intelligently activated preventive measures are provided within their own community.

As to the over-all solution, it seems from what has been said that we are merely at a good starting point, probably not yet at the place of a second wind. No one has been able to say this categorically can be done or that categorically can be done. Whatever has been suggested -- and by the way, I am not talking about these smaller, yet very important steps of centers and things of that sort which have already proven themselves -- but as to any solution or meeting of the over-all problems, there seems to be as yet no common agreement, except that it is something that should be studied, surveyed, and something with which and concerning which we should all work together in whatever our respective capacities are.

I think for a brief summary, that does it. If any of you participants have anything to add to that brief summary, let's have it. Dr. Harper, you look as though you have a pertinent thought.

DR. HARPER: May I say just one word in support of Dr. Byron Johnson's very fine proposal? The American Women's Volunteer Society in Santa Barbara has developed the finest home for older people that I have ever seen. They are making it self-liquidating and expect to really have a little profit on less rental than even Dr. Johnson's suggested plan, and I thought if you knew of one that was in existence very similar to the plan he suggested, it would help to support his proposal.

CHAIRMAN McGLONE: I thought Dr. Harper was giving a type of glance towards me which said there was something left unsaid.

CHAIRMAN McGLONE (continued):

Not Tax Economy But Wise Expenditure of Tax Dollars Needed

I do feel, not as a summary of what has been said, but as a conclusion reached by me personally in listening to this problem and something that's been worrying me for some time, there seems to be a definite wave for tax economy, no matter what the cost. I think those of us who are interested in the welfare of the human beings that constitute the population of a community have to gauge tax costs by a measure other than just dollars. Those who are measuring tax costs in dollars for some reason or another seem to measure them even in the old-time dollars, and those old-time dollars purchased many times what the present dollars will purchase.

I think we have to re-orient our perspective insofar as tax dollars are concerned, and I think we have to re-define government economy insofar as tax spending is concerned. I think this problem is not going to be solved except with the assistance of government -- federal, state and local. If we are going to try to spend fewer dollars than was spent by government in 1940 or 1920, or 1913, we are not going to solve the problem. I think it's essential, if we are going to solve any of these problems in which government must be a participant, that we look upon a fine, economically operating government as a government which spends dollars wisely, gets a dollar's worth of value for every dollar spent, and does not waste a single penny. I think if we want government assistance in these programs, we have to take the lead and re-orient the thinking from the dollar itself into the dollar wisely spent and no money wasted.

I think that is all. We are dismissed until two o'clock.

... Whereupon, the session was concluded at 12:30 o'clock p.m. ...

* * * * * * * * * * *

RESOLUTIONS APPROVED BY THE RESOLUTIONS COMMITTEE
AND ADOPTED BY THE CONFERENCE

* * * * * * * * * * *

COMMENDATION OF THE THIRTY-NINTH GENERAL ASSEMBLY FOR ITS ACTIONS
RELATIVE TO FUNDS FOR HANDICAPPED CHILDREN AND
PENSIONS TO THE AGED IN STATE INSTITUTIONS

BE IT RESOLVED that the Governor's Conference on Colorado's Problems Relating to the Aged, the Mentally Ill, and the Mental Defectives, herewith declares that much progress has been made in recent years regarding the care and treatment of these classifications due to the intelligent and courageous stand taken by the General Assembly, particularly as it has acted in regard to increasing the appropriation of funds for the training of mentally retarded and other handicapped children in our public schools and in relation to legislation making it possible for pension funds to be granted to many persons in our State Institutions in order that they can, in turn, help pay part of the cost of their care provided by the State.

ADOPTED by the Conference.

* * * * * * * * * * *

REVISION OF STATUTES
RELATING TO THE MENTALLY ILL, THE INCOMPETENT AND THE INSANE

BE IT RESOLVED that this Conference recommends that the revision of State laws relating to the Mentally ill, Incompetent, and Insane, now being developed by the Committee on Mental Health of the Colorado Bar Association in cooperation with the Medical Profession and other groups, be completed for presentation to the General Assembly in 1955.

ADOPTED by the Conference.

* * * * * * * * * * *

DETERMINATION OF STATE AND COUNTY RESPONSIBILITY FOR CARE OF MENTAL DEFECTIVES

BE IT RESOLVED that this Conference recommend to Honorable Dan Thornton, Governor of the State of Colorado, that he call upon the General Assembly;

First: To declare a firm policy as to the respective responsibilities of State and County in regard to the provision of institutional facilities for the care, training, and education of mental defectives; and

Second: To take whatever legislative steps are necessary to relieve the several counties of the State from claims by the State for past services and care of mental defectives; and

Third: To establish a firm policy with regard to future liability, if any, of the counties for contributing to the cost of institutional care, training, and education of mental defectives whose families are unable to pay for such care.

ADOPTED by the Conference.

* * * * * * * * * * *

EVALUATION AND GUIDANCE CENTERS

BE IT RESOLVED that existing institutions and agencies, which have specialized services available, be encouraged to set up Guidance and Evaluation Centers to help the mentally retarded, the mentally ill, and the aging and aged to attack their problems realistically.

ADOPTED by the Conference.

* * * * * * * * * * *

ESTABLISHMENT OF A CONTINUING CITIZENS' COMMISSION

BE IT RESOLVED that this Conference recommend to the Governor and the General Assembly that a continuing Citizens' Commission be set up to study the problems -- tremendous in scope -- relating to Colorado's aged and aging, the mentally ill, the mentally retarded, and the mentally defective, item by item as they exist in the sixty-three counties of Colorado; and, also, to study either at first hand or by competent reports the programs of other States wherein real attempts are being made to solve the same problems; and, further, that this Commission report its findings at regular intervals to the Governor and the General Assembly.

ADOPTED by the Conference.

* * * * * * * * * * *

INCREASED SALARIES FOR PROFESSIONAL PERSONNEL

BE IT RESOLVED that salaries of professional and technical personnel, in State Institutions and Departments concerned with Mental Health, be increased to the extent necessary to assure adequate staffs; and that appropriations sufficient to accomplish this objective be provided.

ADOPTED by the Conference.

* * * * * * * * * * *

NURSING HOMES FOR THE AGED

BE IT RESOLVED that it is the recommendation of this Conference that our aged senile people be cared for, insofar as possible, in the family homes and in suitable nursing homes adjacent to general hospitals in the various communities of Colorado, reserving the State Hospital at Pueblo for those persons who require intensive psychiatric and related treatment; and

BE IT FURTHER RESOLVED that all private institutions, fraternal orders, and foundations interested, be encouraged to activate facilities in their communities throughout the State.

ADOPTED by the Conference.

* * * * * * * * * * *

COMBINATION HOSPITAL, RECEIVING AND ADMINISTRATION BUILDING FOR COLORADO STATE HOSPITAL, PUEBLO

BE IT RESOLVED that this January 1954 Conference recommend to the Governor and the General Assembly that a financing program be developed and approved which will assure the early construction of a combination Hospital, Receiving and Administration Building at the Colorado State Hospital at Pueblo, in order that the administrative operations of this large institution can be carried on more efficiently; in order that it can provide the necessary medical and surgical care and treatment for its more than 5,400 patients; and in order that it can rehabilitate more of the patients for discharge from the Hospital.

ADOPTED by the Conference.

* * * * * * * * * * *

THE STATE MILL LEVY AS A METHOD OF FINANCING BUILDINGS AND IMPROVEMENTS AT THE STATE'S INSTITUTIONS, INCLUDING THE MENTAL INSTITUTIONS

WHEREAS the State of Colorado, for a period of many years, has used a State Mill Levy on property as a method of providing funds for new buildings and improvements at all of the State's 22 institutions -- educational, penal, mental, and eleemosynary -- and the total of these levies is 1.07 mills; and

WHEREAS through this method, buildings and improvements have been made since the end of World War II at the State's mental institutions, as follows:

1. Construction of additional buildings and improvements to existing facilities at the State Home and Training School at Grand Junction at a cost of almost $1,000,000, thereby increasing the capacity of the institution by 225 beds to a total of approximately 685 beds in the institution at the present time;

2. Remodeling and improvements at the State Home and Training School, Ridge, costing $525,000, which have been completed and which provide approximately 104 more beds at the institution; thereby increasing its capacity to more than 400;

3. Construction of new buildings and facilities at the Colorado State Hospital which cost $5,691,000 and have given the Hospital 1,070 more beds to relieve overcrowding, temporarily, of the more than 5,400 patients there; and

WHEREAS the above improvements as well as new buildings and improvements at the State's other institutions have been financed by Colorado's taxpayers by means of these very modest continuing mill levies over a period of several years; now, therefore

BE IT RESOLVED that this Conference recommend to the Governor and the General Assembly that, until a sounder plan is developed by the State, if that can be accomplished, the State continue to rely on the State mill levy for financing the construction of buildings and improvements at all of the State's institutions, including its mental institutions.

ADOPTED by the Conference.

* * * * * * * * * * *

RESOLUTIONS SUBMITTED FROM THE FLOOR
AND ADOPTED BY THE CONFERENCE

* * * * * * * * * * *

INCREASED APPROPRIATION FOR SPECIAL EDUCATION CENTERS IN COLORADO

BE IT RESOLVED that this Conference recommend to the General Assembly that it appropriate a sufficient amount of money to support Special Education Centers in the Public Schools throughout Colorado in order that the thousands of mentally retarded children, who are now neglected because of inadequate and inappropriate educational facilities, can receive proper training, and in order that all school districts which establish such Special Education Centers can be reimbursed for the excess costs of such educational programs.

ADOPTED by the Conference.

* * * * * * * * * * *

W. K. KELLOGG FOUNDATION GRANT OF $43,860

BE IT RESOLVED that this Conference express its sincere appreciation to the W. K. KELLOGG FOUNDATION of Battle Creek, Michigan, for its grant of $43,860 to the Colorado State Department of Public Health for the purpose of financing a three-year study of the problems of Chronic Illness, Aging, and Rehabilitation in Colorado, which study is now in progress under the direction of a specially appointed State Advisory Committee of 24 members selected by the State Board of Health and its Executive Director.

ADOPTED by the Conference.

* * * * * * * * * * *

TO GOVERNOR DAN THORNTON AND CONFERENCE PARTICIPANTS

BE IT RESOLVED that this Conference express its sincere appreciation to Governor Dan Thornton for calling this important Conference and to the many participants who have contributed so generously to its discussions and deliberations.

ADOPTED by the Conference.

* * * * * * * * * * *

RESOLUTIONS COMMITTEE
FOR THE
GOVERNOR'S CONFERENCE

MILT ANDRUS, Chairman, Manager, Pueblo Chamber of Commerce; Vice-chairman, Committee on Mental Health, State Planning Commission

WILLIAM F. McGLONE, Vice-chairman, Attorney, Denver; President, Colorado State Board of Health

DR. ROY L. CLEERE, Executive Director, State Department of Public Health

DR. WARD DARLEY, President, University of Colorado

HUBERT D. HENRY, Attorney, Denver; President, Denver Public Health Council

DR. LYNWOOD HOPPLE, Director of Mental Hygiene, State Department of Public Health

GEORGE M. KIRK, Pueblo, Manager of Employees' Service Department, Colorado Fuel and Iron Corporation; General Chairman of the Conference

DR. BRADFORD MURPHEY, Denver Psychiatrist; Past President, Denver Area Welfare Council

WILLIAM HEDGES ROBINSON, JR., Chairman, Executive Committee on Mental Health of the Colorado Bar Association

DR. CHARLES A. RYMER, Denver Psychiatrist, Associate Clinical Professor of Psychiatry, University of Colorado School of Medicine

ROCCO SANTARELLI, Sapinero, Chairman, Committee on Mental Health, Colorado State Planning Commission

MRS. PAUL V. THOMPSON, Boulder; League of Women Voters of Colorado

MISS JANE WOODHOUSE, Assistant City Attorney, City and County of Denver; President, Colorado Association for Mental Health, Inc.

W. M. WILLIAMS, Director, Colorado State Planning Commission

* * * * * * * * * * *

Secretarial Services for the Conference
Provided by the Staffs
of the
COLORADO STATE PLANNING COMMISSION
and the
COLORADO STATE DEPARTMENT OF PUBLIC HEALTH

* * * * * * * * *

GOVERNOR'S CONFERENCE ON THE MENTALLY ILL, THE AGED, AND THE RETARDED

JANUARY 4 AND 5, 1954

Alphabetical list of Registrants, compiled as accurately as possible from registration records.

ODVEN J. AAKRE, El Paso County Department of Public Welfare, Colorado Springs
SIMON ABRAHAMS, M.D., Acting Chief, Chronic Disease Section, Department of Public Health, Denver
MRS. DOROTHY C. ADAMS, Medical Social Consultant, State Public Welfare, Denver
MRS. VIOLET ADAMS, Denver
HARRY A. ALLEN, Principal, Las Animas Public Schools, Las Animas
GORDON L. ALLOTT, Lieutenant Governor, State of Colorado, Lamar
JOHN H. AMESSE, M.D., Physician, Denver
CYRUS W. ANDERSON, M.D., Chairman, Legislative Committee, Colorado State Medical Society, Denver
MRS. MARY L. ANDREWS, Adult Education Council, Denver
RAY C. ANDREWS, Assistant Director, State Planning Commission, Denver
MILT ANDRUS, Manager, Chamber of Commerce, Pueblo
ELIZABETH K. ARP, Denver Department of Welfare, Denver
H. O. ASHTON, County Judge, Boulder
MRS. JOHN ATKINSON, Chairman, Public Affairs, American Association of University Women, Denver
L. C. AUSTIN, Board of County Commissioners, Boulder

MARY-ETHEL BALL, Dean of Women, University of Colorado, Boulder
LEWIS BARBATO, M.D., Psychiatrist, Denver
THOMAS BARTLEY, Personnel Director, Colorado State Hospital, Pueblo
JOHN W. BARTRAM, Assistant to President, University of Colorado, Boulder
LOUISE A. BASHFORD, Social Worker, Denver
R. Y. BATTERTON, Board of Directors, Wallace School, Denver
MARTIN D. BAUM, M.D., Veterinary Section, State Dept. of Public Health, Denver
MRS. WAYNE BEATTIE, Colorado League of Women Voters, Boulder
MARGARET E. N. BEAVER, M.D., Director, Mesa Co. Dept. Public Health, Grand Junction
MRS. J. D. BERWICK, American Association of University Women, Denver
E. G. BILLINGS, M.D., President, Colorado Neuro-Psychiatric Society, Denver
E. L. BINKLEY, M.D., Director, Cerebral Palsy Clinic, Children's Hospital, Denver
CHARLINE BIRKINS, Director, Denver Department of Welfare, Denver
MRS. JAMES E. BLUE, American Association of University Women, Denver
C. S. BLUEMEL, M.D., Psychiatrist, Denver
MRS. C. S. BLUEMEL, American Association of University Women, Denver
CLAUDE D. BONHAM, M.D., President, Colorado State Medical Society, Denver
MRS. KATHERINE BRANNING, Grand Junction
HAROLD K. BRASELL, Exec. Ass't., Children's Speech Clinic, Univ. of Denver, Denver
CHARLINE BRIDWELL, Social Worker, State Industrial School for Boys, Golden
J. PRICE BRISCOE, Director, Department of Public Institutions, Denver
DAVID BROFMAN, County Judge, Denver
A. A. BROWN, Secty., Colorado Association of School Administrators, Littleton
JOHN R. BROWNE, State Representative, Jefferson County
ARTHUR BUELL, Mayor pro Tem., Golden
MRS. ROSALIE S. BUNGE, Board of Control, State Industrial School for Girls, Denver
NATT B. BURBANK, Superintendent of Schools, Boulder
ELMER L. BURKHARD, Superintendent, Sterling Public Schools, Sterling
NORRIS F. BUSH, Director, Special Education, Denver Public Schools, Denver
ELDON BUTLER, State Representative, Ramah

BLANCHE CALDWELL, Consultant, State Department of Public Welfare, Denver
HELEN CANNON, Chief, Social Service Section, Department of Public Health, Denver
MRS. ELIZABETH M. CARLSON, State Planning Commission, Denver
MRS. ELEANOR CARR, State Representative, Denver
BERNARD B. CARRAHER, Director, Colorado Association for Mental Health, Denver
VERNON A. CHEEVER, State Senator, Colorado Springs
MRS. GLEN E. CHELEY, President, Denver Branch, American Association of University Women, Denver
MARK R. CLAY, State Representative, Hotchkiss
ROY L. CLEERE, M.D., Executive Director, State Dept. of Public Health, Denver
RUTH COHIG, Medical Social Consultant, State Dept. of Public Health, Denver
MRS. FRANK COLCORD, Christian Business Committee, Denver
REGINA L. COLLINS, Supervisor, Social Work, Denver Public Schools, Denver
MRS. ROBERT COLWELL, Denver
E. C. COMSTOCK, Director, State Board for Vocational Education, Denver
W. R. CONTE, M.D., Psychiatrist, Greeley
L. M. COOLEY, Chairman, State Planning Commission, Denver
GERTRUDE COPLEY, Denver
PEARL PARVIN COULTER, Professor of Public Health Nursing, Univ. of Colo., Boulder
MRS. BLANCHE COWPERTHWAITE, American Association of University Women, Denver
NEVA CRAIG, Personnel, U. S. National Bank, Denver
RUTH K. CRAWFORD, Exec. Secty., Child Welfare Committee, American Legion, Denver
MARIE A. CREIGHTON, Chairman, Dept. of Welfare, Colo. Fed. of Women's Clubs, Denver
RAE CROWNER, OAP Supervisor, Denver Department of Welfare, Denver
THOMAS W. CUMMINS, Denver
MARGARET CURRY, State Parole Officer, Denver

RUTH DALTON, Aurora
REVEREND DALE DARGITZ, Director, Social Service Dept., Denver Council of Churches, Denver
WARD DARLEY, M.D., President, University of Colorado, Boulder
JUDITH DAVIDSON, Supervising Nurse, Northeast Colorado Health Dept., Sterling
CHARLES H. DAVIS, Superintendent of Schools, Pueblo
MICHAEL DI NUNZIO, Representative, State, County & Municipal Employees, (A.F. of L.)
MRS. MADOLIN DICKINSON, Professor, School of Nursing, Univ. of Colo., Boulder
NEAL DILLEY, State Representative, Kersey
BERNICE DI SESSA, Nursing Director, State Department of Public Health, Denver
JOHN DOOLEY, County Judge, Greeley
ROBERT A. DOWNS, M.D., Director, Preventive Medical Services, State Department of Public Health, Denver
THOMAS B. DOHERTY, Administrative Assistant, Public Schools, Colorado Springs
H. L. DOTSON, Vice-President, Colorado A and M College, Fort Collins
CHARLES G. DOWLING, Business Manager, Colorado State Hospital, Pueblo
CAREY J. DOWNING, Director, Special Education, State Dept. of Education, Denver
PAUL DOZIER, M.D., Greeley
VICTOR E. DUERKSEN, Assistant Administrator, Porter Hospital, Denver
DAVID R. L. DUNCAN, M.D., Medical Director, Tri-County Health Department, Denver
DONALD P. DUNKLEE, State Senator, Denver
EDWARD V. DUNKLEE, President, United Nations Chapter, Denver
JOHN T. DUNLAP, Assistant Superintendent of Schools, Pueblo

FRANKLIN G. EBAUGH, M.D., Psychiatrist, Denver
MRS. JOHN F. EHRHART, President, League of Women Voters of Denver, Denver
E. A. ELLIFF, M.D., State Senator, Sterling
CHARLOTTE ELLIOTT, Public Health Nurse, Denver

ALICE S. FAIRCHILD, Board of Control, State Industrial School for Girls, Boulder
STAN FELLERS, Director, Public Relations, Colo. Tuberculosis Ass'n., Denver
MRS. HERMAN FEUCHT, Wheatridge
LEONARD H. FISHER, JR., Regional Director, United Cerebral Palsy Ass'n., Denver
EDWARD FISKE, County Attorney, Sedalia
LLOYD FLORIO, M.D., Manager, Health and Hospitals, Denver
MRS. L. C. FORD, Boulder
FRED FRAGNER, Director, Social Service, J.C.R.S. Hospital, Spivak
SIDNEY J. FRAZIER, Consultant, State Planning Commission, Denver
C. A. FREDRICKSON, Fremont County Judge, Canon City
MRS. C. A. FREDRICKSON, Welfare Chairman, State Fed. of Women's Clubs, Canon City
PIERPONT FULLER, Board of Control, Colorado Childrens' Home, Denver

MARJORIE GALLAHER, Ass't. Exec. Secretary, Denver Area Welfare Council, Denver
BERT GARMAN, County Attorney, Holyoke
HERBERT S. GASKILL, M.D., Professor of Psychiatry, University of Colorado Medical School, Denver
MRS. HERBERT S. GASKILL, Teacher, Denver
G. H. GILBERT, M.D., Member, Colorado State Board of Health, Arvada
FRANK L. GILL, State Senator, Hillrose
E. ELLIS GRAHAM, Chairman, Clinical Services & Special Education, University of Denver, Denver
JANET E. GRAUBERGER, Logan County Superintendent of Schools, Sterling
MRS. CARLETON GRIFFITH, Student Supervisor, Denver Welfare Department, Denver

MRS. HOWARD L. HACKSTAFF, President, Board of Control, Industrial School for Girls, Denver
MRS. BYRON B. HALL, Board of Directors, Wallace School, Denver
ROBERT M. HALL, Assistant Superintendent, Brighton
R. C. HANSEN, Administrative Ass't., State Home & Training School, Ridge
EMMA HARLING, Mental Health Nursing Consultant, State Health Department, Denver
MRS. G. C. HARMAN, Denver
HEBER HARPER, M.D., Retired, Denver
SHELBY F. HARPER, Director, Legislative Council, Denver
FRED H. HARTSHORN, M.D., Member, State Board of Health, Denver
FRED W. HAWKINSON, Washington County Hospital, Akron
FRANK L. HAYS, State Representative, Denver
E. P. HAZARD, State Senator, Saguache
JEANNE HEETDERKS, Psychiatric Nurse, Denver
BERTHA HEID, Adams County Superintendent, Brighton
GLADYS R. HEIKENS, Supr., Public Health Nursing, Weld Co. Health Dept., Greeley
MARTHA HEMPEL, Director, Psychiatric Social Service, University of Colorado Medical Center, Denver
CARL W. HENRY, Member, State Board of Health, Greeley
MRS. CARL W. HENRY, Greeley
HUBERT D. HENRY, Chairman, Health Division, Denver Area Welfare Council, Denver
REVEREND C. S. HIGBY, Boulder
M. C. HINDERLIDER, State Engineer, Denver
J. E. HINDS, Executive Assistant, State Home and Training School, Ridge
W. C. HINKLEY, Superintendent of Schools, Aurora
DON T. HOLLADAY, Psychiatric Social Worker, Denver General Hospital, Denver
LYNWOOD M. HOPPLE, M.D., Chief, Mental Health Section, State Department of Public Health, Denver
J. HOROWITZ, M.D., Department of Health and Hospitals, Denver
LEAH HOROWITZ, Denver
MRS. FANNY HOUTZ, Psychiatric Case Worker, Dept. of Health & Hospitals, Denver

RUTH B. HOWARD, M.D., Director, Maternal & Child Health, State Department of Public Health, Denver
SAMUEL G. HOWARD, Director, Wallace School, Denver
MRS. ANN BAYLEY HUSTON, Denver

NANCY JAGGARD, Group Work Consultant, State Child Welfare, Denver
AVERILL JOHNSON, Member, Civil Service Commission, Denver
BETTY JOHNSON, Denver
BYRON L. JOHNSON, Associate Professor of Economics, Univ. of Denver, Denver
MRS. CLYDA M. JOHNSON, Nursing Consultant, State Dept. of Public Health, Denver
MRS. NELLIE S. JOHNSON, Denver

H. W. KASSEL, M.D., Medical Health Officer, Public Health Service, Denver
R. MALCOLM KEIRY, State Representative, Monte Vista
FLOYD W. KELLEY, Greeley Police Department, Greeley
FRANK E. KENDRICK, JR., State Representative, Leadville
W. V. KENNETT, Elbert County Judge, Kiowa
EMMA M. KENT, M.D., Director, Mental Health Services, Department of Health & Hospitals, Denver
EVELYN D. KING, County Superintendent of Schools, Kiowa
GEORGE M. KIRK, Manager, Employees' Service Dept., C. F. & I. Corp., Pueblo
K. V. KNIPER, M.D., Medical Director, Bethesda Hospital, Denver
MRS. CLAYTON D. KNOWLES, Denver
MONSIGNOR ELMER J. KOLKA, Associate Director, Catholic Charities, Denver

MRS. B. D. LANDES, Chairman, Round Table, American Association of University Women, Denver
MRS. JESSICA LEE, Denver
GRAYCE LEYDEN, Board Member, Girls' Industrial School, Denver
JOHN A. LICHTY, M.D., Pediatric Consultant, State Dept. of Public Health, Denver
WILLIAM A. LIGGETT, M.D., Denver
MARIAN LOCKWOOD, Morgan County Superintendent of Schools, Fort Morgan
WALTER E. LOCKWOOD, Project Director, State Dept. of Public Health, Denver
ARTHUR LOWTHER, City Manager, Golden
MRS. PAUL LUETTE, Associate Professor of Psychology, Univ. of Denver, Denver
REVEREND ALEX LUKENS, Rector, St. Barnabas Episcopal Church, Denver

R. P. MacLEISH, Director, Hospital Standards & Consultation Services, Denver
LUCILE H. MAHANNAH, County Superintendent of Schools, Grand Junction
FRANCIS R. MANLOVE, M.D., Director, Univ. of Colo. School of Medicine, Denver
MIRIAM MARTENSEN, County Superintendent of Schools, Golden
C. E. MARTIN, County Superintendent of Schools, Colorado Springs
MRS. T. P. MASLIN, League of Women Voters, Boulder
HELEN MASON, Medical Social Consultant, State Dept. of Public Health, Denver
REVEREND MARTIN E. MAYER, Lutheran Service Society, Denver
MRS. C. T. McCONNELL, Board Member, Colo. Association for Mental Health, Greeley
WILLIAM McFETRIDGE, Property & Supply Officer, State Home & Training School, Ridge
WILLIAM F. McGLONE, President, State Board of Health, Denver
AVESTA McGONEGAL, Child Welfare Worker, La Junta
PARNELL McLAUGHLIN, Rehabilitation Staff, Dept. of Vocational Education, Denver
MRS. RECTOR F. McNAUGHT, Denver
ELLA A. MEAD, M.D., Weld County Health Department, Greeley
FRANK MEAKER, State Representative, Montrose
ALBERT R. MENARD, JR., Associate Professor of Law, Univ. of Colorado, Boulder
LEVETTE MENDEL, Director, Health Education, Dept. of Health & Hospitals, Denver
ANNA MIDDLEBROOK, Director, Public Welfare, Akron

MRS. C. H. MILLER, Board Member, Colorado Association Mental Health, Denver
CRAIG P. MINEAR, Executive Secty., Colorado Education Association, Denver
HERBERT D. MOE, Director, Hospital Facilities Section, State Department of Public Health, Denver
MARTIN C. MOLHOLM, State Senator, Lakewood
REVEREND WILLIAM MONAHAN, Catholic Charities, Denver
RALPH P. MONELL, Superintendent, Canon City Schools, Canon City
VERY REVEREND MONSIGNOR JOHN R. MULROY, Director, Catholic Charities, Denver
BRADFORD MURPHEY, M.D., Psychiatrist, Denver
ALTA MURRAY, American Legion Auxilliary, Denver

FRITZ A. NAGEL, Board of Control, Colorado Childrens' Home, Denver
QUIGG NEWTON, Mayor, Denver

MRS. BRETA O'ROURKE, State Department of Revenue, Denver
EDWARD OSHIER, Emily Griffith Opportunity School, Denver
ED OWENS, Supervisor, Catholic Charities, Denver

S. T. PARSONS, State Representative, La Jara
MRS. BELSONIA PAUL, Psychiatric Social Worker, Colorado Springs
MRS. CLAUDE E. PEAVY, Legislative Chairman, American Association of University Women, Denver
MRS. ELIZABETH E. PELLET, State Representative, Rico
MRS. GLEN W. PENNOCK, County Superintendent of Schools, Boulder
JOHN F. PERO, Director, Recreation & Social Service, State Home and Training School, Ridge
ANNA C. PETTEYS, Member, State Board of Education, Sterling
NORMA PFRIMMER, Orthopedic Nursing Consultant, State Health Department, Denver
T. H. PICKENS, Superintendent of Schools, Las Animas
ELEANOR J. PINGREY, Supervisory Nurse, Otero County Health Department, La Junta
MRS. SHERMAN S. PINTO, Denver
GUY POE, State Representative, Holyoke
MRS. LOUIS POLLOCK, Denver Area Welfare Council, Denver
MISS BETTY PORTNER, Superintendent, Girls' Industrial School, Morrison
ELSIE SEELYE PRATT, M.D., Physician, Denver
CARL PRIOR, Coordinator, Emily Griffith Opportunity School, Denver
DORA PURCHARD, M.D., Consulting Psychologist, Denver
HELEN M. PURINTON, Denver Area Welfare Council, Denver

RUTH J. RAATAMA, M.D., Director, Maternal & Child Health, Denver Health and Hospitals, Denver
GLADYS RAY, Public Health Nurse, State Health Department, Denver
ROGER H. REID, Assistant Director, Wallace School, Denver
MRS. ALMA RENNIE, State Department of Public Health, Denver
MAXINE A. RENTFRO, Denver
MRS. EUGENE REVELLE, Chairman, Colo. Citizens Comm. on Children & Youth, Denver
VERGYL H. REYNOLDS, President, County Attorney's Association of Colo., Boulder
H. E. RICE, Hospital Administrator, Porter Sanitarium & Hospital, Denver
DORSEY RICHARDSON, State Supervisor, Vocational Rehabilitation, State Department of Vocational Education, Denver
ELEANOR L. RICHIE, Research Consultant, State Dept. of Public Health, Denver
GLENN RIPPEN, Board of Control, Trinidad
C. O. ROBERTS, M.D., Director, Boulder City-County Health Department, Boulder
GERTRUDE ROBERTS, R.N., Technical Consultant, Hospital Facilities Section, State Department of Public Health, Denver
PAUL ROBERTS, Dean, St. John's Cathedral, Denver

WILLIAM H. ROBINSON, JR., Chairman, Colorado Bar Association Committee, Denver
LAURENCE S. ROGERS, Chief Clinical Psychologist, Denver Mental Hygiene Unit, Denver Veterans' Administration, Denver
RANGER ROGERS, State Senator, Arapahoe County
MRS. HILDA ROSS, Rocky Mountain Council on Family Relations, Denver
MRS. JAN RUHTENBERG, Chairman, Finance Committee, Colorado Mental Health Association, Colorado Springs
CHARLES A. RYMER, M.D., Psychiatrist, Denver

KENT L. SANBORN, Superintendent of Schools, Longmont
ROCCO SANTARELLI, Member, State Planning Commission, Sapinero
RIKKI SANTARELLI, Sapinero
MRS. R. A. SANTARELLI, Sapinero
MRS. ALLEGRA SAUNDERS, Member, State Board of Education, Denver
NORA S. SCOTT, Gilpin County Superintendent of Schools, Central City
WILLIAM T. SECOR, Chairman, Child Welfare, American Legion, Denver
DICK SHAVER, Director, Northeast Colorado Health Department, Sterling
MRS. LEON A. SHELTON, Denver
JACOB L. SHERMAN, Attorney, Denver
L. V. SIMMONS, Superintendent of Schools, Rocky Ford
CLARK J. SIMON, El Paso County Judge, Colorado Springs
MARY SIMONSON, Denver
A. W. SIMPSON, Rehabilitation Staff, State Dept. of Vocational Education, Denver
MARIE C. SMITH, Director, Child Welfare Division, State Dept. of Public Welfare, Denver
G. F. SOELBERG, Superintendent, Boys' Industrial School, Golden
A. H. SPARKS, State Representative, Canon City
PAULINE G. STAATS, M.D., Englewood Public Schools, Englewood
WALTER R. STALKER, State Representative, Kirk
C. E. STANFIELD, M.D., Chairman, Sub-Committee - Mental Health, Colorado State Medical Society, Denver
MARY LOU STEPHENSON, Psychiatric Social Worker, Univ. of Colorado, Boulder
MARY N. STEPHENSON, Director of Public Assistance, State Dept. of Public Welfare, Denver
L. T. STIFFINGTON, State Representative, Manitou Springs
JOHN C. STODDARD, Director, Board of Standards of Child Care, Denver
MRS. GLADYS STOREY, State Department of Public Health, Denver
HAL A. STOREY, Director, Colorado Highway Safety Council, Denver
MARION V. STORTZ, Juvenile Bureau, Denver Police Department, Denver
L. P. STRAIN, State Senator, La Junta
A. C. SUDAN, M.D., Superintendent, State Home & Training School, Grand Junction
R. BRUCE SULLIVAN, State Senator, Durango
REYNOLD SWANSON, Coordinator, Longmont Public Schools, Longmont

WILLIAM Y. TAKAHASHI, M.D., Boulder
J. P. TATUM, Superintendent, Myron Stratton Home, Colorado Springs
MRS. RENA MARY TAYLOR, State Representative, Palisade
MARY E. TERRIERE, Clerk, Morgan County Court, Fort Morgan
MRS. KATE S. TESKEY, Case Work Supervisor, State Dept. of Public Welfare, Denver
JAMES S. THOMAS, Warden, State Reformatory, Buena Vista
MRS. PAUL V. THOMPSON, League of Women Voters, Boulder
EARL TOWNING, Assistant Chief of Police, Greeley Police Department, Greeley
MARIANNE TROUTMAN, Occupational Therapist, Colorado Springs
E. S. TURRELL, M.D., Medical Director, Colo. Psychopathic Hospital, Denver
W. E. TYLER, Member, Civil Service Commission, Denver

OTTO UNFUG, Mayor, Sterling

CLARENCE VAN DEREN, Community Chest, Denver
IVY B. VAN ETTEN, Exec. Secty., Colo. Citizens Committee on Children & Youth, Denver
REVEREND CLARENCE VAN HEUKELOM, Chaplain, Bethesda Sanitarium, Denver
H. RICHARD VAN SAUN, Professor of Psychology, Colorado College, Colorado Springs
FRANKLIN C. VAUGHN, Education Director, Colo. Assoc. for Mental Health, Englewood
BEN VELTRI, State Senator, Trinidad
EUGENE H. VERVALIN, United Cerebral Palsy Assoc. of Colorado, Denver
H. GRANT VEST, State Commissioner of Education, Denver
LLOYD L. VOIGHT, Assistant Director, State Parole Department, Greeley

CLEO S. WALLACE, Director, Wallace School, Denver
MRS. SALMA A. WATERS, State Planning Commission, Denver
FRANK J. WEBER, M.D., Regional Medical Director, U. S. Public Health Service, Denver
WILLIAM WEIDMAN, Rehabilitation Staff, State Dept. of Vocational Education, Denver
ERNEST WEINLAND, State Representative, Loveland
ORVILLE A. WELLER, President's Round Table, Public Service Company, Denver
WILLIAM R. WELSH, President, Civil Service Commission, Denver
LOUIS C. WERTZ, State Representative, Center
MRS. CHARLES WESKAMP, Health Chairman, Colo. Federation of Womens Clubs, Denver
FRANKLIN P. WHERRY, M.D., Chairman, Mental Health Committee, Denver
MARIE WICKERT, Consultant, State Department of Public Health, Denver
LAURA A. WILCOX, Case Worker, Travelers' Aid Society, Denver
PAUL M. WILLIAMS, State Representative, Ordway
W. M. WILLIAMS, Director, State Planning Commission, Denver
W. GILBERT WISE, Executive Director, Lutheran Service Society, Denver
MRS. V. E. WOHLAUER, Brush
LYLE L. WOODFIN, M.D., Chief, Neuropsychiatric Service, Veterans Hospital, Denver
JANE WOODHOUSE, Assistant City Attorney, Denver
A. M. WYATT, State Representative, Durango

F. H. ZIMMERMAN, M.D., Superintendent, Colorado State Hospital, Pueblo
RABBI JOEL Y. ZION, Temple Emanuel, Denver

Date Due

Griffith			
AG 4 '55			
Tinsley			
FE 23 '59			
Capen			
July 20			
Hanson			
AG 2 '61			